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Ministry of Health

NATIONAL VIOLENCE PREVENTION AND RESPONSE PROTOCOL

A MEANS TO ENHANCING HIV PREVENTION AMONG KEY POPULATIONS

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NATIONAL VIOLENCE PREVENTION AND RESPONSE PROTOCOL

A protocol to provide guidance on responding to and preventing violence against key populations in Kenya, and to increase their access to HIV prevention and care services

July 2017

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Foreword

The Government of Kenya, through the Ministry of Health has made significant strides in combating HIV and AIDS in the country. The National AIDS Control Council (NACC) and National AIDS and STI Control Program (NASCOP), which are the institutions mandated to spearhead the fight against HIV and AIDS, have come up with policies, strategies and programs to ensure achievement of the same. The Kenya AIDS Strategic Framework 2014/15-2018/19 (KASF) takes cognisance of violence, stigma and discrimination as some of the key barriers to accessing HIV service. Key populations (KPs) have been identified as priority populations for HIV prevention in the country.

Violence, HIV and AIDS are mutually reinforcing. Violence against KPs is a proven risk factor for HIV acquisition and is a human rights violation. Women KPs, especially young women including female drug users, female sex workers (FSW) and transgender women, experience high rates of violence. According to the Polling Booth Survey (PBS) 2015, 49% FSW, 26% (MSM) men who have sex with men (MSW) male sex workers and 43% (PWID) People Who Inject Drugs reported experiencing violence from different perpetrators including the police and county 'askaris'. A stigma index survey spearheaded by NACC and other stakeholders in 2014 revealed that sex workers face disproportionately higher levels of stigma, in society and public institutions, including health facilities.

There is an urgent need to put in place proactive measures to prevent and respond to the high incidence of violence affecting KPs in Kenya. NACC and NASCOP have supported such measures by developing various policies and guidelines. The Key Population National Technical Working Group (KP-NTWG) has set up a sub-committee on advocacy to address issues of violence, stigma and discrimination among key populations. In line with the KASF and the policy for the prevention of HIV infections among key populations in Kenya, several counties have already set up Key Population County Technical Working Groups (KP-CTWG) and others are in the process of establishing them. These platforms at national and county level will spearhead the structural interventions and support the implementing agencies, research agencies and other partners who provide services to KPs.

This document has been developed out of the increasing need to set up standards and procedures to prevent and respond to violence against key populations. In line with Strategic Direction 3 of the KASF, responding to violence will address some of the key structural barriers, and increase access to HIV services, among key populations in Kenya.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CAB	Community Advisory Board
CBO	Community-based Organization
CRF	Case Record Form
CSO	Civil Society Organization
DIC	Drop-in Centre
FSW	Female Sex Workers
GBV	Gender-based Violence
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HPP	Health Policy Project
HRN	Harm Reduction Network
IAVI	International AIDS Vaccine Initiative
IBBS	Integrated Bio-Behavioural Survey
IEC	Information Education Communication
IP	Implementing Partner
IPC	Inter-Personal Communication
IPV	Intimate Partner Violence
KASF	Kenya AIDS Strategic Framework
KNASP	Kenya National AIDS Strategic Plan
KPs	Key Populations
KPMRF	Kenya Police Medical Report Form
KP-TSU	Key Populations Technical Support Unit
KP-CTWG	Key Populations County Technical Working Groups
KP-NTWG	Key Populations National Technical Working Groups
LE	Law Enforcers
MOT	Modes of Transmission
MSM	Men who have Sex with Men
MSW	Male Sex Workers
NACC	National AIDs Control Council
NASCOP	National AIDs and STI Control Programme
NGO	Non-Governmental Organization
NPTs	New Prevention Tools/ Technologies
ORW	Outreach Workers
PBS	Polling Booth Survey
PE	Peer Educators
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PRCF	Post Rape Care Form
PrEP	Pre-Exposure Prophylaxis
PTSD	Post Traumatic Stress Disorder
PWID	People who Inject Drugs
RC	Research Centre
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
SRH	Sexual & Reproductive Health
SW	Sex Workers
TOTs	Training of Trainers
TG	Trans-gender
WHO	World Health Organization
WWID	Women who Inject Drugs
UN	United Nations

Definition of Terms

Alternative Dispute Resolution
includes dispute resolution processes and techniques that act as a means for parties in disagreement to come to an agreement short of litigation. It is a collective term for the ways in which parties can settle disputes, with (or without) the help of a third party.

Direct Service Providers
individuals who provide outreach, counseling, psychological, medical, legal, or other types of support services to KPs. These providers could be working in services managed by government or non-government organisations (NGOs).

First-line Support
includes active listening, the provision of key messages and information on rights, safety planning, and referrals to other services to victims of violence.

Gender
is a culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements and obligations, associated with being female and male, as well as the power relations between and among women and men, and boys and girls. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, age and sexual orientation. All individuals, regardless of their gender identity, are subject to the same set of expectations and sanctions (IGWG, 2014).

Hotspot
is a geographical area where KPs live, work, solicit, cruise or use drugs.

Implementing Partners (IP)
are the institutions and/or agencies that implement a project/s with KPs in partnership with the national programme.

Key Populations (KPs)
are population groups that, due to specific higher risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social barriers that increase their vulnerability. The Kenya AIDS Strategic Framework (KASF) 2014/15- 18/19 focuses on three sub-populations: FSW, MSM and PWID.

Men who have Sex with Men (MSM)
describes males who engage in sexual and/or romantic relations with other males. The term encompasses the large variety of settings and contexts where male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities/orientation and various identifications with any particular community or social group. MSM in Kenya also reflect a range of sexual and gender identities while many also have sex with women.

People who Inject Drugs (PWID)
refer to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include but are not limited to opioids, amphetamine - type stimulants, cocaine, hypno-sedatives and hallucinogens. Injections may be through intravenous, intramuscular, subcutaneous, or other injectable routes.

Perpetrator
a person, group, or institution that inflicts, supports, or condones violence or other abuse against a person or a group of persons.

Protocol
is a system of rules that explain the formal conduct and procedures to be followed in specific situations. Under this context, a Protocol includes principles and procedures to be followed while responding to violence against KPs by state or non-state actors.

Research Agencies/Partners
are institutions, clinical research centers, and service provision centers that conduct research (e.g. HIV prevention research) with and/or in partnership with KPs, NACC, and NASCOP and other funders or partners operating in Kenya.

Research Centres
refer to designated research facilities that conduct research e.g. New Prevention Technologies (NPTs) with KPs.

Sex Workers (SW)
include consenting female, male and transgender adults - as well as young people over the age of 18 years who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, and it can take many forms and varies between and within countries and communities.

Survivor
is a person who withstands, remains standing after an attack e.g. physical or psychological, especially a person surviving and/or enduring an occurrence and/or omission of an event in which others have not. A survivor is a person who carries on despite hardships or trauma of the violation.

Victim
is a person harmed, injured, or killed as a result of violence, crime, accident, or other event or action. The terms 'victim' and 'survivor' are often used when referring to an individual who has experienced violence. These terms are sometimes used interchangeably. Ultimately, it should be up to the individual who experienced violence to determine how to identify him/herself. Some people who have experienced violence and abuse choose to describe themselves as victims - someone who has been violated or abused - someone who has been victimized. They feel they are victims of a crime or other human rights violation. Others prefer to be identified as survivors. They feel this is an empowering term that implies strength and resilience.

Violence
is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences, sexual orientation/ behaviour and social behaviour or other practices.

A P3 Form
is a Kenya Police Medical Report Form, used by the police. Simply put, the P3 form acts as evidence that a violent act occurred and is therefore referred to as an 'Exhibit' in court. The P3 form must be handled as evidence at all times.

Post Rape Care Form (PRCF)
is an examination documentation form for survivors of rape/sexual assault (to be used as clinical notes to guide filling in of the P3 form).

CHAPTER 1

Introduction

1 Introduction

Kenya has the joint fourth-largest HIV epidemic in the world (along with Mozambique and Uganda) in terms of the number of people living with HIV[1]. There is a mixed and geographically heterogeneous HIV epidemic with an estimated adult HIV prevalence of 5.9%[2]. However, in recent years several research studies have identified concentrated epidemics among certain groups who are particularly vulnerable to HIV transmission. The government's current HIV and AIDS strategy- the Kenya AIDS Strategic Framework 2014/2015 - 2018/2019 (KASF) acknowledges this, describing the epidemic as 'deeply rooted among the general population' alongside 'concentration of very high prevalence among key populations.'[3]

Country-wide mapping conducted by NASCOP in 2012 shows that Kenya has a high number of KPs. The KASF identifies KPs as one of the priority populations for HIV prevention, and defines them (the KPs) as MSM; PWID and SW. The Modes of Transmission study conducted by NACC in 2009 revealed that 33% of all new infections in the country are attributed to KPs. HIV prevalence among KPs is high - 29.3% FSW, 18.2% MSM and 18.7% PWID. Mapping conducted in 2012 estimates that the number of KPs in Kenya is high.

Interventions for KP groups have already been initiated in many counties with funding support from PEPFAR and The Global Fund since their prioritization in the Kenya National AIDS Strategic Plan III (KNASP III). NACC and NASCOP have developed policies, guidelines and strategy documents to clearly define the country's position and plans to continue working with KPs in the HIV response across the country, e.g. there are 81 interventions with KPs spread over 33 counties which report to NASCOP on a regular basis. The annual behavioural surveys conducted using Polling Booth Surveys (PBS) show that Kenya has made progress related to behavioural and biomedical intervention areas of the programmes. The accessibility and use of condoms have improved, access to services and peer outreach has increased, testing and linkages to care have progressed well. However, experiences of violence especially by police and county askaris have remained high. While most interventions with key KPs have successfully integrated biomedical and behavioural components, the focus on structural interventions especially violence prevention and response has been low. Recent evidence shows strong links between violence and HIV, which makes it critically important for HIV prevention programmes specifically to address issues of violence faced by KPs.

Key populations work and live in complex environments dominated by power structures within family, community, workplace and the state. They are highly stigmatized and condemned within the Kenyan cultural milieu, and categorized as immoral, a threat to the moral fabric of society and a nuisance in Kenya. Cultural attitudes and punitive policies towards the behaviours associated with KPs contribute to the high rates of violence. Currently, the Kenyan legal framework and county by-laws do criminalize behaviours related to sex work, same-sex relationships and drug use. As such KPs in Kenya are exposed to 'punishing' acts and actions including physical violence, emotional abuse, rape, and extortion from a range of actors, including law enforcement officers and county government workers. Thus, their control over their lives is constrained, hampering their access to health and justice.

[1] https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/kenya

[2] Kenya HIV estimates report, NACC, 2015

[3] Kenya AIDS Strategic Framework 2014/15 - 2018/19

Research in Kenya has shown that KPs have difficulties in accessing health services due to several barriers. Some of these barriers include (but are not limited to) punitive policies and laws, cultural and societal norms, and criminalized status. The most visible forms of barriers are violence and stigma. Results from the PBS of 2015 indicate that 20% FSW, 13% MSM and 8% PWID had experienced sexual violence in the preceding six months. Similarly, 48% FSW, 26% MSM, and 43% PWID reported having experienced violence by law enforcement officers/agencies in the preceding six months. Further, the stigma and utilization of health services in Kenya survey conducted by Health Policy Project among sex-workers in October 2015 revealed that almost all sex-workers experienced internalized stigma; additionally, 48% MSW and 65% FSW reported avoiding/delaying going to a health service in the last 12 months as they feared stigma from healthcare providers. A modelling exercise conducted to measure the impact of reducing violence against FSW on HIV epidemics in Ukraine and Kenya[4] found approximately 25% reduction in HIV infections among FSW when physical and sexual violence were reduced, and the cumulative infections averted were 21,200 and 4,700 in Kenya and Ukraine respectively.

1.1 Rationale for Preventing and Addressing Violence in Key Population Programmes

Violence, HIV and AIDS are mutually reinforcing (UN Women, 2012). Violence against KPs has been shown to be a risk factor for HIV acquisition. Violence is fuelled by imbalance in the power dynamics of gender and by prejudice and discrimination against persons perceived to depart from conventional gender and sexuality norms and identities. Also, multiple structural factors influence vulnerability to violence, including discriminatory or harsh laws and policing practices and cultural and social norms that legitimize stigma and discrimination. Presence of violence in the lives of KPs dramatically increases their risk and vulnerability to HIV. Rape, coercion to have sex without condoms with individuals within power structures, and coercion in intimate relationships to have sex without condoms or to share used needles directly, put the KPs at risk. In addition, fear of violence discourages KPs from coming to places where commodities (condoms/needles) or services are available, or participate effectively in HIV prevention research. This fear also forces them to engage in sex or inject in a hurried manner neglecting their safety. Constant experience of violence also leads to anxiety, depression, loss of self-esteem and lower priority given to health thus making them vulnerable to HIV.

Such violence is *'common'* in the lives of KPs. It can take various forms - physical, sexual or psychological (see Annexure 1). Women, especially young women KPs including women who inject drugs (WWID), FSW and transgender (TG) women, experience particularly high rates of physical, sexual, and psychological abuse. Reported rates of violence against SW and TG women are high but nonetheless are likely to be underreported where certain behaviours of KPs are illegal. Homophobic violence is also high in countries where policies and laws ban same-sex activity and make it a criminal offence.

Violence against KPs is not only widespread but is also perpetrated, legitimized and accepted by many, including law enforcement authorities, gatekeepers, managers, clients and intimate partners. Sexual violence is often unprotected and is significantly associated with accepting more money, inconsistent condom use, STI symptoms and STI/HIV infections.

Police violence also discourages KPs from approaching the police for protection. Arrests, raids and imprisonment are also associated with unprotected sex and STI/HIV symptoms and infections and higher frequency of inconsistent condom use with clients.

[4] https://www.ncbi.nlm.nih.gov/pubmed/23387931

Beattie et al, 2015 found that SW who reported experiencing violence in the past year were significantly less likely to report condom use with clients, to have accessed the HIV intervention programme or have ever visited the project sexual health clinics and were more likely to be infected by STIs and HIV. Among FSW in Mombasa, a study found that high-risk sexual behaviour, low control and frequent violence in relationships with emotional partners heighten the vulnerability of FSW to HIV, requiring targeted interventions.

In the context of MSM, Ana Maria Buller and her colleagues through systematic review and meta-analysis of evidence[5] found that MSM who are victims of intimate partner violence (IPV) are more likely to engage in substance use, suffer from depressive symptoms, be HIV positive, and engage in unprotected anal sex. Shaw et al in their study in Karnataka, India found that HIV prevalence among MSM-TG who reported sexual violence was 20%, compared to 12% among those not reporting sexual violence.

Brandon D.L. Marshall et al[6] in their study with prospective cohorts of PWID in Vancouver report that 66% of females and 70% of males reported experiencing violence during the study period. In multivariate analyses, mental illness, frequent alcohol use, frequent crack use, homelessness and requiring help injecting were positively associated with experiencing violence for both sexes. In another study in Bangkok[7] with PWID, the respondents reported various forms of police misconduct, including false accusations, coercion of confessions, excessive use of force, and extortion of money. However, respondents were reluctant to report misconduct to the authorities in the face of social and structural barriers to seeking justice.

Fear of arrest is a barrier to HIV testing and evidence shows that where KPs move underground to avoid police detection, there is greater risk of being pressured into unprotected sex. Additionally, seizure of condoms and syringes by the police also prompts unprotected sex and unsafe injecting practices. Syringe confiscation is also associated with HIV infection.[8]

1.2 Purpose and Scope of the Protocol

This Protocol aims to provide guidance to prevent and respond to violence against KPs in Kenya and to increase their access to HIV prevention and care services including participation in HIV prevention research. This Protocol will be applicable to all partners and research institutions working for and with the KPs. This includes inter alia national and county governments, KP programmes, and non-governmental organizations (NGOs), community-based organizations (CBOs), research centres or institutions and both local and international KP service delivery institutions working in Kenya.

The **KASF** recommends adaptation and scaling up of effective evidence-based combination HIV prevention intervention which includes structural interventions. The **Strategic Direction 3** of the KASF recommends use of a human right based approach to facilitate access to services. The **National Guidelines for HIV and STI programming for Key Population (2014)** detail the violence prevention and response system that needs to be established in all programmes working with KPs.

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[5] http://dx.doi.org/10.1371/journal.pmed.1001609

[6] Marshall BDL, Wood E, Li K, Montaner JSG, Kerr T. Physical violence among a prospective cohort of injection drug users: A gender-focused approach. 6th International Conference on Urban Health. Baltimore, MD. Oct. 31 - Nov. 2, 2007. Abstract no. 65[3] Kenya AIDS Strategic Framework 2014/15 - 2018/19

[7] Kanna Hayashi, Will Small, Joanne Csete, Sattara Hattirat, Thomas Kerr. Experiences with Policing among People Who Inject Drugs in Bangkok, Thailand: A Qualitative Study, Plos Medicine 2013

[8] Michele Decker et al, Human rights violations against sex workers: burden and effect on HIV, The Lancet, HIV and sex workers, July 2014

In addition, the recently launched **Policy for the Prevention of HIV infections among Key Populations in Kenya (June 2016)** clearly outlines the objective of increasing access to scaled up and comprehensive services for KPs. Within this objective, the development of violence prevention and response system in programmes to address violence and discrimination against KPs is a key policy direction for NACC and NASCOP.

Based on this guidance, the Ministry of Health through NACC and NASCOP set up a national advocacy sub-committee under the KP-NTWG which has, amongst its mandate, the task to design and implement an advocacy strategy to address violence, stigma and discrimination against key populations as well as come up with a guidance document to respond and prevent violence against them. This has led to the development of this Protocol referred to as 'National Violence Prevention and Response Protocol - a means to enhancing HIV Prevention among the key populations in Kenya'. This document complements the national guidelines and training curricula that have been developed for prevention and response to violence against key populations. The development of this document has been necessitated by the increasing violence and stigma against KPs and the growing need to standardise a response mechanism. This will create an enabling environment in which KPs feel safe and confident to access HIV services and participate freely in HIV prevention research.

CHAPTER 2

Principles for Violence Prevention and Response

Principles

There are ten fundamental principles that provide the foundation for violence response within the national programme. These principles are:

Principle 1

Do not harm

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

- Get informed consent from KPs before providing services and making referrals;
- Act in the best interests of KPs;
- Avoid harming or causing further harm to KPs;
- Provide universal access to services without judgment or negative repercussions for KPs;
- Be aware of the needs and wishes of KPs.

Principle 2

Promote the full protection of human rights of KPs and reject any intervention based on the notion of rescue and rehabilitation.

This means embracing the belief that people have a right to live their lives free of violence, and enjoying their rights to information, respect and dignity. This includes the right to: non-discrimination; personal security and privacy; recognition and equality before the law; due process of law and the highest attainable standards of health; employment under fair conditions; peaceful assembly and association; freedom from arbitrary arrest and detention, and from cruel and inhumane treatment; and protection from violence. Additionally, interventions based on the notion of rescue and rehabilitation should be rejected. Empowering and supporting KPs to make their own choices and gain a sense of power and control over their lives is central to the programmes. Raids and other interventions that claim to 'rescue and rehabilitate' KPs, deprive them of their agency (the choice, control and power to act for themselves), are counter-productive, and increase their likelihood to experience violence (WHO, 2013).

Principle 3

Respect the rights of KPs to make informed choices (self-determination) and to access the full range of services recommended for victims of violence (provided to them free of stigma and discrimination).

- KPs have the right to make informed choices about their lives, which may involve not reporting or seeking legal services for violence, not seeking support services, or deciding to stay in an abusive relationship. It should always be the decision of KPs, and not the provider to report violence and/or to pursue legal action against a perpetrator. A provider's role is to offer information about KPs' rights and available services so KPs can weigh this information against the possible risks of retaliation by a perpetrator, further stigmatization and abuse, and/or loss of basic needs (e.g. shelter, food, financial support).

- KPs have the right to access and receive services without being subjected to stigma or discrimination. Since KPs often face stigma, discrimination, and violence and abuse by the same professionals who are charged with protecting and providing services to them (e.g. police officers, health care workers), stigma and discrimination against KPs must be proactively addressed in programmes so KPs can access these important services.

KP programmes should:

1
- Conduct ongoing training with all staff and direct service providers involved in the continuum of care on the rights and unique needs of KPs;

- Do more than train. Challenge stakeholders on issues of stigma and discrimination, and;

2
- Address barriers faced by KPs while accessing health care services, including access to pre- and post-exposure prophylaxis for HIV and other prevention and post-violence services.

Principle 4

Promote gender equality and challenge harmful gender norms that contribute to violence. All training curricula used to sensitize and train programme implementers and direct service providers should include content that promotes gender equality and challenges harmful gender norms.

The content should build knowledge of participants about issues that are relevant to KPs, including concepts of gender and sexual orientation, gender norms. It should also include awareness on how rigid gender norms affect those who conform to them and those who are perceived as not conforming to them. These trainings should also highlight how power imbalances make people more vulnerable to stigma, discrimination, and violence.

Principle 5

Be responsive to local patterns of violence and barriers to accessing services.

In order to develop violence response programs that are relevant to specific KP communities in any geographic location, it is important for programme implementers to **utilize a variety of mechanisms to understand the local patterns of violence against KPs and barriers to accessing services** in their communities; how KPs are currently coping with violence; the services available and accessible to KPs who experience violence; and the attitudes of service providers who provide health, psychosocial, and legal services to KPs. This information should be used to directly inform the development of response mechanism to violence.

Principle 6

Place KPs at the centre of design, implementation, and evaluation of violence prevention and response activities and identify/build on existing KP community-led efforts to prevent and respond to violence, stigma and discrimination. Use participatory methods to ensure that KPs are involved in design, implementation, and evaluation activities.

KPs have a right to have their voices heard. One way is to establish meaningful ways to include KPs, particularly those who have experienced violence, in all aspects of programme planning, implementation, and evaluation - including direct services, community mobilization and outreach, and system-level advocacy. KPs have detailed knowledge of the legal, social, cultural, and institutional constraints that block their access to services and deny them their rights (WHO, 2013).

Principle 7

Build capacity of programme staff and KP communities to understand and address the links between violence and HIV.

All KP programme and implementing partner staff, i.e. PEs, ORWs, and other providers involved in the KP programme should be sensitized to issues that are relevant to and affect KPs, and can respond effectively to KPs who experience violence. They should be trained to utilize and link KPs to a crisis response system (e.g. hotlines, WhatsApp groups), identify violence, and provide first-line support to KPs who disclose violence, including linking them to health, psychosocial support, and legal services. Additionally, KPs should be aware of the links between violence and HIV; their human and legal rights; what they can do if they experience violence; and how they can access health, psychosocial support, and legal services. In line with a public health approach, sensitization and training should be viewed as ongoing as opposed to one-time activities.

Principle 8

Integrate violence prevention and response into HIV prevention, care/treatment programming and research.

Violence prevention and response services should not be separate programmes; rather, these services should be integrated into existing KP programmes including research with KPs, and viewed as key components of HIV research, prevention, care, and treatment programmes for KPs.

Principle 9

Ensure privacy, confidentiality, and informed consent during all interaction with victims of violence.

Privacy and confidentiality are essential for the safety of KPs in any setting. Providers can put the safety of KPs at risk if they share sensitive information with partners, family members, or friends without their (KPs) consent. This includes sharing information about KPs with other service providers within one's own organization or within the referral network without the explicit consent of the KP member. A breach of confidentiality about pregnancy, sexual violence, contraception, HIV status, or a history of sexual abuse can put KPs at risk of additional emotional, physical, and sexual violence.

Principle 10

Monitor and evaluate programmes to identify any unintended harmful impacts and develop strategies to improve violence prevention and response programming.

Data collection tools and tracking mechanisms should be utilized to inform and improve programming. These data collection forms and tracking mechanisms will allow PEs/ORWs and other providers to document disclosures of violence, services provided, referrals made, dates for follow-up services (e.g. clinical follow-up dates related to PEP), and whether KPs followed through with referrals and scheduled follow-up visits. Documentation of this information is necessary for programmes to be able to analyse what types of violence KPs are experiencing; perpetrators of the violence; services offered; and services KPs received. This information is also necessary to track trends, identify gaps, and make programme improvements based on what is happening in KP communities.

CHAPTER 3

Essential Programme Components of Violence Prevention and Response

Programme Components

The Kenya AIDS Strategic Framework (KASF) 2014/15- 2018-19, while identifying KPs as a priority population recommends inclusion of structural interventions in the package of interventions for them in strategic direction1. The strategic direction 3 of the KASF recommends use of a human right based approach to facilitate access to services for specific populations including KPs. The **national guidelines for STI/HIV programming among key populations (NASCOP 2014)** outline the key activities related to violence prevention and response as follows:

Programme Element 1

Core Knowledge among Implementers, Researchers and KP Communities

- A trained core team of staff at national, county and implementation level. Several national training curricula are available in Kenya for this;

- Activities to build an understanding of violence among the KP communities using the lens of gender, power, and human rights. These activities will also strengthen community cohesion and agency among key population members (e.g. discussions of power, gender norms and inequalities at the root of stigma, discrimination, and violence against key populations, rights education etc) can lead the design and implementation of a tailored comprehensive violence prevention and response programme for KPs.

Programme Element 2

An Understanding of Violence against KPs and Existing Efforts to Address Violence

- **Mechanisms in place (e.g. assessment, focus groups, stakeholder interviews, micro-planning, mapping, training) to increase understanding of violence experienced by KPs**, including types of violence; common perpetrators, key hotspots, needs of KPs when they experience violence, and barriers to accessing violence response services. It is also important to understand the coping mechanisms that KPs adopt in response to violence and safety tips that they adopt to prevent violence.

Programme Element 3

Networks to Ensure Access to Health, Psychosocial, and Legal Services for KPs

- A referral network and directory of service providers. The network includes trained focal points at health[10], psychosocial support[11], and legal[12] services facilities, including safe spaces like drop-in-centres (DICs) and emergency shelters. This could be also KP networks and other support groups.

[10] Health services that should be accessible via either referral are: treatment of injuries, HIV testing, PEP, emergency contraception, STI testing and treatment, rape kits/forensic exam, Hepatitis B screening and treatment if needed

[11] Psychosocial support that should be accessible via either referral are: support groups, mental health assessment, and other psychosocial support (short and long-term)

[12] Legal services that should be accessible via either referral are: documentation of an incident of violence and support to interact with the justice system (i.e., access to a lawyer or paralegal)

- Sensitized and trained referral points that the programme has formal relationships with;
- Efforts to build acceptance for violence prevention and response, including work with media and engaging with civil society and the government.

Programme Element 4

Systems to Identify, Prevent and Respond to Violence

- **SOPs for identifying, preventing and responding to violence among KPs;**
- **Information, Education, and Communication (IEC) and Interpersonal Communication (IPC) materials (see annexure 2) developed and disseminated.** These materials should target KPs and other stakeholders (e.g. HCWs) and include information on the definition of violence; violence as a human rights violation that affects many people; and available violence response resources. NASCOP has developed a prototype of these IPC materials;
- **Sensitized and trained peer educators and outreach workers.** Raise awareness about violence; detect violence among community members; provide first-line support (see annexure 3) to victims of violence; and accompany victims of violence to seek additional services;
- **Sensitized and trained health care providers.** Detect violence among clients and provide first-line support and clinical services to victims of violence;
- **Mechanisms are available to support/supervise individuals engaged in violence prevention and response and promote self-care and personal safety** (e.g. peer education supervision, support groups for providers);
- **An operational crisis response system (see annexure 4)** (e.g. hotline, WhatsApp groups), including an identified and trained crisis management team that is responsible for handling incoming calls/texts and the resources to support implementation of the crisis response system. A checklist of factors to be considered/assessed periodically; when operating in areas considered hostile to KPs and putting in place measures to deal with areas of weakness from the assessment.

Programme Element 5

Accountability to Prevent Violence

- **Sensitized and trained police and other uniformed officers (if possible).** These officers commit to serving KPs who experience violence and pledge not to perpetrate violence against KPs;
- **Sensitized power structures** (e.g. religious leaders, tribal leaders, bar and lodge owners, pimps). They commit to connecting victims of violence to available services and condemning violence against KPs.

Programme Element 6

1 Documentation and Monitoring

- **Report and document every incident of violence (see annexure 5);**
  Aggregated information on cases of violence to identify trends and inform programming;

2

- **Systems in use to monitor and evaluate violence prevention and response programs,** including opportunities for feedback from victims who use violence response services.

3

This Protocol adopts that all programmes and research institutions working with KPs in Kenya already have robust violence prevention and response systems including all the programme elements as defined in the national guidelines. **The response mechanism as defined in this Protocol is nested within this assumption**. A checklist is available as annexure (see annexure 6) to assess inclusion of violence response and prevention activities for programmes in KP programmes.

CHAPTER 4

Minimum Package of Violence Prevention and Response and Its Implementation

4.1 Violence Response

Violence is an umbrella term for any harmful act that is perpetrated against a person, against his/her will, and that is based on socially ascribed (gender) differences, sexual orientation/ behaviour, social behaviour, profession and practices. There are various kinds of violence that KPs experience.

There are different ways the KP programme and research institutions may come to know about experiences of violence of KPs:

- A situation where violence is the **presenting condition**: KPs may visit a facility or reach out for help utilizing the crisis response system or contacting direct service providers with the intention to seek assistance;
- A situation where there exists a **spontaneous disclosure**: KPs may spontaneously disclose experiences with violence when they are seeking or receiving other services like HIV testing or care services;
- A situation where disclosure is through **violence screening**[13]: KPs may disclose violence in response to violence screening done during outreach or during clinical services;
- A situation where disclosure is through **research and surveys**: KPs may disclose violence in response to research and surveys during the research and or survey data collection process.

Based on the severity, scale and impact of the experience of violence, an emergency or non-emergency response may be required. Some example of emergency and non-emergency situations would include:

	EMERGENCY	NON-EMERGENCY
Physical	Murder, assault, mass arrest/ detainment, stabbing, strangling, burning, mutilation etc.	Hitting, pinching, hair-pulling, arm-twisting, punching, pushing, slapping, beating, shoving, kicking, biting, force-feeding, or any other rough treatment.
Sexual	Rape, severe beating sexual parts of the body, non-medical genital mutilation, forcing a person to perform sexual acts that may be degrading or painful etc.	Touching an individual in a sexual manner without consent, forcing participation in pornographic filming, humiliating, criticizing or trying to control a person's sexuality.
Psychological/ Emotional	Kidnap, illegal mass detainment, immense threats and stalking from an individual and or group of persons, tabling a punitive bill, executive decrees, continuous online	Blackmail, humiliation, harassment, intimidation, destruction of property, forceful eviction, online bullying.

[13] Ref: Identifying and Responding to Violence: Training Curriculum for Key Population Direct Service Providers in Kenya, NASCOP, 2017

contd.

	EMERGENCY	NON-EMERGENCY
Economical	Mass extortion by a person and or group of persons.	Extortion, acts of fraud; pulling off a scam against a person (conning), illegal eviction/sacking from employment etc.

**This is not an exhaustive list. A non-emergency can become an emergency if it becomes severe, effects many people and has a life-threatening impact.*

The perpetrators of violence are many including clients/paying partners, drug peddlers/barons, law enforcers, family members, brothel madams, bar owners, pimps, and general community policing agencies, boda boda riders, IPs, religious leaders or community leaders, among others.

A minimum package of response services should be available with every KP programme to enable response to disclosure of violence:

Minimum package of violence response services

- Assess the situation;
- Provide first-line support;
- Provide/refer to violence related clinical and non-clinical services (physical health, mental health, safety and security);
- Provide support to report the violence to the authorities;
- Provide/refer to legal services;
- Document and report to KP-CTWG and KP-NTWG;
- Follow-up with clients who previously disclosed violence;
- Establish mechanisms to support individuals engaged in violence response.

Assess the situation: Assess the report to understand the situation of the violation and need of the victim/survivor. It is always good to have a multi-disciplinary team/crisis management team (outreach, programme management, clinical, advocacy) assessing whether the situation is an emergency or non-emergency and plan for the response including allocating responsibilities.

The situation may have to be assessed by visiting the site of the violence especially where violence is present and visible. Sometimes in situations where urgent response is required, there may not be time to conduct the consultation with other team members or even follow the laid-down protocols of communication and action must be taken. Consequently, the crisis management team needs to be trained to build their skills to make these decisions. In such cases the teams should then conduct these consultations with the multidisciplinary team after the response to assess if the response has been adequate and to plan follow-up. This is an important element of the response as the response is only as good as the assessment of the situation of violence.

Provide first-line support: When KPs have the courage to share their experiences of violence it is important that providers respond in a compassionate and non-judgmental manner. If KPs feel disrespected or judged, they are less likely to share details of their experiences and are less likely to engage in important follow-up services. Depending on the situation and where disclosure happens, first-line support can be provided by various service providers. If the KP has used the helpline to disclose violence, then the CMT would provide first-line support. However, if the KP has disclosed his/her experience while screening in the service centre then the health care provider will provide first-line support. First-line support includes:

- Using active listening skills to:
  - ✓ Acknowledge that it can be difficult to share one's experiences of violence;
  - ✓ Let KPs know their attempt to share their experiences is appreciated;
  - ✓ Provide non-judgmental support and validate the experiences of the KPs.
- Deliver core messages;
- Assess safety and explore safety strategies;
- Explore strengths, existing support systems, and next steps;
- Provide information and make referrals to available resources.

Provide/refer violence-related clinical and non-clinical services (physical health, mental health, safety and security): KPs who have experienced violence are at increased risk of negative health outcomes, including unintended pregnancies, HIV and other STIs, and complications from incomplete or unsafe abortions. Early and appropriate care by trained service providers for KPs who have experienced violence can mitigate these negative effects, including eliminating and or reducing barriers to HIV care and treatment. Post-violence clinical services can either be offered directly by the implementing partners or through referral to services which offer gender-based violence (GBV) services like the GBV recovery centers that are available in many counties. Kenya has national-level clinical protocols for post-violence services (such as the post-rape protocols for health facilities), and implementing agencies providing direct post-violence clinical support should follow those guidelines. Post-violence clinical services normally include:first-line support. First-line support includes:

- History taking and medical examination[14];
- Treatment of injuries;
- Rapid HIV testing and linkage to care if needed;
- Post Exposure Prophylaxis (PEP) with 72 hours;
- STI screening, diagnosis and treatment;
- Emergency contraception (within five days);
- Hepatitis B screening and vaccination.

Part of providing quality health care to clients includes provision or referral to counseling and mental health services. Sometimes trauma-related symptoms are not evident in the client until days, weeks, or months after an assault. All KPs experiencing violence should be screened to assess for acute stress, depression, drug and alcohol challenges, self-harm/suicide, and ability to function and perform day-to-day activities, as well as other symptoms of post-traumatic stress disorder (PTSD). Safety and security become important issues for KPs who experience violence.

[14] Medical examination may (with consent from the victim) include collection of samples and evidence to support a case against a perpetrator.

As a response to violence, the security needs of the victim should be explored. It is important to understand if the person feels safe where they stay, and/or with the people they stay. The programme should offer safety tips to the KP to ensure that in the future such events of violence can be avoided. Referrals to shelters, safe homes, support groups, KP networks should be facilitated, where required.

Safety and security become important issues for KPs who experience violence. As a response to violence, the security needs of the victim should be explored. It is important to understand if the person feels safe where they stay, and/or with the people they stay. The programme should offer safety tips to the KP to ensure that in the future such events of violence can be avoided. Referrals to shelters, safe homes, support groups, KP networks should be facilitated, where required.

Provide/refer to legal services: Due to the extremely high levels of stigma, discrimination, violence, and other human rights violations experienced by KPs, perpetuated sometimes by even state actors like the police and other uniformed officers, ensuring that they have access to information about their legal rights and access to justice is important. Legal services can be provided by implementing partners through a full-time hired lawyer or one on retainer basis, or through referral to a legal firm which works on human rights issues. Some implementing partners also train peer educators as paralegals to provide first level legal support. KPs need legal support in the event they are arrested or detained by police/askaris, require other criminal or civil legal services including when they face prosecution.

Document and report to KP-CTWG and KP-NTWG: Documentation of cases of violence is very important. NASCOP has developed reporting formats that document violence. These include the peer/outreach calendar which is completed by a peer educator. The clinical registration and follow up formats also encourage health care providers in KP clinics to screen for and document violence. The violence reporting tool documents in detail, each episode of violence including information about the perpetrator, description of the situation of violence, timing and follow up action. The incidence of violence and accompanying response is monitored through quarterly reports that each implementer shares with the KP programme at county and national levels. The national programme also monitors incidence of violence annually through PBS. It is expected that all incidences of violence will be reported to KP-CTWG and KP-NTWG regularly. If the particular situation of violence is an emergency, then it is to be reported immediately to KP-CTWG and KP-NTWG. However, in non-emergency situations, it can be reported and discussed quarterly.

Follow-up with clients who previously disclosed violence: It is important to follow-up on all KPs who disclose violence. Follow-ups should be done at intervals of one and two weeks, three and six-month intervals. These follow-ups can be done by peer educators or health care providers depending on who the KP has consented to interact with. Documentation of follow-ups is equally important. Follow-up entails getting to know the progress of the judicial, clinical/medical and or security process of the survivor.

Establish mechanisms to support individuals engaged in violence response: Working with KPs who have experienced violence can be rewarding, but difficult. Working with survivors of violence takes a lot of energy, and can leave providers feeling drained, upset, frustrated, or fearful. This may be especially true during times of increased workloads or heightened personal stress. It is important that providers always try to maintain a balance between their professional and personal lives and take care of their own health and well-being. Projects should create spaces for responders to share their experiences, stress and dilemmas. Provisions must be made to provide psychosocial support to the responders as may be required.

4.2 Violence Prevention

As stated in the national guidelines, working with the police and law-enforcement agencies continues to be a key element of efforts to reduce violence against key populations.

Sensitization workshops with the police and law enforcement agencies to raise their awareness of laws related to KPs and human rights. These workshops also build relationships between KPs and law-enforcement agencies to minimize police harassment and violence. In some settings, such workshops have been led by key populations, in other places they have involved lawyers, and in some settings SW, police and NGOs have jointly conducted trainings. The National programme has developed curriculum to train the police and have conducted training of trainers (TOTs) involving police officials, NGO staff and key population advocates. These TOTs have been done in partnership with Police AIDS Control Unit.

Regular advocacy meetings with police as well as with high-level law enforcement authorities to reduce police harassment of sex workers and community outreach workers (e.g. getting letters of support from the police that are carried by the outreach workers) and to ensure the commitment of frontline officers to the workshops. Reflections on police training from organizations involved in these efforts suggest that police training and working with the police may provoke a backlash against KPs and hence this needs to be monitored. It is important to gain support at senior levels in the police hierarchy to get and sustain support from police lower down and hold them accountable for their actions. Building relationships with police and educating them about sex worker rights must be a continuous process.

Sensitize power structures (e.g. religious leaders, tribal leaders, bar and lodge owners, pimps) regularly so that they commit to connecting victims of violence to available services and publicly condemning violence against KPs. These power structures have lot of influence and can be involved to advocate for health and rights of key populations.

4.3 Implementation of the Response and Prevention Mechanism

The **Policy for Prevention of HIV Infections among Key Populations in Kenya-June 2016** provides guidance on roles of different institutions at the national and county level in KP programming. The Respect, Protect, Fulfil Guidance 2015, provides a checklist (see annexure 7) of security questions to consider for HIV prevention researchers working with MSM particularly on HIV-NPT research including HIV vaccines, microbicides and long-acting Pre-exposure prophylaxis (PrEP)

NACC as outlined in the KASF has the mandate to ensure a proper multi-sectoral approach by developing policies which will ensure accountability with regard to HIV prevention. NACC is committed to promoting social rights and dignity for SW, drug users and MSM. It is also required that they review by-laws that promote stigma by 2020 and remove barriers to access (e.g. age limits) of HIV and reproductive health education and services[15].

NACC has also set up structures to address any form of complaints in relation to HIV and not only for the KPs but for the general population as well. Here, complaints against institutions who provide HIV prevention services, may it be programming, research and or implementation, can and are addressed. They have set up complaints committees through which all the complaints are channelled, and it works closely with the HIV and AIDS Tribunal.

[15] Kenya HIV Prevention Revolution Roadmap

The KP-NTWG provides technical leadership and coordinates programming with KPs, at the national level. The KP-CTWGs co-ordinate and lead the KP programmes at county levels.

The Protocol proposes a mechanism where response and prevention to violence against KPs is addressed at three levels:

Implementing Partners/ CBOs and Research Institutions:

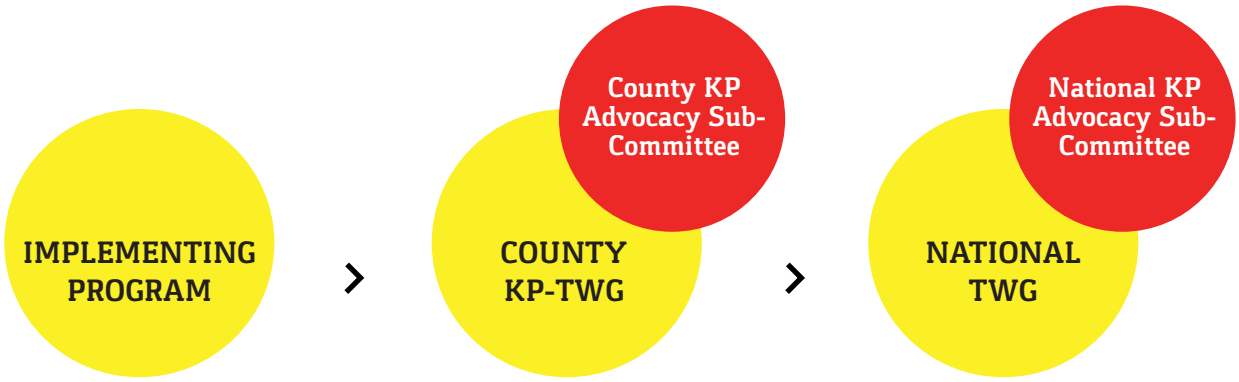
These operate at hotspots and or ground levels and are responsible and accountable for KPs in the hotspots. They are almost always the first point of contact at the time of violence;

KP-CTWGs

These operate at the county level and are responsible for leading the advocacy efforts for KPs at the county;

KP-NTWG

It operates at the national level and is responsible for providing technical guidance, coordination, leadership and resource mobilisation support to respond to violence against KPs.



4.3.1 Implementing Violence Prevention Response Mechanisms at Implementing Partners/Research Institutions/Community-based Organisation Levels

This is the most critical level of violence prevention and response system, given that most of the violations either occur or originate from hotspots, IP sites (includes research centres working with KPs) and CBOs that implement programmes with KPs. The main actors/people who provide violence responses at these levels are research and implementing programme staff, PE and/or ORW.

At this level, they handle all the violations against the KPs as shown in the table below:

Type of Response	Action	Actors
Emergency Response	✓ Receive information on violations (either through crisis response systems or screening during peer education or during clinic visits etc); ✓ Assess the violations to advice on the direction to be taken; ✓ Provide immediate care and treatment (if necessary and as appropriate) to the victim and prevent further harm; Form a team and visit the scene of violence (if applicable) - collect first-hand accounts and document them. ✓ Provide first-line support • Give core messages to the victims/survivors; ✓ Provide/refer victims for post-violence clinical services; ✓ Provide/refer victims for counselling and support including psychosocial support; Take the victims/survivors to a safe space as required; ✓ Assist the victims with reporting to the necessary authorities and fill in a P3 form where applicable (see annexure 8); ✓ Provide legal support if necessary ✓ Contact the KP - CTWG for support and action; ✓ Document the violation; ✓ Follow-up the incident as stipulated in the Protocol at regular intervals; ✓ Report to NASCOP through quarterly reporting; ✓ Conduct outreach in hotspots to sensitize KPs on violence and human rights and promote the violence response system; ✓ Conduct regular sensitization of the police, county officials and community surrounding the site on the need to safeguard the rights of all Kenyans including KPs. If someone has broken the law report to authorities, rather than take matters into their hands; ✓ Conduct regular meetings of the response teams to discuss their experiences, address stress and dilemmas; ✓ Develop plans/strategies with KP-CTWG to prevent future occurrences.	PE, ORW, Paralegal staff, Clinicians, Counsellors, Project Managers, security and crisis response teams
Non-emergency Response	✓ Receive information on violations; ✓ Assess the violations and advice on the direction to be taken; ✓ Form teams and visit the scene of violence if applicable - collect first-hand accounts and document them; ✓ Provide first-line support: • Give core messages to the victim/survivor; • Administer first-aid and provide referrals where applicable and necessary.	

contd.

Type of Response	Action	Actors
Non-emergency Response	✓ Conduct alternative dispute resolution (where applicable and necessary); ✓ Provide/refer to clinical, mental health services if necessary; ✓ Document the violations; ✓ Report to the CKP -TWG during TWG meetings; ✓ Follow-up the incident as stipulated in the Protocol; ✓ Report to NASCOP through quarterly reporting; ✓ Conduct regular meetings of the response teams to discuss their experiences, address stress and dilemmas; ✓ Assess current strategies and continuously improve violence prevention and response strategies which are in place.	

4.3.2 County Level

KP-CTWGs should be developed in all counties and should consist of all the KP implementing partners and/or programmes and stakeholders in that specific county.

The KP-CTWGs are headed by the County AIDS Coordinator (CASCO) and co-chaired by the Constituency AIDS Control Coordinator (CACC). It has sub-committees which include the County Advocacy Sub-committees. The KP-CTWG reports directly to the national KP-NTWG. The following table summarises the response activities at the county level:

Type of Response	Action	Actors
Emergency Response	✓ Hold urgent meetings with stakeholders to address emergency situations emanating from the implementing programs and or other institutions; ✓ Assess the situation and understand the violations and concerns of KPs; ✓ Develop urgent responses including all stakeholders; ✓ Implement the response plans in partnership with stakeholders; ✓ Undertake follow-ups with the relevant authorities to expedite actions; ✓ Conduct sensitisation meetings with specific groups of perpetrators/as required; ✓ Update the county leads to keep them informed of the situation; ✓ Communicate the actions to the TWG members; ✓ Discuss the issues in the KP-CTWG to reflect on the situation and develop prevention strategies; ✓ Mobilise resources for the responses and prevention; ✓ Publish media reports or statements in support of the HIV programme if needed;	KP-CTWG County KP Advocacy sub-committee

Contd.

Type of Response	Action	Actors
Emergency Response	✓ Organise sensitisation of religious leaders to build their sensitivity towards KPs; ✓ Conduct regular sensitisation of elected leaders to help them understand the risk and vulnerabilities of the KPs and build a support base; ✓ Report to the KP-NTWG through quarterly reporting.	
Non-emergency Response	✓ Analyse the documented cases of violence to understand trends and gaps; ✓ Discuss the issues in the KP-CTWG to reflect on the situation and develop prevention strategies; ✓ Report to the KP-NTWG; ✓ Undertake follow-ups with regard to advocacy action plans to be implemented for the KPs by the implementing partners; ✓ Mobilize resources.	

4.3.3 National Level

The national level is the next and final level of violence prevention and response in this Protocol. The national response is led by the KP-NTWG. Under the National-TWG, there are other sub-committees which include the Advocacy Sub-committees which spearhead the advocacy work related to KPs.

Type of Response	Action	Actors
Emergency Response	✓ Hold urgent meetings with stakeholders to address violence-related emergencies from the implementing partners/KP-CTWG and or any other institution; ✓ Assess the situation and support the KP-CTWG to understand the violation and concerns of KPs; ✓ Hold stakeholder meetings at the county-level if necessary; ✓ Develop urgent responses including all stakeholders at the national level; Mobilise resources for the responses and prevention; ✓ Implement the response plan in partnership with stakeholders and CTWG; ✓ Undertake follow-ups with the relevant authorities to expedite actions; ✓ Support the CTWG to organise sensitisation meetings with specific groups of perpetrators/supporters if required; ✓ Sensitise the power structure and other perpetrators on violence, HIV and rights; ✓ Strategize with the advocacy sub- committee members on prevention of such violence in the future; ✓ Discuss with religious groups to condemn such acts of violence to prevent such violence in the future;	KP-NTWG National Advocacy Sub-Committee

contd.

Type of Response	Action	Actors
Emergency Response	✓ Discuss with religious groups to condemn such acts of violence to prevent such violence in the future; ✓ Work with media to share the correct facts of the incident and share the risks and vulnerabilities of the KPs; ✓ Work with elected representatives if necessary to share the facts of the incident and update them; ✓ Report to the Head of the KP programme at the national level; ✓ Ensure there is continuous communication on the update/progress to the TWG members; ✓ Publish media reports or statements in support of the HIV programme if needed; ✓ Discuss the issues in the KP-NTWG to reflect on the situation and develop prevention strategies; ✓ Compile rights violation reports at the national level.	
Non-emergency Response	✓ Discuss the issues in the KP-NTWG to reflect on the situation and develop prevention strategies; ✓ Analyse the reports on violations to understand trends and gaps; ✓ Follow up on the advocacy action plans for the KPs as implemented by the IPs; ✓ Mobilize resources for the response and prevention; ✓ Sensitise the power structure and other perpetrators on violence, HIV and rights; ✓ Strategize with the advocacy sub-committee members on prevention of such violence in the future; ✓ Discuss with religious groups to condemn such acts of violence to prevent such violence in the future; ✓ Work with media to share the correct facts of the incident and share the risks and vulnerabilities of the KPs; ✓ Undertake surveys to measure outcomes related to violence through PBS and IBBS.	

Annexure 1
Forms of Violence

Form of Violence	Characteristics
Physical Violence: Physical violence occurs when someone uses a part of their body or an object to control a person's actions	• Using physical force which results in pain, discomfort or injury; • Hitting, pinching, hair-pulling, arm-twisting, strangling, burning, stabbing, punching, pushing, slapping, beating, shoving, kicking, choking, biting, force-feeding, or any other rough treatment; • Assault with a weapon or other object; • Threats with a weapon or object; • Deliberate exposure to severe weather or inappropriate room temperatures; • Murder
Sexual Violence: Sexual violence occurs when a person is forced to unwillingly take part in sexual activity	• Touching in a sexual manner without consent (i.e. kissing, grabbing, fondling); • Forced sexual intercourse; • Forcing a person to perform sexual acts that may be degrading or painful; • Beating sexual parts of the body; • Forcing a person to view pornographic material; forcing participation in pornographic filming; • Using a weapon to force compliance; • Exhibitionism; • Making unwelcome sexual comments or jokes; leering behaviour; • Withholding sexual affection; • Denial of a person's sexuality or privacy (watching); • Denial of sexual information and education; • Humiliating, criticizing or trying to control a person's sexuality; • Forced prostitution; • Unfounded allegations of promiscuity and/or infidelity, and; • Purposefully exposing the person to HIV and AIDS or other STIs
Emotional Violence: Emotional violence occurs when someone says or does something to make a person feel stupid or worthless	• Name calling; • Blaming all relationship problems on the person; • Using silent treatment; • Not allowing the person to have contact with family and friends; • Destroying possessions; • Jealousy; • Humiliating or making fun of the person; • Intimidating the person; causing fear to gain control; • Threatening to hurt oneself if the person does not cooperate;

contd.

Form of Violence	Characteristics
Emotional Violence: Emotional violence occurs when someone says or does something to make a person feel stupid or worthless	• Threatening to abandon the person, and; • Threatening to have the person deported (if they are immigrants).
Psychological Violence: Emotional violence occurs when someone uses threats and causes fear in a person to gain control	• Threatening to harm the person or her or his family if she or he leaves; • Threatening to harm oneself; • Threats of violence; • Threats of abandonment; • Stalking/criminal harassment; • Destruction of personal property; • Verbal aggression; • Socially isolating the person; • Not allowing access to a telephone; • Not allowing a competent person to make decisions; • Inappropriately controlling the person's activities; • Treating a person like a child or a servant; • Withholding companionship or affection; • Use of undue pressure.

Annexure 2
First Line Support

The information included in this section draws directly from Developing and Implementing a Comprehensive Violence Prevention and Response Program for Key Populations, LINKAGES Project, FHI 360, 2017

- Use Active Listening Skills
- Deliver Core Messages (Supportive Statements)
- Ask about Safety and Explore Safety Strategies
- Explore Next Steps with Client
- Provide Information and Make Referrals to Available Resources
- Follow-up with Client

1. Use Active Listening Skills (4 skills)

- **Attentive Listening:** The most important thing to do is be a good listener. Much of being a good listener is demonstrated through body language, being comfortable with silence, and not rushing the person
  - ✓ Lean forward;
  - ✓ Maintain good eye contact;
  - ✓ Nod your head to let the person know you hear them;
  - ✓ Be comfortable with silence and pauses.

  There are also things we can say that show we are being good listeners (Skills 2 through 5):

- **Reflecting:** Use statements that reflect back what the person is saying to you. This lets the person know you're listening. It also gives them an opportunity to clarify how they feel:
  - ✓ *So, it sounds like*
  - ✓ *What I hear you saying*
  - ✓ *I get the sense that*
  - ✓ *You appear to be feeling*

- **Avoid statements such as:**
  - ✓ *'I know' or 'I understand'*
  - ✓ Labeling an experience: *'You were raped.'*

- **Validating:** Use statements that let the person know that what they are feeling or experiencing is okay or normal:
  - ✓ *'It makes sense that you feel that way.'*
  - ✓ *'It's understandable that you feel that way after what happened.'*
  - ✓ *'Many people feel this way after experiencing this.'*

— **Inquiring/Clarifying:** Use open-ended questions/statements to clarify information or obtain more information:

1

- ✓ *'What would you like to share?'*
- ✓ *'Tell me a little about how you've been feeling.'*
- ✓ *'I'm not sure if I fully understand what you mean. Could you tell me a little more?'*

2

II. Deliver Core Messages (Supportive Statements)

— **Deliver core messages and supportive statements that convey:**

3

- ✓ That you appreciate them sharing their experiences with you;
- ✓ That you believe them;

4

- ✓ That what happened wasn't their fault;
- ✓ That their experience has happened to other people and they are not alone;
- ✓ That their feelings are normal;
- ✓ That they have the right to live without threats, violence, and abuse;
- ✓ That it's safe for them to talk to you about her experience;
- ✓ That you will support them and the choices they make.

— **Supportive Statements to Help Clients Cope with Specific Feelings (WHO, 2014b)**

Feeling	Some ways to respond
Hopelessness	*'Many people manage to improve their situation. Over time, most people feel hopeful again.'*
Despair	Focus on the person's strengths and how they have been able to handle a past dangerous or difficult situation. For example: *'You showed a lot of courage by...'* *'By the way you handled that situation, you showed determination and strength.'* *'With all the obstacles you have right now, it's impressive that you've been able to stay strong.'*
Powerlessness	*'You have some choices and options today in how to proceed.'*
Flashbacks	*'These are common and often become less frequent or disappear over time.'*
Denial	*'I'm taking what you have told me seriously. I will be here if you need help in the future.'"*
Guilt/ self-blame	*'You are not to blame for what happened to you. You are not responsible for the abuser's behavior.'*
Shame	*'There is no loss of honor in what happened. You are a valuable person.'*

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contd.

Feeling	Some ways to respond
Fear	Emphasize, *'You are in a safe place now. We can talk about how to keep you safe.'*
Numbness	*'This is a common reaction to difficult events. You will feel again. For most people, this changes over time.'*
Mood swings	*'Mood swings are common and should ease with the healing process.'*
Anger at abuser	*'It makes sense that you are angry at this person after what they did to you.'*
Anxiety	*'This is common, but we can discuss ways to help you feel less anxious.'*
Helplessness	*'I am here to support you.'*

2. DO NOT

- ✕ **Blame the client**
  'You put yourself at risk.'
- ✕ **Say anything that judges what the client has done or will do**
  'You should feel lucky that you weren't more injured.'
  'You shouldn't feel this way.'
- ✕ **Question the client's story (doubting the client) or interrogate the client**
  'What I don't understand is why he would have attacked you?'
- ✕ **Say anything that minimizes how the client feels**
  'Everyone has bad days. You'll get over it.'
- ✕ **Lecture, command, or advise**
  'What you need to do is.'
  'You have to stop thinking about what happened.'
  'You need to come up with a plan to avoid this happening again.'
- ✕ **Ever recommend that they change their profession, sexual orientation, or gender identity to avoid violence**
  'You need to leave sex work. It's just a violent profession.'
  'If you stopped being so open about who you are, you would be safer.'

III. Ask about Safety and Explore Safety Strategies

Your questions can help assess current safety and identify opportunities to increase safety e.g. Do you have concerns about your safety? If client does not feel safe, ask:

- *'Is there anywhere that you feel safe?'*
- *'Is there someone that you feel safe with?'*
- *'Are there others in your community that you can talk to about how to stay safe?'*
- *'What strategies have you used in the past to stay safe?'*

IV. Explore Next Steps

1 — **Help the person identify and use their existing strengths:** Use your questions to help clients recognize their strengths and existing coping mechanisms:

- ✓ *'What has helped you cope with difficult situations in the past?'*
- ✓ *'What kinds of activities help you when you're feeling anxious or tense?'*

2 —

- ✓ *'How could what has worked in the past be helpful now?'*

3 — **Help the person explore existing support networks:** Use your questions to help clients recognize their existing support networks *(Even if the client does not wish to share their experience with others, spending time with people they trust and enjoy is important):*

- ✓ *When you're not feeling well, who do you like to be with?'*

4 —

- ✓ *'Who has helped you in the past? Could they be helpful now?'*
- ✓ *'Are there people who you trust that you could talk to about this?'*

Arrange follow-up and ask:

- ✓ *'Is it okay if I follow-up with you tomorrow or some other time soon to see how you're doing? How can I get in touch with you?'*

V. Provide Information and Make Referrals to Available Resources:

- Provide printed information about rights and available services;
- Provide caution about taking printed materials home if they live with an abuser;
- Some clients have needs that are beyond what can be provided during first-line response;
- Talk to the client about their options;
- Provide specific information about referral points:

A

- ✓ Name of focal point at referral sites;
- ✓ Hours of operation;
- ✓ Services available at the referral site;
- ✓ Offer to go with the person (or send someone with the person) to referral site.

- Do not pressure anyone to seek additional services;
- Track referrals to ensure completion and satisfaction.

VI. Follow-up

- It is important to follow-up with clients who previously disclosed GBV. This is an opportunity for you to identify any barriers for the client in accessing any referrals that were made and assist the peer in following through with referrals.

Annexure 3
Establish Crisis Response System

The information included in this section draws directly from "Community-led Crisis Response Systems -A Handbook, New Delhi: Bill & Melinda Gate Foundation, 2013."

KP community-led crisis response is a method for responding to the violence, abuse, harassment, and discrimination experienced by KPs. Crisis response must be led by KP communities to be effective and sustainable, so throughout the process, KPs must shape the effort. While implementing partner staff will play an important role in developing and refining the crisis response system, it is important to manage the process in a way that ensures that KPs participate in its leadership from the beginning and gain the skills needed to take over its management.

GUIDENCE FOR IMPLEMENTATION

What is a crisis response system?

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

- ✓ Assessing the nature and urgency of the crisis;
- ✓ Responding to crisis, addressing immediate danger, and providing support;
- ✓ Assisting KPs in resolving crisis and taking steps to prevent future violence;
- ✓ Following up with KPs who access the crisis response system;
- ✓ Working with stakeholders and power structures to advocate on KPs' behalf.

Why is a crisis response system important?

- ✓ Provides immediate and rapid support for KPs who experience crisis;
- ✓ Builds connection and cohesiveness among KPs;
- ✓ Improves self-esteem and ability to negotiate safe sex;
- ✓ Empowers KPs to challenge perpetrators and report/reach out for help;
- ✓ Reduces impunity of the power structures (e.g. Holds police who perpetrate violence against KPs, accountable).

What resources are needed to establish and implement a crisis response system?

A. People/Crisis Response Team

- ✓ A dedicated team, which could include a mix of service providers and implementing partner staff and/or PE and ORW who are trained as members of the crisis response team (PE and ORW can be selected from hotspots/venues/stations where violence is high); Crisis response team members can work in teams of 2-4 on a rotational basis (e.g. weekly rotation);

- ✓ Peer educators and outreach workers raise awareness about the crisis response system among KPs during outreach and other activities;

- ✔ Lawyer(s) on call - as full-time or on retainer basis-who can provide legal support to KPs who are detained and/or arrested by police;
- ✔ Local human rights activists who can assist/advise the crisis response team on regular or as-needed basis.

B. Materials/equipment

- Dedicated mobile phones to be used by crisis response team members during rotation;
- Printed cards with phone numbers and information about how to seek help during a crisis (to be distributed to KPs during outreach and other activities);
- Reporting forms (for crisis response team members to document incidences).

C. Venue/budget

- A drop-in center or other venue for crisis response team meetings;
- Budget to pay for local transport, mobile costs, promotional events/materials, and crisis response team trainings and meetings

Assess the need for and nature of crisis response: When developing any programme or intervention, it is important to understand the needs of the people who will be utilizing the service/system. Use information gathered from assessment activities to understand the:

- Types of violence that KPs experience;
- Barriers that prevent KPs from accessing services when they experience violence;
- Strategies KPs use to protect themselves;
- Needs of KPs who experience violence and other types of crisis;
- Strategies KPs use to cope when they experience violence.

This information should be used to inform the development of the crisis response system to ensure that the system serves the direct needs of KPs who experience violence or other types of crisis

Decide what type of communication system will be used for the crisis response system: The type of communication system that is utilized will depend on available resources, but could include a network of mobiles phones (to be used as hotlines) or phone apps (e.g. WhatsApp group) that is established and shared with KP communities. Phone-based communication systems are recommended so that a person in crisis can contact the response team and get help as quickly as possible. When a person is in crisis, they can call the crisis/hotline number or send text messages using the phone app that has been established. The crisis response team member who receives the call/text/message will determine who in the team is closest to the scene and call that person or persons with the information so that they can respond. They travel to the scene quickly and call other member of the crisis response team for back-up, if needed.

Communications networks can operate at local levels or on regional or state levels: In a local crisis response system, several phones should be purchased for use by the team members, who take turns being the person who will respond to calls. In the beginning, pay-as-you-go SIM cards can be used if it will take time to set up monthly billing for the phones. A coordinator must be appointed to receive calls and mobilize the other team members as needed. When the response system is first set up, the coordinator (usually an NGO staff member) along with a community member is trained. Once several community members have been trained, they can, by rotation, take on the role of coordinator. The coordinator contacts implementing partner staff to keep them informed and oversees any immediate logistical and back-up support for each incident as well as the reporting of the incident.

Print cards with information about how to access the crisis response system and distribute to KPs and other key stakeholders: These cards should be delivered to KPs during outreach activities and other events/activities and provided to key stakeholders involved in the referral network.

1

Organize a crisis response team: The crisis response team should be made up of trained KP members:

2

- KPs should be representative of the localities they are serving and of the different sub-groups of KPs (e.g. brothel-based, street-based sex workers);
- Peer educators are usually members of the team;

3

- Implementing partner staff may also be represented by a staff outreach worker, a staff member working on advocacy, and/or the drop-in centre manager;

4

- The team should be supported by a lawyer (on a retainer or pro-bono), who can be contacted on a 24-hour basis, as needed (this is important because calls often come at night). In the initial stages, especially when KPs are less able to advocate for their rights, the lawyer may be called on to negotiate with the police for the release of those who are wrongfully arrested. As the crisis response system matures, legal support takes the form of educating the KP community about their legal rights and entitlements;
- Implementing partners (e.g. CBOs) may form the basis for the crisis response team, but volunteers from within the group must be designated, and specific training must still be provided;
- Crisis response team members should possess the following qualities:
  - Known to community members and trusted by them;
  - Assertive and willing to speak out to local authorities;
  - Good listening skills;

A

  - Committed to being available by phone 24 hours a day when on duty;
  - Committed to responding to crisis incidents immediately when called on;
  - Disciplined and ready to work as part of a team, including attending trainings and meetings and doing follow-up work when needed.

Train the crisis response team: Crisis response team training should include the following topics and be refined and strengthened with input from KP members:

- Situation assessment of violence and need for crisis response system;
- Identification of the sources of and reasons for violence;
- Identification of other types of crises that the response system should address;
- Functions of a crisis response system;
- Roles and responsibilities of crisis response team members;
- Steps in implementing the crisis response system and responding to crises;
- Hotspots/locations to focus on and the total population to be served;

1

- Stakeholder analysis (institutions and individuals that are perpetrators in crisis situations; others who may influence crises indirectly; leaders who could help in crisis situations and long-term preventive action);

2

- Identification of priority issues, and understanding of the institutional levels at which to address them;

3

- Legal knowledge for emergencies: Under what circumstances a person can be arrested:
  - Correct police procedures when charging a person with a crime and/or detaining them;
  - Rights of a person who is being arrested, charged, and detained.

4

- Legal knowledge for advocacy:
  - Legal status of sex work, homosexual sex, and drug use;
  - How to support cases in court.

- Counseling skills (e.g. providing first-line support, including emotional support, safety planning, exploring options);

- Communication skills, negotiation, conflict management;

- Recordkeeping and documentation;

- Media advocacy.

A

Annexure 4
Reporting Tool

Ministry of Health

VIOLENCE REPORTING FORM

Country _____ Implementing Partner _____

Name of Programme Staff _____ Date ☐☐ ☐☐ ☐☐☐☐

KP Type _____

1 Name _____ Gender (Male/Female/Transgender _____ Age _____

Place of Incident _____ Unique ID _____

2 Date of Incident _____ Time of Incident _____ AM ☐ PM ☐

3 Was the Abuse Against: a) An Individual Yes ☐ No ☐

b) Group Yes ☐ No ☐

4 Form of Incident: Harrasment ☐ Verbal Abuse ☐ Discrimination ☐

Assault/Physical Abuse ☐ Rape/Sexual Assault ☐ Illegal Arrest ☐

5 Perpetrators:

KP being Discriminated/Harassed/Abused by: _____

Rowdies: Yes ☐ No ☐ Family: Yes ☐ No ☐ Police: Yes ☐ No ☐

Partner: Yes ☐ No ☐ General Public: Yes ☐ No ☐ Health Provider: Yes ☐ No ☐

5

Clients: Yes ☐ No ☐ School: Yes ☐ No ☐

Local Authority: Yes ☐ No ☐ Neighbours: Yes ☐ No ☐

Community members: Yes ☐ No ☐ Other KPs (specify) _____

Mob Justice: Yes ☐ No ☐

6

Date and time the KP team made its first attempt to address the incident through its staff

Date

☐☐ ☐☐ ☐☐☐☐ Time _____ AM ☐ PM ☐

7

Actions taken by the office/staff:

a) Was it reported to law enforcement agency? Yes ☐ No ☐

b) Was the KP taken to hospital? Yes ☐ No ☐

c) Linked to paralegal support Yes ☐ No ☐

8

Where is the person now?

Dead ☐ Incarcerated ☐ Hospitalized ☐ At home ☐

9

Follow-up actions that need to be taken? Yes ☐ No ☐

10

Date issue was completely addressed

☐☐ ☐☐ ☐☐☐☐

Annexure 5
Violence Prevention and Response Checklist for Programmes

Ministry of Health

NATIONAL AIDS AND STI CONTROL PROGRAMME

Name of Implementing Agency: _____

Name of County: _____

Type of Key Populations Served: _____

Date: _____

Topic	Questions	Current Status (Y/N)	Remarks
Programme Element I: Core Knowledge Among Implementers and KP Communities	Selected staff in implementing partner trained in advocacy as per national curriculum		
	Selected staff in implementing partner trained in violence prevention and response as per national curriculum		
	Crisis management team identified and trained as per national curriculum		
	Activities to increase knowledge among Key populations in violence and rights planned and implemented		

contd.

Topic	Questions	Current Status (Y/N)	Remarks
Programme Element 2: An Understanding of Violence against KPs and Existing Efforts to Address Violence	IP has conducted discussions with KPs to understand their experiences and concerns related to violence		
	IPs use Micro planning tools used to understand violence (site maps and peer plans) and plans are developed accordingly		
	IP has mapped all the support structures required to address violence including health, mental health, safety and legal support and first line support.		
Programme Element 3: Networks to Ensure KPs' Access to Health, Psychosocial, and Legal Services	A referral directory of services available with all the peer educators at the IP level.		
	IPs sensitise and train referral points with whom the program using national guidelines		
	IPs set up formal MoUs with the referral points		
	IPs trained KPs as media spokesperson using national curriculum in partnership with county KP TWG		
	IPs organised media round tables at county level in partnership with county KP TWG every quarter		
Programme Element 4: Systems to Identify and Respond to Violence	IPs have SOPs for how to identify and respond to violence among KPs		
	IPs have copies of the interpersonal communication (IPC) materials developed by the national programme and have disseminated the same to KPs in their geography		

contd.

Topic	Questions	Current Status (Y/N)	Remarks
	IPs have train all peer educators and outreach workers to identify violence and provide first-line support to victims of violence; and accompany victims of violence to seek additional services		
	IPs have trained their health care providers on violence identification and support		
	IP has established a crisis response system and has made it operational		
	IP has a system where violence response teams meet regularly and support each other		
Programme Element 5: Accountability to Prevent Violence	IPs have mapped the police stations which perpetrate violence		
	IPs regularly meet officials in those identified police stations to sensitise them and seek support for KP programme		
	IPs organise quarterly sensitisation meeting of police and askaris in partnership with the county police and KP-CTWG		
	IPs provide resources to train at the police training academy in partnership with KP-CTWG using national curriculum		
	IPs organise 6 monthly sensitisation of the judiciary in partnership with KP-CTWG using national curriculum		

contd.

Topic	Questions	Current Status (Y/N)	Remarks
	IPs organise 6 monthly sensitisation with religious leaders in partnership with KP-CTWG using national curriculum		
	IPs organise 6 monthly meetings/ updates with county elected rep in partnership with County KP TWG		
	IPs sensitise bar owners and brothel keepers regularly to sensitise them on services available when KPs experience violence and to support them to prevent violence		
Programme Element 6: Documentation and monitoring	IPs document incidents of violence regularly and report to NASCOP quarterly		
	IPs analyse the data and discuss it with the team to improve their strategies to address and prevent violence		

Annexure 6
Violence Prevention and Response Checklist for Research

CHECKLIST FOR SECURITY OF DATA, VOLUNTEERS, AND STAFF IN RESEARCH CONTEXTS

Security in research settings refers to a state in which research data, volunteers, and staff are protected from any threat and/or danger that may come as a result of working with KP communities. Though this may seem difficult to guarantee, measures can be put in place to progressively ensure security is maintained.

Factors to be considered by researchers, community based organizations, program implementers and research funders to protect data, volunteers, and staff:

Data can be physical (print) or electronic and will be classified under:

- **Ultra-Risk Data -** Patient's name or national ID number, biometrics with information pertaining to a study
- **High-Risk -** Volunteer ID and/or date of birth with lab data
- **Low-Risk -** Volunteer ID without sensitive data
- **Electronic Data -** Data stored in any electronic data processing system or device, such as computers, disks, etc., that contain trial data. Good clinical practice (GCP) provides guidelines under section 5.5.3 on how this can be secured (Barnett Educational Services, 2014).
- **Closed System -** Refers to a system in which access is controlled by a person(s) who is/are responsible for the content of electronic records.
- **Open System -** Refers to a system in which access is not controlled by a person(s) who is/are designated responsible for the content of electronic records.[34]

DATA			
Topic	**Questions**	**Current Status**	**Notes**
Planning/ Setup	Is print data securely locked all the time?		
	Have the databases been validated and confirmed as working properly?		
	Are there processes to uniquely identify volunteers?		
	Have the various enrolment (e.g. snowball, online) strategies been assessed for possible security risks to volunteers?		

contd.

Topic	Questions	Current Status	Notes
Operations	Is there any unauthorized access to data?		
	Is the list of authorized users up-to-date?		
	Are **table-top exercises*** scheduled to test a hypothetical situation, e.g. a raid?		
	Are reputable/secure courier services used to transfer sensitive hard copy documents?		
Implementation Phase	Are there adequate data back-ups?		
	Are changes to Case Report Forms (CRFs) documented?		
	Are there audit trails showing how data is moved?		
	What continuous monitoring and evaluation is being done to ensure confidentiality, integrity, authentication, and non-repudiation?		
Close-out & Archiving	Have access privileges been revoked from users who have left the organization?		
	Is there a policy on record retention/ archiving?		

VOLUNTEER			
Topic	**Questions**	**Current Status**	**Notes**
Planning/ Setup	Is there an emergency response and crisis management plan in place (if yes, was it developed with inputs from the community)?		

VOLUNTEER			
Topic	**Questions**	**Current Status**	**Notes**
Planning/ Setup	Is there a contingency budget to assist in emergency situations?		
	Who has access to detailed volunteer-identifying information? And what levels of controls are in place to ensure confidentiality?		
	Which documents contain volunteer-identifying information?		
	Is patient-identifying information/ data shared on email?		
	What plans are to be undertaken to empower and strengthen CSOs working with KPs to provide legal and security support?		
	Are there linkages with paralegals, partners, and other NGOs who support the work of KPs?		
Operations	Does the research institution engage with communities or institutions with the power to support, inflict harm on, or disrupt research activities (e.g. community leaders, law enforcement, the Ministry of Health, religious groups, other CSOs)?		
	Are there any best practice guidelines in use to protect volunteer security? List them.		
Implementation Phase	Are photographs and/or biometrics of volunteers taken at enrolment and volunteer visits?		
	What measures are in place to protect volunteers against entrapment based on existing laws?		

contd.

VOLUNTEER			
Topic	**Questions**	**Current Status**	**Notes**
Implementation Phase	Are volunteers discouraged from sharing their full names with other volunteers?		
	How is sensitive print data destroyed/filed/audited/stored?		
Close-out and Archiving	What plans are in place to share data with the community and society at large when the research is complete? Are there plans to manage any negative responses from the public?		

STAFF			
Topic	**Questions**	**Current Status**	**Notes**
Planning/ Setup	What communication plans for the community advisory board (CAB) are in place to ensure regular updates and feedback are provided to the community?		
	Are there referral mechanisms with legal aid entities and CSOs that support staff?		
Operations	Is staff adequately trained on working with KPs?		
	Is there sufficient security to protect against a mob raid/attack?		
	Are there security escalation and response mechanisms in place, from the county up to the national level?		
	Are standard operating procedures (SOPs) discussed at meetings and what mechanisms exist to ensure implementation?		

contd.

STAFF			
Topic	**Questions**	**Current Status**	**Notes**
Operations	What security drills are conducted at the facility? How often?		
Implementation Phase	What mechanisms exist to ensure that the right staff is hired?		
	Is the staff aware of any available support in case of a breach of security?		
	What security mechanism exists to ensure access to the facility is controlled?		
Close-out and Archiving	What mechanism exists to ensure that all data is returned to the facility when a staff member leaves?		
	What mechanisms are there to ensure all study documents are archived or destroyed appropriately?		

Table-top exercises: These are activities designed to test the theoretical ability of a group (e.g. researcher/community collaborative research project teams) to respond to a situation. These exercises allow staff to test a hypothetical case without causing disruption to the research centre and community. They also help test cooperation and readiness to respond to such situations. In these exercises, a facilitator lays out a scenario to which the study team responds. The scenario shifts and continually evolves depending on how the staff responds, and other external factors.

Recommendations for securing data

Electronic and non-electronic data

It is important to ensure confidentiality, integrity, authenticity, and where possible non-repudiation of electronic and non-electronic data for both open and closed systems. To do this the following may be useful suggestions:

- Protect data/records from unauthorized access, e.g., by securing electronic data in databases with passwords and limiting access to data considered ultra-risk.
- Non-electronic ultra-risk data that could link a participant unique identifier and his/her actual name or ID should be kept separately and under lock and key.
- Assign a person(s) who will maintain electronic data storage and manage the database containing sensitive data—this includes regular backups, time-stamps, etc.

- Restrict access to data rooms/filing centres to authorized personnel.
- Ensure that data are stored accurately and can be easily retrieved when needed for the entire retention period.
- Establish data management and storage policies and protocols that will be enforced.
- Ensure regular updates and upgrades of passwords and access codes, andperform tests to check the robustness of the security system.
- Conduct regular tabletop exercises to help test readiness to respond to hypothetical situations that may threaten data security.

Source of Security Checklist: Respect Protect Fulfill Guidance

Annexure 7
Police Reporting Tool (P3 form)

THE KENYA POLICE MEDICAL EXAMINATION REPORT P3

PART I

(To be completed by the Police Officer Requesting Examination)

From _____ Ref _____

_____ Date _____

To the _____ Hospital/Dispensary

I have to request the favour of your examination of:-

A Name _____ Age _____ If known

Address _____

Date and Time of the alleged offence _____

Sent to you/Hospital on the _____ 20___ under escort of _____

and of your furnishing me with a report of the nature and extent of bodily injury sustained by him/her.

Date and time report to police _____

Brief details of the alleged offence _____

_____

_____

_____ _____

Name of Officer Commanding Station Signature of the Officer Commanding Station

(This P3 form can also be downloaded from: http://www.nationalpolice.go.ke/downloads/category/4-police-forms.html)

PART II
MEDICAL DETAILS

(To be completed by Medical Officer or Practitioner carrying out examination)

(Please type four copies from the original manuscript)

'SECTION A'
THIS SECTION MUST BE COMPLETED IN ALL EXAMINATIONS

1. Medical Officer's Ref. No _____

State of clothing including presence of tears, stains (wet or dry) of blood, etc.

_____

_____

_____

_____

2. General medical history (including details relevant to offence) _____

_____

_____

General physical examination (including general appearance, use of drugs or alcohol and demeanour)

_____

'SECTION B'
TO BE COMPLETED IN ALL CASES OF ASSAULT, INCLUDING SEXUAL ASSAULTS, AFTER THECOMPLETION OF SECTION 'A'

1. Details of site, situation, shape and depth of injuries sustained: - _____

a) Head and Neck _____

_____

_____

b) Thorax and Abdomen _____

_____

_____

c) Upper limbs _____

1 _____

_____

2 d) Lower limbs _____

3 _____

_____

4 2. Approximate age of injuries (hours, days, weeks) _____

_____

3. Probable type of weapon(s) causing injury _____

_____

4. Treatment, if any, received prior to examination _____

_____

A 5. What were the immediate clinical results of the injury sustained and the assessed degree, i.e. 'harm', or 'grievous harm'.*

DEFINITIONS:

'Harm' means any bodily hurt, disease or disorder whether permanent or temporary. 'Maim' means the destruction or permanent disabling of any external or organ, member or sense.

'Grievous Harm' means any harm which amounts to maim, or endangers life, or seriously or permanently injures health, or which is likely so to injure health, or which extends to permanent disfigurement, or to any permanent, or serious injury to external or organ.

_____

Name & Signature of Medical Officer/Practitioner

Date _____

This P3 Form is free of charge

'SECTION C'
TO BE COMPLETED IN ALLEGED SEXUAL OFFENCES AFTER THE COMPLETION OF SECTIONS 'A' AND 'B'

1

1. Nature of offence _____

2

Estimated age of person examined _____

2. FEMALE COMPLAINANT

3

a) Describe in detail the physical state of and any injuries to genitalia with special reference to labia majora, labia minora, vagina, cervix and conclusion _____

4

_____

_____

_____

b) Note presence of discharge, blood or venereal infection, from genitalia or on body externally _____

_____

_____

_____

A

3. MALE COMPLAINANT

a) Describe in detail the physical state of and any injuries to genitalia _____

_____

_____

b) Describe in detail injuries to anus _____

_____

_____

c) Note presence of discharge around anus, or/ on thighs, etc., whether recent or of long standing _____

_____

_____

'SECTION D'

4. MALE ACCUSED OF ANY SEXUAL OFFENCE

a) Describe in detail the physical state of and any injuries to genitalia especially penis

b) Describe in detail any injuries around anus and whether recent or of long standing

5. Details of specimens or smears collected in examinations 2, 3 or 4 of section 'C' including pubic hairs and vaginal hair

6. Any additional remarks by the doctor

Name & Signature of Medical Officer/Practitioner

Date

This P3 Form is free of charge

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