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Ministry of Health

RESPONDING TO VIOLENCE AGAINST KEY POPULATIONS TO PROMOTE ACCESS TO HIV SERVICES

TRAINING MANUAL AND REFERENCE

NASCOP

RESPONDING TO VIOLENCE AGAINST KEY POPULATIONS TO PROMOTE ACCESS TO HIV SERVICES

TRAINING MANUAL AND REFERENCE GUIDE

CONTENTS

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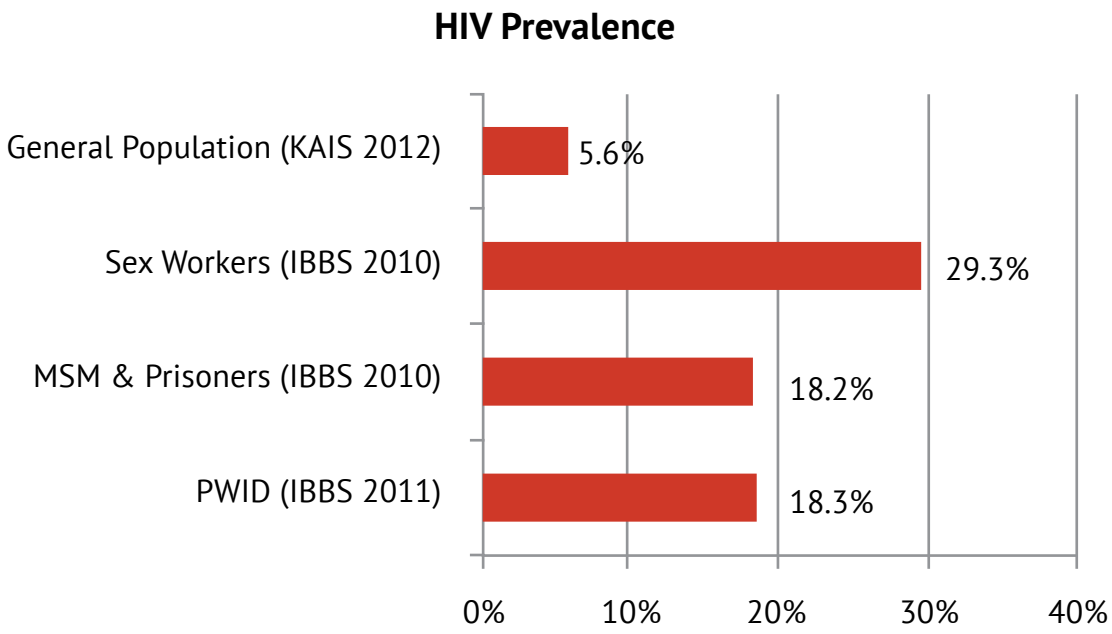
ABBREVIATIONS

ADR	alternative dispute resolution
AIDS	acquired immunodeficiency syndrome
CBO	community-based organization
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DIC	drop-in centre
FGM	female genital mutilation
FSW	female sex worker
HIV	human immunodeficiency virus
KESWA	Kenya Sex Workers Alliance
KP	key population
KRCS	Kenya Red Cross Society
MSM	men who have sex with men
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NGO	non-governmental organization
ORW	outreach worker
PRC	post-rape care
PWID	people who inject drugs or person who injects drugs
SOA	Sexual Offences Act
SOP	standard operating procedure
STI	sexually transmitted infection
SW	sex worker
TSU	technical support unit
UN	United Nations
UNFPA	United Nations Population Fund
VRT	violence response team

INTRODUCTION

To end the HIV epidemic in Kenya, it is essential to reduce HIV prevalence among groups whose behaviours and social marginalization heighten their risk of and vulnerability to infection. Because of their strategic significance for HIV control, such groups are referred to as key populations. The Kenya AIDS Strategic Framework 2014/15–2018/19 (KASF) identifies these key populations as female sex workers (FSWs), male sex workers (MSWs), men who have sex with men (MSM), and people who inject drugs (PWID).[1] Because of their elevated risk and vulnerability, key populations have higher rates of HIV prevalence than the general population, as shown in figure 1.

Figure 1. HIV Prevalence among General and Key Populations in Kenya[2]



In 2008, 14.1 per cent of new HIV infections in Kenya were attributed to sex workers and their clients, 15.2 per cent of new infections were attributed to men who have sex with men and prison populations, and 3.8 per cent were attributed to people who inject drugs.[3] By these figures, approximately 33 per cent of all new infections in the country are attributed to key populations.

Kenya has large populations of sex workers, MSM, and PWID. Recent mapping estimates show that there are 133,675 female sex workers throughout the country, with significant regional

1 National AIDS Control Council (NACC). *Kenya AIDS Strategic Framework (KASF) 2014/15–2018/19.* Nairobi: NACC, Ministry of Health, Kenya.

2 National AIDS and STI Control Programme (NASCOP). 2013. *Kenya AIDS Indicator Survey 2012.* Nairobi: NASCOP. And National MARPs Programme, National AIDS and STI Control Programme (NASCOP) 2014. *2010–2011 Integrated Biological and Behavioural Surveillance Survey among Key Populations in Nairobi and Kisumu, Kenya.* Nairobi: NASCOP, Ministry of Health, Kenya.

3 National AIDS Control Council (NACC). 2009. *Kenya HIV Prevention Responses and Modes of Transmission Analysis.* Nairobi: NACC, Ministry of Health, Kenya.

variations ranging from a high of 29,494 FSWs in Nairobi Province to a low of 2,030 in North Eastern Province. In some cities 15 per cent of women are sex workers. It is estimated that there are 19,175 men who have sex with men and/or male sex workers, and 18,327 people who inject drugs in Kenya.[4] These populations have many connections to the general population, including sexual and drug injecting relationships through which HIV is transmitted between key populations and members of the general population.

To reduce HIV prevalence among key populations, the KASF recommends scaling up HIV-prevention interventions so that 90 per cent of key population members are covered. Interventions targeting key populations in Kenya currently reach only 64 per cent of estimated female sex workers, 47 per cent of estimated men who have sex with men, and 44 per cent of estimated people who inject drugs.[5] A combination of targeted biomedical, behavioural, and structural interventions is required to simultaneously reduce key populations' HIV risk and vulnerability.[6]

STRUCTURAL DRIVERS OF HIV TRANSMISSION

Structural factors such as violence, poverty, stigma and discrimination, and gender inequality increase people's vulnerability to HIV.[7] The KASF specifically takes cognizance of violence against key populations because of its contribution to HIV vulnerability. The significance of violence as a risk factor is evident from epidemiological modelling which has suggested that "elimination of sexual violence alone could avert 17 per cent of HIV infections in Kenya . . . through its immediate and sustained effect on non-condom use among FSWs and their clients in the next decade."[8]

The WHO defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."[9] Gender-based violence has been defined as, "violence involving men and women, in which the female is usually the victim and which arises from unequal power relationships between men and women."[10]

Violence against members of key populations in Kenya is common. In a study with female sex workers in Kenya, 59 per cent reported having been raped.[11] Among sex workers surveyed

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4 National AIDS and STI Control Programme (NASCOP) 2013. *Geographic Mapping of Most at Risk Populations for HIV (MARPs) in Kenya.* Nairobi: NASCOP, Ministry of Health, Kenya.

5 NASCOP programme data, 2014.

6 National AIDS Control Council (NACC). *Kenya AIDS Strategic Framework (KASF) 2014/15–2018/19.* Nairobi: NACC.

7 Gardsbane D. 2010. Gender-based violence and HIV. Arlington, VA, USA, United States Agency for International Development.

8 Shannon K. et al. 2015. Global epidemiology of HIV among female sex workers: Influence of structural determinants. *Lancet.* 385:55–71 http://dx.doi.org/10.1016/S0140-6736(14)60931-4

9 WHO. 2002. World Report on Violence and Health: Summary. Geneva: World Health Organization.

10 Fernandes et al. 2005. Working with Men on Gender, Sexuality, Violence and Health: Trainers' Manual. Vadodara, Gujarat, India: Sahaj. http://menengage.org/wp-content/uploads/2014/06/Working_with_men_on_gender.pdf

11 Federation of Women Lawyers FIDA Kenya. 2008. Documenting Human Rights Violations of Sex Workers in Kenya: A Study Conducted in Nairobi, Kisumu, Busia, Nanyuki, Mombasa and Malindi. Nairobi: FIDA Kenya. https://www.opensocietyfoundations.org/sites/default/files/fida_20081201.pdf

in Coast Province, 66 per cent reported at least one form of sexual violence, including being forced to have sex without a condom, being beaten, or being verbally abused.[12] Forty-four per cent of FSWs, 24 per cent of MSM/MSWs, and 57 per cent of PWID reported experiencing violence from police and askaris in the six months preceding polling booth surveys conducted by NASCOP in 2014. In the same NASCOP polling booth surveys, 22 per cent of FSWs, 17 per cent of MSM/MSWs, and 8 per cent of PWID reported been beaten or forced to have sex in the preceding six months.

Law enforcement agents are a significant source of violence against KPs. Studies by NASCOP in 2014 and 2015 found that violence against KPs by law enforcement agents is common, and that such violence against MSM and FSWs increased in that time period, as shown in Table 1.

Table 1. Proportion of KPs Who Reported Being Arrested or Beaten by Law Enforcement Officers in 2014 and 2015

Polling-booth survey question	FSWs		MSM		PWID	
	2014	2015	2014	2015	2014	2015
In the past 6 months, were you ever arrested or beaten up by police or city Askaris when you were injecting drugs / doing sex work / cruising?	44%	49%	24%	27%	57%	43%

Reports from Mombasa and Nairobi indicate that PWID experience harassment from police and county law enforcement.[13] Such harassment includes excessive use of force, false accusations, coercion of confessions, confiscation of injecting equipment, and extortion of money.

Violence committed by law enforcement agents against KPs significantly complicates and frustrates HIV-prevention interventions. Such violence creates fear and isolation among key populations, making it more difficult for HIV-prevention interventions to reach KPs. Police confiscation of condoms and syringes disrupts harm-reduction efforts and results in unprotected sex and unsafe injecting practices, which carry high risk of HIV transmission.[14] Ignorance, prejudice, and disapproval toward key populations lead to police complacency and inaction when assaults or violations against key populations occur. Through such conduct, law enforcement agents violate key populations' rights to health services, protection, liberty, privacy, and justice.

TARGET AUDIENCE

This manual and reference guide will be used by trainers for training NGO and CBO leaders to train their staff and key populations to understand their human rights and to recognize,

12 Tegang SP, Emukule G, Kitungulu B. 2008. APAHIA II Baseline Behavioral Monitoring Survey Report. Coast – Rift Valley, 2007. Nairobi: Family Health International.
13 KELIN. 2013. Regional Capacity Building Workshop for Senior Law Enforcement Officers on HIV, Human Rights & the Law. 17 to 19 July 2013 in Nairobi, Kenya. Nairobi: KELIN. http://www.hivlawcommission.org/resources/elibrary/REGIONAL-CAPACITYBUILDINGWORKSHOP.pdf
14 Strathdee et al. 2011. Social and structural factors associated with HIV infection among female sex workers who inject drugs in the Mexico-US border region. *PLoS ONE* 6(4): e19048. doi:10.1371/journal.pone.0019048

prevent, respond to, and help survivors seek justice after incidents of violence and other rights violations.

RATIONALE FOR TRAINING KEY POPULATION PROGRAMME IMPLEMENTERS

Key populations are especially vulnerable to violence, which violates their human rights and increases their vulnerability to HIV infection. Key population leaders and people who work with key populations therefore need to be trained to teach key populations how to realize their human rights, how to recognize threats to their rights, how to assist survivors of violence, and how to defend themselves and their rights from violation.

THE OBJECTIVES OF THIS TRAINING

This training's objectives are for NGO and CBO leaders to be able to train their staff and members

- to recognize forms of violence against key populations and violence's impact on them;
- to devise strategies to prevent and respond to violence against KPs;
- to understand human rights and the state's obligation to respect, protect, and fulfill human rights; and
- to develop plans to implement violence prevention and response programmes in their respective projects.

PREPARING FOR THE TRAINING

Facilitators must be well prepared in order to ensure the success of the training. It is crucial for facilitators to allocate ample time for planning and preparation. This entails carefully scheduling the tasks.

Workshop Schedule

A workshop schedule should be prepared with specific tasks to be performed and the persons to perform these tasks. It should also specify the time frame within which these tasks should be performed. Whenever possible, standards should be set against which the success of the activity can be measured.

Workshop Checklist

The trainer should prepare a workshop checklist of items to be bought and tasks to be performed before the workshop. The following list can be used as a guideline:

- **Venue**
  A good venue in comfortable surroundings and with all necessary facilities should be selected, booked, and confirmed beforehand. Ensure there are adequate rooms for boarding, if necessary. Transport to the venue should be arranged early and participants informed in advance. Discuss with management and agree on the menu and other items like snacks, tea, and coffee. Take into account facilities for people with special needs, such as those who have disabilities.

- **Become Familiar with this Manual/Guide**
  The presenter or facilitator should read through this training manual/reference guide weeks before the training.

- **Workshop Programme**
  Ensure that you have a clear and detailed programme that gives each facilitator clear guidance on tasks ahead (see annex 1 for an overview of the modules and sessions). Allocate enough time for breaks, rest, leisure, and exercise. This should be circulated early to the facilitators and participants to acquaint themselves with the workshop session and time allocation.

- **Resources**
  Ensure that you have adequate finances and resources for the workshop.

- **Participants**
  Think about the people you are preparing the course for. Consider how you can adapt some of the activities to make them fit the local context. Can you do anything to make the content and activities more relevant and stimulating for your group? Consider the difficulties and challenges that might arise among the group you will be working with and how you would address them. Communicate to the participants in advance to ensure that they know what to expect from the workshop, what to prepare for and what to bring to the workshop, dress code, how to get to the venue, the workshop programme, and the topics, etc. Prepare name badges for the participants and yourself, and ensure that all participants know where to find facilities, such as the toilets.

- **Scheduling the Training**
  This is a three-day training workshop.[15] The facilitator is at liberty to tailor-make his/ her training workshop; however, the following tips are useful:
  1. Hold the workshop during normal working hours.
  2. Ensure that the participants are a manageable number of persons. To enable discussion and encourage everyone to participate, it is advisable to have not more than 35 participants.
  3. Determine beforehand the length of the course.
  4. Prepare a module plan to guide you on how much time to spend on each topic. Do not overload the programme. There should be enough time for tea/coffee breaks and lunch.
  5. Provide for recreational events to enable participants to relax.
  6. Difficult and intense topics should be presented and discussed in the morning when participants are still fresh and alert. Afternoon should be for activities that keep participants awake.
  7. Prepare the materials you will need for the training. Use whatever materials are appropriate and available to you. These may include overheads, flip charts, PowerPoint presentations, or other presentation materials.

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15 This three-day training can be merged with the National AIDS Control Council's two-day human rights training to make a five-day training (National AIDS Control Council 2015. *Training of Trainers Manual: Guidance for Trainings on Key Populations' Human Rights.* Nairobi: NACC.) The training manual is available at the NACC's website: http://www.nacc.or.ke/

- **Pre- and Post-Training Assessment**
  It is necessary to administer a questionnaire to assess participants' familiarity with the issues before and after the workshop (see handout 1 for the pre-/post-training assessment questionnaire). The questionnaire should be given on the first day, and again on the final day. The assessment should be brief and not technical.

- **Evaluation**
  A comprehensive evaluation of the workshop should be undertaken at the end of the workshop. It should assess all the aspects of the workshop and seek recommendations.

- **Workshop Report**
  This should be finalized three weeks after the workshop and should detail the actual workshop process. It should include the names of the participants and their contacts.

TIPS FOR FACILITATORS

- Facilitators should be well organized and plan in advance.
- Facilitators should always arrive at the venue well before the participants to ensure the room is ready and to sort out any problems so the session can begin on time.
- They should use this manual flexibly and adapt it to fit local circumstances and the needs of the participants.
- The facilitator should know that violence presents some particular challenges, as many issues are complex and can be difficult to talk about. They are likely to address family relationships, parent-child relationships, and sexual relationships and practices. These areas are sensitive at the best of times and will be particularly so during the course.
- The facilitator should be aware of the feelings of the participants, take a break if people become upset, and tell participants it is fine to leave the session for a while if they need to.
- The facilitator should
  - Be a good listener and respond to the needs that participants express.
  - Be sensitive to the needs and emotions of individuals and groups.
  - Make all participants feel safe, respected, and valued.
  - Encourage everyone to take part. Give quiet people a chance to speak.
  - Tell people who speak too much that the group needs to hear other people's thoughts.
  - Motivate and inspire people.
  - Ask people to help when appropriate.
- The facilitator should help people to get the most from the course content by
  - Providing guidance and leadership. For example, make sure the agreed content of modules is followed. This will happen only if you keep time effectively and move people on when necessary.
  - Being flexible, so that you can include important issues as they arise, while recognizing the importance of keeping to the timetable.
  - Knowing the course well, so you can link activities to lessons, topics to people's individual needs, and themes between sessions.
  - Clarifying the important points from participants' contributions and summarizing them to the group.
  - Being thought-provoking, and challenging people to think.

    - Admitting when you do not know something. Participants will generally appreciate your honesty.
    - Being ready to tell participants where they can get help and support after the course ends.
- The facilitator should be able to deal with differences by
    - Appreciating that participants have had a range of experiences and are likely to be at different starting points. Their levels of engagement and the pace at which they move will also differ. Be ready to explain things more than once and to summarize points.
    - Being prepared to manage tensions and conflict—for example, by making clear what is and is not relevant and appropriate to the course. Ask individuals to resolve their differences at another time, if necessary.
- The facilitator should maintain confidentiality and anonymity. Participants want to share information about their experiences working with violence survivors and their families. Any incidents or cases that participants want to discuss should be disguised in a way that removes any potentially identifying information. For example, change the age of the survivor, the location of the incident, and/or some details about the incident. Never mention real names or locations.

MODULE 1

GETTING STARTED

Total time: 3 hours and 15 minutes

OBJECTIVES

By the end of module 1, participants will have

- introduced themselves to each other,
- shared their expectations and learned the workshop's objectives, and
- become acquainted with each other and with the setting.

MATERIALS NEEDED

- **Handout 1:** Pre-/ post-training assessment questionnaire
- Flip chart
- Markers

SESSION 1:
WELCOME AND INTRODUCTIONS

Time: 30 minutes

Steps

1. The facilitator either places the registration form at the entrance or circulates the registration form to the participants and asks them to register themselves. The facilitator collects the registration form once everyone has registered themselves, verifies that all have registered properly, and then enters the names into a computer.
2. The facilitator welcomes participants and thanks them for their presence.
3. The facilitators introduce themselves. (Note: A list of the participants, their addresses, and contact points should be available to the trainers/facilitators before the workshop and it should be verified and updated during the course.)
4. The facilitator explains to the participants the purpose of the pre-training assessment: *The purpose of the pre-training assessment is for the facilitator to learn each participant's knowledge regarding the topics that will be covered during the training. This same questionnaire will be administered at the end of the training to determine what the participants learned during the training. A final score is given at the end of the training.*
5. The facilitator distributes the pre-training questionnaire **(handout 1)** to each participant.
6. The facilitator asks participants to respond to the questionnaire as honestly as possible.
7. Although the questionnaire is self-explanatory, the facilitator should answer participants' questions if they are uncertain about anything.
8. For participants who are not able to read and write, the facilitator assists them to complete the questionnaire.
9. The facilitator collects the questionnaires and makes sure that the participants see that the collected questionnaires are sealed by the facilitator in an envelope.
10. The facilitator asks the participants to undertake self-introductions utilizing the following guideline:
    - Complete name, including the preferred name
    - Station (location or county where they work)
    - One unique thing about each participant
    - One expectation they have for this training workshop (what they hope to learn/accomplish, any difficulties they anticipate, how they hope to be able to use the training).
11. The facilitator writes participants' expectations on the flip chart.

SESSION 2:
GROUP NORMS

Time: 20 minutes

Steps

1. The facilitator asks participants to brainstorm norms/ground rules and lists them on a flip chart.
2. The facilitator can add any important rules that participants may have omitted (see below).
3. The facilitator then posts them in a visible spot in the room for reference as needed throughout the training.

The following are some suggested ground rules:

- Participate actively.
- Respect each other's opinions and experiences.
- Be on time for all activities.
- Responsible use of phones: either turn mobile phones off or silence them during the training.
- Roles and responsibilities: team leader/ welfare, spiritual, time keeper, energizer.
- De-role to create equality (exercise – give them a paper and instruct them to list their titles, collect the papers, and then inform them that they are all participants).
- Confidentiality – whatever the participants discuss or share during the training will be kept confidential by the participants.

SESSION 3:
OBJECTIVES AND EXPECTATIONS

Time: 20 minutes

Preparation

The facilitator prepares a flip chart or a PowerPoint presentation on the objectives of the training.

Workshop objectives

This training's objectives are for NGO and CBO leaders to be able to train their staff and members

- to recognize forms of violence against key populations and violence's impact on them;
- to devise strategies to prevent and respond to violence against KPs;
- to understand human rights and the state's obligation to respect, protect, and fulfill human rights; and
- to develop plans to implement violence prevention and response programmes in their respective projects.

Steps

1. The facilitator presents the workshop's objectives and compares them to participants' expectations shared by the participants during session 1.
2. The facilitator also presents the training timetable to the class.
3. The facilitator then invites the participants to ask any questions or seek any clarifications. Where realistic, note the additional, relevant objectives based on participants' expectations.
4. The facilitator addresses any emerging issues (e.g., concerns about participants' accommodation, money matters, health issues).

SESSION 4:
TAKE A STAND

Time: 45 minutes

Steps

1. Write on separate sheets of paper or on separate flip-chart sheets the following three statements, so that there is one statement on each sheet:
   - AGREE
   - DISAGREE
   - UNDECIDED
2. Pin up these statements at various corners of the training room. Ensure there is adequate space for participants to stand around the statements without overlapping with participants standing near other statements.
3. Instruct participants that you will read out various assertions, after which they are to stand beside the statement that best resonates with their opinion about the assertion.
4. Read out the following assertions (you may vary the assertions as appropriate for the trainees/audience):
   - *Men are by nature promiscuous, but women should be faithful.*
   - *Homosexuality is a creation of the West and has no place in African society.*
   - *Those who get raped are most of the time to blame.*
   - *Prostitution is immoral.*
   - *Those who inject or use drugs are to blame for their problem because they can stop the habit if they want to.*
5. Assertion-by-assertion, open discussion to the entire group. Give your input.
6. Present the myths and facts found in **annex 3**.

MODULE 2

INTRODUCTION TO VIOLENCE

Total time: 4 hours and 40 minutes

OBJECTIVES

By the end of module 2, participants will

- understand now violence increases key populations' HIV vulnerability;
- understand the roles of power, force/violence, and consent in social relations;
- be aware of human rights and Kenya's Bill of Rights;
- be able to differentiate between myths and facts about gender roles and violence;
- understand confidentiality;
- have an overview of how to plan a violence prevention and response intervention.

MATERIALS NEEDED

- PowerPoint presentation entitled *Violence Prevention among Key Populations as a Means to HIV Prevention in Kenya*
- Flip chart
- Markers
- **Handout 2:** Planning a violence prevention and response intervention

SESSION 1: INTERSECTION BETWEEN HIV AND VIOLENCE

Time: 30 minutes

Steps

1. Make the presentation entitled *Violence Prevention among Key Populations as a Means to HIV Prevention in Kenya*, found in **annex 4**.

SESSION 2: POWER WALK

Time: 45 minutes

Steps

1. Inform the participants that they are going to be involved in an exercise. The exercise entails volunteers assuming assigned roles (described in point 3). Ask for eight volunteers (or however many is appropriate for the number of trainees).
2. Inform the volunteers that they will be asked basic health rights-related questions. They will take one step for each statement that resonates positively to their role. If the statement does not relate to their role, they are to remain where they are.
3. Some of the roles that can be assumed by volunteers are (this can be varied depending on context, audience, and target issue)
   (a) A 30-year-old sex worker who lives in Homabay with her 3 under-5 children
   (b) A 22-year-old female drug user operating in Ngara, Nairobi
   (c) A 25-year-old MSM rejected by his family, living with friends in the beach side of Ukunda, Kwale
   (d) A 19-year-old orphaned street-based sex worker staying with her grandmother in Nakuru
   (e) A 40-year-old male drug user and rag picker in Mombasa
   (f) A police officer from Starehe police station in Nairobi
   (g) A nurse from the government hospital in Eldoret
   (h) A housewife from Nyali in Mombasa
4. Inform the non-volunteering participants that their tasks will be to observe and validate the moves to ensure that the volunteers take moves that reflect the lived reality of the persons whose roles they have been assigned.
5. Read aloud the following statements:
   - I am assured of my next meal.
   - If in need of sexual and reproductive health services, I can walk into a nearby public health facility.
   - If I was to have sex, I would make a decision on the safest way to engage in it (sex).
   - I am assured of my safety when walking about in the community.
   - In case I am sexually assaulted, I am assured of getting help from a police station near me.
   - I have friends whom I can depend on.
   - My family will support me whatever I do.
   - I can take care of my children and send them to good school and feed them well.
   - I will get a clean needle whenever I want.
   - I can have a loving relationship with my partner/ lover/ spouse.

   Note: Reiterate that for each statement the participants should take steps as appropriate to their roles.
6. After all the questions are asked, ask the observing participants if the steps taken are valid in reference to the real life situation in the community or not.
7. Ask the participants to observe if one of the volunteers is ahead of other.
8. After the exercise, engage the participants in a plenary discussion on

what they learnt.

Likely observations and points to emphasize on a flip chart sheet at the top of which you write POWER:

- Who took most steps ahead? Why?
- Who was left behind? Why?
- Who has most access to resources?
- What makes someone powerful (education, social acceptance, position in the society, job with a good reputation)?
- What makes someone powerless (profession, sexuality, addiction)?
- How do we behave with people who have power?
- How do we behave with people who have less power?

Discuss why it is important to protect the rights of the powerless, and our role in protecting their rights.

Points to note

People can have "real" or "perceived" power. Some examples of different types of power and powerful people:

- Social—peer pressure, bullying, leader, teacher, parents.
- Economic—the person who controls money or access to goods/services/money/favors: sometimes husband or father.
- Political—elected leaders, discriminatory policies and laws, leader of country or party.
- Physical—strength, size, use of weapons, controlling access or security: soldiers, police, robbers, gangs.
- Gender-based (social)—because of cultural and religious beliefs and practices, males are usually in a more powerful position than females.
- Age-related—often, the young and elderly people have the least power.
- Profession—the kind of work one does, depending on its acceptability in the society, can give one power.
- Sexuality—because of cultural and religious beliefs, some sexual preferences may not be acceptable, like same-sex relationships.

Power is directly related to choice. The more power one has, the more choices available. The less power one has, fewer choices are available. Un-empowered people have fewer choices and are therefore more vulnerable to abuse.

Violence involves the abuse of power. Unequal power relationships are exploited or abused.

SESSION 3:
USE OF FORCE

Time: 20 minutes

Steps

1. On a new blank flip chart, write the word VIOLENCE.
2. Ask each participant to take a piece of paper and write two words or phrases to describe what we mean by "violence". This is an individual activity, not group work. Allow a few moments for everyone to write their two words.
3. Go around the room, one by one, asking each person to give one word/phrase they wrote.
4. Put the words on the flip chart. Keep going around the room until you have everyone's words on the flip chart. This should be a very quick exercise; ask participants not to repeat things from their lists that others have already said. Participants usually give a combination of examples of types of violence, as well as some definitions of violence. Write all on the flip chart.
5. Stand back from the flip chart and facilitate a short discussion to thresh out the points to note. Clarify any confusing points; cross out any words or phrases that participants agree do not belong on the list.
6. At the top of the flip chart, write USE OF FORCE next to VIOLENCE. It should look like this:
   VIOLENCE / USE OF FORCE
7. Summarize by explaining that violence in this context involves the use of some type of force, real or implied (which means that someone believes they have this force), and this is a key element in defining what we mean when we say "violence."
8. Tape the VIOLENCE flip chart on the wall near the POWER flip chart, where they both can be seen and referred to later in the session.

Points to note

Force might be physical, emotional, social, or economic in nature. It may also involve coercion or pressure. Force also includes intimidation, threats, persecution, or other forms of psychological or social pressure. The target of such violence is compelled to behave as expected or to do what is being requested, for fear of real and harmful consequences.

Violence consists of the use of physical force or other means of coercion such as threat, inducement, or promise of a benefit to obtain something from a weaker or more vulnerable person. Using violence involves forcing someone to do something against her/his will—use of force.

It is very important to highlight that physical force is not the only kind of force. There are many kinds of force that are equally effective.

SESSION 4:
INFORMED CONSENT

Time: 15 minutes

Steps

1. On a new blank flip chart, write the word CONSENT.
2. Ask participants what consent means to them. Write their responses on the flip chart.
3. If this is a new idea to them, explain this concept. You can give the example of medical care.

Medical care example

A person must have all the information they need in order to make an informed decision about a medical procedure—what exactly is involved, all the risks and benefits—before they make the decision. The decision should be their decision only, and they should not be pressured to make the decision by the doctor or anyone, as it is their life, their body. Discuss their responses and be sure to stress the two necessary components of consent: that it is informed and voluntary.

4. Summarize the session by pointing to all three flip charts—POWER, VIOLENCE/USE OF FORCE, and CONSENT. Quickly review the main points of each of these key concepts and answer participants' questions.

Points to note

Consent means saying "yes," agreeing to something. Informed consent means permission granted in full knowledge of the possible consequences.

Acts of violence occur without informed consent. If a woman says "yes," this is not true consent if it was said under pressure—for example, if the perpetrator(s) used some kind of force to get her to say yes, such as intimidation or deceit. Children (under age 18) are generally deemed unable to give informed consent for acts such as marriage, sexual relations, etc.

Ask participants to share their experiences of power, violence, or consent, and the consequences of the same.

SESSION 5:
THE KENYAN CONSTITUTION AND HUMAN RIGHTS

Time: 30 minutes

Steps

1. Write THE KENYAN CONSTITUTION on the flip chart and ask participants if they know any provisions in the Constitution that protect human rights.
2. Write HUMAN RIGHTS on the flip chart. Ask participants, "Who has human rights?" and write their responses on the paper. Explain that everyone has human rights.
3. Ask the respondents who or what grants human rights. Explain that nobody gives or grants these rights to you. You have them automatically from birth. Human rights are inherent to all humans.
4. Ask participants for examples of human rights, and write their responses on the paper.
5. Discuss their responses.
6. Explain that human rights and Kenya's Bill of Rights will be presented in more detail in module 6 of this workshop.

Points to note

Human rights are universal, inalienable (cannot be taken away), indivisible, interconnected, and interdependent. Everyone is entitled to all rights and freedoms, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.

Prevention of and response to violence are directly linked to the protection of human rights because acts of violence violate a number of human rights principles enshrined in chapter four of the Kenyan Constitution. These rights include

- the right to life, liberty, and security of person;
- the right to the highest attainable standard of physical and mental health;
- the right to freedom from torture or cruel, inhuman, or degrading treatment or punishment;
- the right to freedom of opinion and expression, education, social security, and personal development;
- the right to freedom of movement;
- the right to enter into marriage with free and full consent and the entitlement to equal rights at the time of the marriage, during the marriage, and at its dissolution; and
- the right to cultural, political, and public participation; equal access to public services; work; and equal pay for equal work.

Several international instruments specifically address violence against women and girls. These include

- the Convention on the Elimination of All Forms of Discrimination against Women,
- the United Nations Declaration on the Elimination of Violence against Women, and
- the Beijing Declaration and Platform for Action.

SESSION 6: CONFIDENTIALITY

Time: 20 minutes

Steps

1. The facilitator asks the participants to brainstorm on what they understand by the term confidentiality and its importance when responding to violence.
2. The facilitator writes the responses on a flip chart.
3. The facilitator then addresses the definition and the importance of confidentiality when responding to violence.

Notes for facilitators

Confidentiality
Confidentiality is the agreement between two individuals (client and helper) not to share anything that is said or done with anyone else without the express permission of the client. Confidentiality is important when responding to violence since it

- enables the survivor to feel safe in the helping session,
- protects the survivor after the helping session, and
- promotes trust between the survivor and the helper.

SESSION 7: PLANNING A VIOLENCE PREVENTION AND RESPONSE INTERVENTION

Time: 2 hours

Steps

1. Across the top of a white board or on three sheets of chart paper, write the following headings: PREVENTION ACTIVITIES, RESPONSE ACTIVITIES, CROSS-CUTTING ACTIVITIES.
2. Distribute **handout 2**: Planning a violence prevention and response intervention.
3. Ask the participants to read the handout and to categorise the activities into prevention activities, response activities, and cross-cutting activities.
4. Write all the activities under these categories on a white board or chart paper.
5. Ask the participants whether their organisations have implemented any of these activities. If they have done so, ask them to share some of their successes and challenges.
6. Conclude by stating that this training will help them understand and plan for the activities that are needed to prevent and respond to violence.

MODULE 3

UNDERSTANDING VIOLENCE AGAINST KEY POPULATIONS

Total time: 3 hours and 15 minutes

OBJECTIVES

By the end of module 3, participants will be able to

- list types of violence,
- identify common perpetrators of violence,
- explain the causes of and factors contributing to violence, and
- explain the effects of violence, including its impact on HIV vulnerability.

MATERIALS NEEDED

- **Handout 3:** Case Studies
- Four flip charts
- Markers

SESSION 1:
TYPES OF VIOLENCE

Time: 1 hour

Steps

1. Ask the group to give some examples of violence against key populations. Stop the discussion when you have 5–8 examples. Examples are rape, domestic violence, and sexual exploitation.
2. Clarify that there are many forms of violence. Explain also that there are similarities in the types of assistance provided to survivors of any form of violence.
3. Write the following types of violence on the top of four flip charts:
   - SEXUAL
     - Violates sexually.
   - PHYSICAL
     - Hurts the body.
   - PSYCHOLOGICAL
     - Emotional, mental, social—hurts feelings.
   - ECONOMIC
     - Controls access to money, resources, or property.
4. Explain that we can group the different types of violence that we see into these four main groups.
5. Divide participants into four small groups. Assign each group one of the general types of violence you wrote on the flip charts in step 3.
6. Ask groups to brainstorm and come up with examples of their type of violence. They should write these examples on a flip chart paper. Give the groups 10 minutes to complete their assigned tasks. (Note: facilitator should move around the room to see how groups are doing and offer assistance if they are stuck. The group with economic violence may need some assistance.)
7. When groups are finished, they should post their lists around the room for others to see.
8. One representative from each group should remain with the flip chart to answer or clarify any questions that may come up.
9. Instruct participants to walk around the room, to read what the other groups have written, and to discuss any questions with the group's representative.
10. Allow 5–10 minutes for participants to view each group's work and to discuss among themselves. Monitor progress; allow more or less time as needed.
11. Ask everyone to return to their seats. Ask a few discussion questions; discuss for approximately 10 minutes:
    - Ask, "Were there any examples listed that you disagree with?"
    - Ask, "Did anything surprise you?"
    - Ask, "Are there examples of VIOLENCE that were repeated in different groups?"
    - Instruct participants to look around the room at the different kinds of interpersonal violence.
    - Ask, "What does this mean to you?"

Types of violence experienced by KPs are found in **annex 5**.

SESSION 2: SURVIVORS AND PERPETRATORS OF VIOLENCE

Time: 15 minutes

Steps

1. Write SURVIVOR and VICTIM on the flip chart.
2. Ask the group to explain the difference between these two terms. Discuss.
   - What comes to mind when you hear the word "victim"? "Survivor"?
   - What does a survivor look like? What does a victim look like?
   - Survivor is the preferred term for those who have lived through a violent incident.
   - Who might be especially at risk of becoming a victim or a survivor?
3. On a blank flip chart, write the word PERPETRATOR.
4. Explain that a perpetrator is a person who commits an act of violence. There might be only one perpetrator, or there might be more.
5. Ask the group to list types (i.e., categories or groups) of people who can be perpetrators—no names, just types of people. Write responses on the flip chart. Continue to ask until you have a long list (at least 5 types of people).
6. Close the session by emphasizing to the group that in any act of violence there is a survivor and a perpetrator. Therefore, all of our actions in prevention must address potential survivors and potential perpetrators. And all of our actions in response need to address both the survivor and the perpetrator, when the perpetrator is known.

Points for Discussion

Survivor is the preferred term for a person who has lived through an incident of violence. It is useful to visually demonstrate with your body language what a victim looks like and what a survivor looks like:

- The word "victim" conjures an image of someone who is weak, sick, small, hunched over, crying, clothed in rags, unable to function in the world. It is a sad, disempowering word.
- The word "survivor" conjures an image of someone who stands straight and tall, uses eye contact, walks with confidence, lives life to the fullest. It is a powerful, empowering word.

Survivors/victims can include

- sex workers
- women, because they are usually second class, culturally considered inferior
- men who have sex with men
- people who inject drugs

A perpetrator is a person, group, or institution that inflicts, supports, or condones violence or other abuse against a person or group of persons. Characteristics of perpetrators:

- persons with real or perceived power
- persons in decision-making positions
- persons in authority

Categories or groups of people who are potential perpetrators:

- intimate partners (husbands, boyfriends)
- lodge managers
- brothel owners
- clients
- pimps
- drug peddlers
- law enforcers (e.g., police, askaris)
- anyone who is in a position of power

For any incident of violence, there is a survivor and a perpetrator. Therefore, all our actions in prevention and response need to address both the survivor and the perpetrator.

SESSION 3:
CAUSES OF VIOLENCE

Time: 1 hour

Steps

1. Separate participants into four groups, and explain that each group will review a case study from a handout. (The case studies are in **handout 3**.)
2. Number the groups from 1 to 4 and assign one case study to each group to read.
3. Distribute the handouts with the case studies on them.
4. Give the groups about 10 minutes to read the case studies.
5. Instruct the groups to choose a group member to take notes.
6. Ask each group to read their case study and identify what type of violence is listed in their story. They should also identify the causes of violence that they see and imagine from reading the stories.
7. List the causes identified by the groups on one or more flip charts.
8. Conclude this session by pointing out that violence is an outcome of society's attitudes towards and practices of gender discrimination, which place women in a subordinate position to men.

Causes of and factors contributing to violence are in **annex 6**.

Notes for facilitators

Many factors contribute to acts of violence in any setting. In general, the overriding causes are

- gender inequity
- abuse of power
- lack of respect for human rights

The root causes of violence are society's attitudes toward and practices of gender discrimination—the disparity between men's and women's roles, responsibilities, limitations, privileges, and opportunities. Note that addressing the root causes through prevention activities requires sustained, long-term action, with change occurring gradually over a long period of time. Contributing factors do not cause violence, although they are associated with some acts of violence.

SESSION 4:
CONSEQUENCES OF VIOLENCE

Time: 1 hour

Steps

1. Divide the participants into groups of four or five people and ask them to develop a very short role play showing ways in which violence is used against KPs and the consequences of such violence.
2. Have the groups perform these role plays for everyone. After the role play, ask the characters to stay in the role for a few minute while you invite the rest of the group to ask the characters questions.
3. The characters should answer questions in these roles. The sort of questions that they might get are
   - How does he/she feel when he does this? What does she fear?
   - Why does he do this? How does he feel?
   - Who else is there? Who witnesses it? Who is involved in it?
   - How do they feel?
   - What does the woman/man do? Why does he/she respond in this way?
   - What do other people do? Why do they act in these ways?
4. List the consequences identified by the groups on one or more flip charts, grouping the consequences into four categories:
   - health
   - psychological/emotional
   - social
   - economic
5. It is important to de-role after this exercise. Ask each person in turn to say their name and make a statement about themself from real life (e.g., "I am Gloria, and I am not abused by my husband.")
6. Conclude this session by pointing out that consequences and after-effects of violence are primarily related to health and psychosocial issues. Survivors often need access to health and counseling services in order to begin to heal. They deserve confidential and sensitive care when they seek these services.

More information about the consequence of violence is found in **annex 7**.

Information about and common indicators of trauma are in **annex 8**.

MODULE 4

RESPONDING TO VIOLENCE

Total time: 8 hours and 45 minutes

OBJECTIVES

By the end of module 4, participants will

- understand the health, emotional, social, and security needs of survivors from the point of view of the survivor;
- know the kinds, symptoms, and consequences of trauma;
- recognize the importance of basic survivor assistance (response) services;
- understand the importance for all actors to respond in accordance with recommended guiding principles; and
- be able to set up a violence-response system.

MATERIALS NEEDED

- **Handout 4:** Setting up a violence response system
- **Handout 5:** Case study of gruesome murders of sex workers in Nakuru
- Four chits labelled with incidents of violence:
  a) beating by an intimate partner;
  b) repeated verbal abuse by a client;
  c) rape by a police officer; and
  d) abuse by general public
- Flip chart
- Markers

SESSION 1:
HEALTH AND SAFETY NEEDS AFTER VIOLENCE

Time: 45 minutes

Preparation

Before the session, find out if there are any organizations or NGOs that provide services for survivors of violence. The services could be medical, psychosocial, legal, etc. . . Also find out details of the nearest violence response centre. Find out their contact details and which services they offer.

Steps

1. Divide participants into four small groups.
2. Read the following case study to everyone:

Maggy is a 21-year-old woman living in Kasarani Estate. She sells sex in order to make money to feed her family. She operates from Simmers pub and Koinange Street in the center of the city. One Friday, she decided to dress in a very short miniskirt that exposes her underwear when she bends or sits. She was happy her outfit attracted clients to her. As usual, she carried her condoms in her handbag and decided to operate from her spot in the street. She was extremely excited because the streets seemed deserted, and even Agnes and Triza, who normally occupy street joints next to her, had not reported that day. "This is my day, I will have all the clients today," she told herself excitedly. Maggy was unaware that Agnes and Triza had joined a network of sex workers who are alerted by a few trusted police when the police are coming for "street sweeps."

At 10 p.m. she got the first client who wanted a short engagement. She was paid 2,500 shillings. "Wow, this is the beginning! By morning, if things continue this way, I will definitely be 10,000 shillings richer, and I will be able to pay my rent and clear my son's school fees," she thought. However, her jubilation was short lived. At 11 p.m., out of nearby buildings came two policemen pointing guns at her. "Usikimbie wee Malaya!" [16] they said in Swahili. She couldn't believe it. "We will take you in for breaking the law and spreading HIV," a policeman said. This was like a sharp arrow in her heart. An arrest meant that she would be in custody for the rest of the weekend. She didn't have any paralegal number to call for help, and she didn't understand why she was being arrested.

She was marched to the police car. She sat on one side of the vehicle and the police on the opposite side. Her short dress pulled upward, revealing her underwear. The policemen's continuous gaze on the lower part of her body made her extremely uneasy. Instead of going straight to the police station, the two cops took her to a place where they raped and molested her for hours and took her money. The cops said that she deserved to be raped because she had asked for it by dressing so provocatively. She was taken to the police station in the early morning and charged with loitering. Her friend bailed her out in the evening of the same day, but Maggy never mentioned what had happened to her.

3. Tell the participants to imagine that they are Maggy. Ask each group to answer the following questions:
   - What will be her main concerns?
   - What will be her health concerns?
   - What will be her safety concerns?
   - Whom can she turn to for help?
   - Were the police justified in doing any of the above things?
4. Now, tell the group to imagine that Maggy comes to them for help and

16 "Don't run, prostitute!"

tells them what happened to her. How would they help her? How could they help advocate for her needs? Why is it important for her to get medical attention?

5. In order to bring out any victim-blaming attitudes, ask the participants, "Is Maggy in any way responsible for the rape? Did she do something wrong to make this happen?"
6. Discuss these possibilities in the large group after the small groups have shared their ideas.

Points to Note

Possible concerns of survivor	Possible health concerns	Possible safety or security concerns	Where the survivor can turn to for help
• fear that community will blame her for assault • fear that her husband will blame her • fear that her husband will leave her • fear that she will not be believed • self-blame and shame about the assault	• pregnancy • STIs, HIV • physical injury	• fear that the rapist will return to hurt her again • fear that her husband will want to take revenge against rapist • fear that her husband will be violent toward her as punishment • fear that her husband will not believe that she was raped • feelings of vulnerability and lack of safety	• family, friends, someone she trusts • religious leaders • health staff • police • community leaders • NGOs or CBOs

Victim-blaming

It is possible that participants will say that she is partly responsible for the rape. Help participants challenge these beliefs.

It is very important for individuals and communities to place blame for these acts where they belong: with the perpetrator. If we continue to blame people for being victimized, people will continue to remain silent about abuse and violence. They deserve our help. We need to create a culture of intolerance toward abuse, and part of that means placing responsibility where it belongs. Even if a person did something that the community considers dangerous, such as going out at night, this does not deserve the punishment of rape or violence. It is the perpetrator who deserves punishment, not the victim.

SESSION 2:
RESPONDING TO SURVIVORS OF VIOLENCE

Time: 30 minutes

Steps

1. Point to the CONSEQUENCES/AFTER-EFFECTS list from session 4 of module 3 and remind participants of the discussion about consequences. Be sure to refer to this list throughout this session.
2. Write the word RESPONSE on a flip chart and read it aloud.
3. Ask the group what kinds of help a survivor might need to reduce harmful consequences.
4. Write their responses on a blank flip chart organized into quadrants by sector area. After a few examples are on the flip chart, write the names of the sectors in each quadrant. The flip chart should begin to look something like this:

Sector	Responses
Health	• Provide emergency contraception. • Treat injuries. • Treat STIs.
Psychosocial	• Emotional support & counseling. • Income generation programs. • Skills training programmes. • Group counseling.
Security	• Report to security. • Investigate the case. • Arrest the perpetrators.
Formal and traditional (local council courts) legal justice	• File charges with the court or justice system. • Apply appropriate laws. • Hold perpetrators accountable.

5. Continue to solicit/suggest response actions until you have listed the key response services.

6. Emphasize that response requires the work and attention of many different parts of the community (health, psychosocial, security, and legal justice). The roles and services of various responders and service providers are listed **annex 9**.
7. Close the session by pointing out that we can provide good quality response services ONLY if survivors report incidents of violence and seek assistance. We must create an environment where survivors feel they can safely come forward with their stories and get the help they need. We must earn key populations' trust, and respect confidentiality in order to see this happen.

More points about responding to violence are listed in **annex 9**.

SESSION 3: GUIDING PRINCIPLES

Time: 30 minutes

Steps

1. Begin the session by reminding participants of the consequences and after-effects from session 4 of module 3, discussed earlier. Highlight the emotional and social issues brought out in that discussion.
2. Write GUIDING PRINCIPLES on the flip chart.
3. Explain that all actors who provide services or assistance to survivors must bear in mind those consequences and follow a set of guiding principles in their work with survivors. These principles guide the work that we do in every way.
4. Write the three guiding principles on the flip chart:
   - SAFETY—ensuring the safety of the survivor, her family, and those helping her
   - CONFIDENTIALITY
   - RESPECT—for the wishes, dignity, and rights of the survivor at all times
5. Go through each principle, using either lecture and/or discussion.
6. Ask how participants can ensure that each principle is carried out. Some examples of discussion points under each principle are as follows:

   Safety

   How would you ensure a woman's safety if she is living with the perpetrator?
   What do you do if a survivor does not want to report the incident?
   Developing an individual safety plan with a survivor is important—discuss with survivor questions such as, "If you fear for your safety, where can you go?"

   Confidentiality

   How do you handle the concept of confidentiality when the survivor is a five-

year-old child?
How can you maintain confidentiality in a small community?

Respect

Do not ask inappropriate questions like, "Are you a virgin?"
All survivors have different ways of coping, and we need to be considerate of them.

Additional information about the guiding principles is located in **annex 10**.

SESSION 4: HOW TO RESPOND TO A SURVIVOR

Time: 30 minutes

Steps

1. On a flip chart, write the headings DO and DO NOT.
2. Ask participants what they could say to a survivor of abuse who has come to them for help.
3. Remind participants that some of the main troubles of survivors are being not believed, feeling ashamed, feeling alone, and feeling out of control.
4. What would they say to help the person with these feelings and thoughts?

Points to note

Remind participants about always following the guiding principles: safety, confidentiality, and respect.

Refer to **annex 11** for things that are helpful to say and things to avoid saying when responding to a survivor of violence.

Summary

Respectful and confidential health, emotional, social, and security services are necessary to address the harmful consequences and after-effects of violence.

Effective prevention requires understanding the root causes of violence and then establishing strategies to reduce or eliminate them.

Both prevention and response require action from a variety of sectors, specialties/disciplines, organizations, and groups.

SESSION 5: SETTING UP A VIOLENCE RESPONSE SYSTEM

Time: 4 hours

Steps

1. Ask the participants to form four groups. Have each group refer to one of the case studies in **handout 3**, which were used during session 3 of module 3.
2. Ask them to read the case study and to discuss how they might respond to each case of violence.
3. After approximately 20 minutes, ask for a volunteer from each group to share their response plan with the larger group.
4. Make sure that the presentations cover the following points:
   - need for a violence response system
   - education of KPs on human rights and violence response
   - mapping services that support survivors of violence
   - formation of KP-led advocacy committee
5. Distribute **handout 4**: Setting up a violence response system.
6. Read and discuss.
7. Ask the participants in their four groups to discuss the following, and write down all responses on a chart paper as participants discuss and suggest ideas:
   - Group 1: How will we form a violence response team? Who should be the members and what should be their roles. What resources would they need to do their job?
   - Group 2: How will we educate the KPs about their rights and the violence response team (VRT)? What resources are needed? How can we reach many KPs with this information?
   - Group 3: What are the services available in the county for survivors of violence? Who could be our allies?
   - Group 4: How will we form an advocacy committee? What would be their roles? How often will they meet?
8. Ask the participants to brainstorm any challenges that they might face while trying to respond to violence. Write down all responses on a chart paper displayed at the front of the training room. Make sure that the following challenges are highlighted: refusal by the survivor to reveal personal details; refusal by the survivor to cooperate with the concerned community staff; refusal by the survivor to assist in taking the case to court; a criminal act is linked to the incident of violence, such as trafficking; late reporting of violence; peer is in danger while trying to respond to violence; backlash from police and other perpetrators while responding to violence; lack of financial support to access timely services; and emotional burn-out of peers and outreach workers.
9. Tell the participants that such challenges can be overcome with the support of people at the CBO or NGO level, where senior staff, supervisors, legal support and VRT members should meet with field staff to offer support on a regular basis. Challenges like the ones that have just been identified should be discussed in monthly meetings and the team can be given opportunities to solve solutions jointly. The presence of other members of the team will help overcome these challenges effectively.

SESSION 6:
DOCUMENTING INCIDENTS OF VIOLENCE

Time: 2 hours and 30 minutes

Preparation

Create four chits labelled with incidents of violence:
a) beating by an intimate partner;
b) repeated verbal abuse by a client;
c) rape by a police officer; and
d) abuse by general public.

Steps

1. Write these three questions on chart paper and display at the front of the training room:
   - Should violence be documented?
   - What are the advantages?
   - What are the challenges?
2. Ask the participants to discuss these questions as a group.
3. Display a chart paper with two columns labelled ADVANTAGES and CHALLENGES. As the participants discuss the issue, write their comments in the appropriate column.
4. Make sure to include advocacy, follow-up, tracking violence cases, and building case history for police complaints as 'Advantages'.
5. Distribute **handout 5**: Gruesome murders of sex workers in Nakuru. Read and discuss.
6. Deliver the following mini-lecture to the participants:
   The degree of violence faced by key populations is very high. However, most incidents of violence are not documented. Therefore, long-term strategies have been limited. I want to introduce you to a simple system of documenting and reporting that you can use. Documentation and reporting facilitate follow-up, compliance, and advocacy. Internally, it helps us review our work and take necessary steps to start new initiatives and design interventions. Documentation structures and informs discussions within the organization, especially with difficult cases or follow-up actions.

   Externally, it helps us to educate others and to conduct advocacy.
7. Ask the participants to form four groups. Give each group one of the chits labelled with an incident of violence:
   a) beating by an intimate partner
   b) repeated verbal abuse by a client
   c) rape by a police officer
   d) abuse by general public
8. Ask each group to develop a short role play based on their incident of violence
9. After 10 minutes, ask each group to perform their role play.
10. Tell each group to fill out the violence reporting form on their group's role play. The violence reporting form is appended to **handout 2**, Planning a violence prevention and response intervention, which was distributed in session 7 of module 2.
11. Ask for a volunteer from each group to explain how they documented the incident of violence. Make sure that everyone is able to identify all the indicators and understand what they mean.

MODULE 5

PREVENTING VIOLENCE

Total time: 40 minutes

OBJECTIVES

By the end of module 5, participants will

- recognize the settings in which violence occurs, and
- be able to use their knowledge of factors that cause or contribute to violence to develop individual-level and community-level violence-prevention actions.

MATERIALS NEEDED

- Flip chart
- Markers
- Note cards

SESSION 1:
VIOLENCE PREVENTION

Time: 40 minutes

Steps

1. Explain that when considering which prevention activities to undertake, it is important to address the causes of violence. Note that prevention is about understanding the causes and contributing factors of violence and establishing strategies to reduce or eliminate them.
2. Refer back to the causes and contributing factors identified in session 3 of module 3.
3. Go back to the case study of Maggy, found in session 1 of module 4.
4. Pass out note cards or small pieces of paper. Divide the participants into four groups. Ask group 1 to spend 10 minutes thinking and writing down five things Maggy could have done to prevent the violence she experiences. Ask participants to think of immediate actions (this week) as well as longer-term actions (the next 3 months). These are individual-level changes.
5. Now ask group 2 to list what the community group (sex work network, MSM network) could do to prevent violence against Maggy. Ask participants to think of immediate actions (this week) as well as longer-term actions (the next 3 months). These are collective-level actions.
6. Now ask group 3 to list what the implementing agency (NGO/ CSO) could do to prevent violence against Maggy. Ask participants to think of immediate actions (this week) as well as longer-term actions (the next 3 months). These are organization-level actions.
7. Ask group 4 to list what the state/ national programme could do to prevent such violence against key populations. Ask participants to think of immediate actions (this week) as well as longer-term actions (the next 3 months). These are state-level actions.
8. When participants are finished, ask each group to tape their note card on the wall in a line around the room so that all the other participants may see them. Allow participants to walk around the room for a few minutes to review what others have written.
9. Discuss what participants have read on the note cards and any remarkable ideas for preventing violence.

See **annex 12** for guidance on preparing a personal safety plan, and information about prevention activities involving society.

MODULE 6

VIOLENCE AND THE LAW

Total time: 3 hours and 5 minutes

OBJECTIVES

By the end of module 6, participants will be able to

- teach others about human rights that are recognized and protected by the Constitution of Kenya,
- understand how laws affect key populations,
- explain the key provisions of the Sexual Offences Act 2006, and
- describe other relevant Acts related to violence.

MATERIALS NEEDED

- **Handout 1**: Pre-/ post-training assessment questionnaire
- The Constitution of Kenya
- The Sexual Offences Act
- The Penal Code
- Municipal By-Laws
- Flip chart
- Markers

SESSION 1:
BACKGROUND TO VIOLENCE AND THE LAW

Time: 15 minutes

Steps

1. Ask the participants to name the human rights found in the Constitution. Write their answers on the flip chart and discuss the answers given.
2. Of the rights listed on the flip chart, ask and assist the participants to identify the critical human rights for key populations.
3. Form the participants into groups.
4. Ask the groups to discuss the articles of Kenya's Constitution and Bill of Rights that are relevant for key populations (found in **annex 13**).

Points to note

The Constitution of Kenya 2010 contains an advanced Bill of Rights, which has justiciable civil, political, and socio-economic rights, meaning that these rights are recognized by the nation's courts.

The protections given to the citizens are drawn from conventions and treaties that Kenya has signed, which mandate the state to protect such rights.

SESSION 2:
HUMAN RIGHTS OF KEY POPULATIONS AND THE LAW

Time: 90 minutes

The human rights of sex workers and the law

Preparation

The facilitator should acquaint herself/himself with the current legislation on sex work and the laws that affect sex workers. The facilitator should be aware of the rights violations that sex workers routinely experience because of the misuse of laws.

Steps

The facilitator should discuss the laws that touch on the rights of sex workers and the laws that protect the rights of sex workers in accordance with the Bill of Rights and other laws, including the following:

- The Constitution of Kenya
- Kenya's penal code
- The Sexual Offences Act
- The Counter-Trafficking in Persons Act
- The Victim Protection Act

Points to note

- Sex workers have human rights, and they should be able to defend and enjoy such rights, just as any other population.
- It is illegal to live wholly or in part on the earnings of prostitution and to aid, abet, compel, or incite prostitution. (Sections 153 and 154 of the penal code)
- Women who sell sex can be arrested by both secular and religious police for breaches of various municipal by-laws against 'loitering for the purpose of prostitution,'

'importuning,' and 'indecent exposure.'
- The lack of protection and lack of adequate legal recourse for sex workers raise a number of legal and ethical issues. One such issue is how to provide medical care and health information to sex workers and their clients while the law perceives them as criminals. By increasing sex workers' vulnerability to violence and discouraging them from seeking medical attention, the criminalization of sex work increases their vulnerability to HIV and STI infection.
- Criminalization compels sex workers to bribe police on a weekly basis.
- Police rape and sexually assault sex workers in their custody. They also extort sex from women with the promise that they will be released from custody. These activities are considered torture and arbitrary detention under both international law and the Kenyan Constitution. Section 24 of the Sexual Offences Act of 2006 prohibits sexual contact between police officers and those in their custody.
- Persons who live on the earnings of prostitution, or compel others to engage in prostitution, or encourage children to participate in prostitution commit an offence.

The human rights of MSM and the law

Steps

1. Explain to the participants that due to the high level of stigma associated with homosexual practices, many MSM live in hiding and conceal their sexual orientation to avoid discrimination. The penal code criminalizes homosexual sex.
2. The facilitator should discuss the laws that affect the rights of MSM, including the following laws:
   - The Constitution
   - The penal code
   - The Sexual Offences Act
   - The Counter-Trafficking in Persons Act
   - The Victim Protection Act

The human rights of PWID and the law

Steps

The facilitator should discuss the various laws that affect the rights of PWID, including the following laws:

- The Constitution
- The Sexual Offences Act
- The Narcotic Drugs and Psychotropic Substance (Control) Act
- The Victim Protection Act

SESSION 3:
ACTION PLANNING

Time: 1 hour

Steps

1. Ask the participants to reflect silently on the following:
   a. Lessons from the training, and
   b. What they propose to do with the knowledge and skills acquired from the training.
2. Ask the participants to share what they propose to do.
3. Ask the participants to work in groups to prepare action plans using what they have learnt, based on what they proposed in step 2.
4. Ask each group to prioritize what they would like to do.
5. Ask each group to create a blank planning matrix on a flip chart for their proposed action (see sample matrix below). The table should have columns that say WHEN, WHAT, FOR WHOM, WHERE, HOW, WHO IS RESPONSIBLE, and WITH WHOM. These relate to
   a. What will be done
   b. When it will be done
   c. For whom (target group)
   d. Where it will happen
   e. How it will be done
   f. Who is responsible
   g. With whom (partners)
6. The participants can formulate objectives for each item they work on, as well as related activities.
7. The plans will be presented to the entire group for discussion. The facilitator will give input during discussions.
8. The participants thereafter refine the plans according to feedback given during the discussions.

Notes for facilitators

Let the interest of the group determine what types of plans are developed. It is important for participants to prioritize their concerns in an objective way. When it comes to the planning, participants should commit to implementing their plans, and they should be realistic, not developed just to conclude the workshop.

Summary Matrix

When	What (activity)	For whom (target group)	Where	How	Who is responsible	Whom I will work with (collaborators)
	(e.g., training on human rights of KPs)	(e.g., CBO members)	(e.g., CBO office, Mombasa)	(e.g., training)	(e.g., trainer's name)	(e.g., other trainers/ organisation)

SESSION 4:
POST-TRAINING ASSESSMENT

Time: 20 minutes

Steps

1. The facilitator distributes the post-training assessment questionnaire to each participant.
2. The facilitator asks participants to respond to the questionnaire as honestly as possible.
3. Although the questionnaire is self-explanatory, the facilitator should answer participants' questions if they are uncertain about anything.
4. For participants who are not able to read and write, the facilitator assists them to complete the questionnaire.
5. The facilitator collects the questionnaires and makes sure that the participants see that the collected questionnaires are sealed by the facilitator in an envelope.

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ANNEXES

ANNEX 1

OVERVIEW OF THE TRAINING MODULES

Session	Objectives	Time	Preparation/Materials
Module 1: Getting Started	By the end of module 1, participants will have • introduced themselves to each other, • shared their expectations and learned the workshop's objectives, and • become acquainted with each other and with the setting.	1 hour and 55 minutes	• Registration forms • **Handout 1:** Pre-/ post-training assessment questionnaire • A flip chart sheet or a PowerPoint presentation on the objectives of the training • Flip chart • Markers
Session 1: Welcome and Introductions		30 minutes	
Session 2: Group Norms		20 minutes	
Session 3: Expectations and Objectives		20 minutes	
Session 4: Take a Stand		45 minutes	
Module 2: Introduction to Violence	By the end of the module 2, the participants will be able to • understand now violence increases key populations' HIV vulnerability; • understand the roles of power, force/ violence, and consent in social relations; • be aware of human rights and Kenya's Bill of Rights; • be able to differentiate between myths and facts about gender	4 hours and 40 minutes	• PowerPoint presentation entitled *Violence Prevention among Key Populations as a Means to HIV Prevention in Kenya* • **Handout 2:** Planning a violence prevention and response intervention • Flip chart • Markers

	roles and violence; • understand confidentiality; • have an overview of how to plan a violence prevention and response intervention		
Session 1: Intersection between HIV and Violence		30 minutes	
Session 2: Power Walk		45 minutes	
Session 3: Use of Force		20 minutes	
Session 4: Informed Consent		15 minutes	
Session 5: The Kenyan Constitution and Human Rights		30 minutes	
Session 6: Confidentiality		20 minutes	
Session 7: Planning a Violence Prevention and Response Intervention		2 hours	
Module 3: Understanding Violence against Key Populations	By the end of module 3, the participants will be able to • list types of violence, • identify common perpetrators of	3 hours and 15 minutes	• **Handout 3**: Case studies • Four flip charts • Markers

	violence, • explain the causes of and factors contributing to violence, and • explain the effects of violence, including its impact on HIV vulnerability.		
Session 1: Types of Violence		1 hour	
Session 2: Survivors and Perpetrators of Violence		15 minutes	
Session 3: Causes of Violence		1 hour	
Session 4: Consequences of Violence		1 hour	
Module 4: Responding to Violence	By the end of module 3, the participants will • understand the health, emotional, social, and security needs of survivors from the point of view of the survivor; • know the kinds, symptoms, and consequences of trauma; • recognize the importance of basic survivor assistance (response) services; • understand the importance for all	8 hours and 45 minutes	• **Handout 4:** Setting up a violence response system • **Handout 5:** Case study of gruesome murders of sex workers in Nakuru • Four chits labelled with incidents of violence: a) beating by an intimate partner; b) repeated verbal abuse by a client; c) rape by a police officer; and d) abuse by general public • Flip chart • Markers

	actors to respond in accordance with recommended guiding principles; and • be able to set up a violence response system.		
Session 1: Health and Safety Needs after Violence		45 minutes	Before the session, find out if there are any organizations or NGOs that provide services for survivors of violence. The services could be medical, psychosocial, legal, etc. Also find out details of the nearest violence response centre. Find out their contact details and which services they offer.
Session 2: Responding to Survivors of Violence		30 minutes	
Session 3: Guiding Principles		30 minutes	
Session 4: How to Respond to a Survivor		30 minutes	
Session 5: Setting Up a Violence Response System		4 hours	
Session 6: Documenting Incidents of Violence		2 hours and 30 minutes	

Module 5: Preventing Violence	By the end of module 5, the participants will • recognize the settings in which violence occurs, and • be able to use their knowledge of factors that cause or contribute to violence to develop individual-level and community-level violence-prevention actions.	40 minutes	• Flip chart • Markers
Session 1: Violence Prevention		40 minutes	
Module 6: Violence and the Law	By the end of module 6, the participants will • be able to teach others about human rights that are recognized and protected by the Constitution of Kenya, • understand how laws affect key populations, • explain the key provisions of the Sexual Offences Act 2006, and • describe other relevant Acts related to violence.	3 hours and 5 minutes	• **Handout 1:** Pre-/ post-training assessment questionnaire • The Constitution of Kenya • The Sexual Offences Act • The Penal Code • Municipal By-Laws • Flip chart • Markers
Session 1: Background to Violence and the Law		15 minutes	

Session 2: Human Rights of Key Populations and the Law		90 minutes	
Session 3: Action Planning		1 hour	
Session 4: Post-Training Assessment		20 minutes	

ANNEX 2

PROGRAMME FOR VIOLENCE PREVENTION AND RESPONSE TRAINING

DAY 1		
Module/Session	**Time**	**Topic**
Module 1		**Getting Started**
Session 1	9:00 to 9:30 a.m.	Welcome and Introductions
Session 2	9:30 to 9:50 a.m.	Group Norms
Session 3	9:50 to 10:10 a.m.	Expectations and Objectives
Session 4	10:10 to 10:55 a.m.	Take a Stand
	10:55 to 11:10 a.m.	Tea
Module 2		**Introduction to Violence**
Session 1	11:10 to 11:40 a.m.	Intersection between HIV and Violence
Session 2	11:40 to 12:10 p.m.	Power Walk
Session 3	12:10 to 12:30 p.m.	Use of Force
Session 4	12:30 to 12:45 p.m.	Informed Consent
Session 5	12:45 to 1:15 p.m.	The Kenyan Constitution and Human Rights
Session 6	1:15 to 1:35 p.m.	Confidentiality
	1:35 to 2:35	Lunch
Session 7	2:35 to 4:35	Planning a Violence Prevention and Response Intervention
Module 3		**Understanding Violence against Key Populations**
Session 1	4:35 to 5:35	Types of Violence
DAY 2		
Session 2	9:00 to 9:15 a.m.	Survivors and Perpetrators of Violence
Session 3	9:15 to 10:15 a.m.	Causes of Violence
Session 4	10:15 to 11:15 a.m.	Consequences of Violence

	11:15 to 11:30 a.m.	Tea
Module 4		**Responding to Violence**
Session 1	11:30 to 12:15 p.m.	Health and Safety Needs after Violence
Session 2	12:15 to 12:45 p.m.	Responding to Survivors of Violence
	12:45 to 1:45 p.m.	Lunch
Session 3	1:45 to 2:15 p.m.	Guiding Principles
Session 4	2:15 to 2:45 p.m.	How to Respond to a Survivor
	2:45 to 3:00 p.m.	Tea
Session 5	3:00 to 6:00 p.m.	Setting Up a Violence Response System
DAY 3		
Session 5 (continued)	9:00 to 10:00 a.m.	Setting Up a Violence Response System (continued)
	10:00 to 10:15 a.m.	Tea
Session 6	10:15 to 12:45 p.m.	Documenting Incidents of Violence
	12:45 to 1:45 p.m.	Lunch
Module 5		**Preventing Violence**
Session 1	1:45 to 2:25 p.m.	Violence Prevention
Module 6		**Violence and the Law**
Session 1	2:25 to 2:40 p.m.	Background to Violence and the Law
Session 2	2:40 to 4:10 p.m.	Human Rights of Key Populations and the Law
Session 3	4:10 p.m. to 5:10 p.m.	Action Planning
Session 4	5:10 to 5:30 p.m.	Post-Training Assessment
Closing	5:30 to 6:00 p.m.	Tea, closing remarks

ANNEX 3

MYTHS, FACTS, AND THE FUNCTIONS OF MYTHS ABOUT VIOLENCE

MYTHS AND FACTS ABOUT DOMESTIC VIOLENCE

MYTH: Battering affects only a small percentage of the population.
FACT: Two million to four million women of all races and classes, including sex workers, are beaten every year worldwide.

MYTH: Differential power structure myths based on the presumption that men are the stronger sex:
a. Only "weak" men can be victims of violence.
b. All violence is perpetrated by men against women.
FACT: In Kenya in 2009 over 1.5 million men were battered.

MYTH: Battering is only a momentary loss of control.
FACT: Battering can go on for hours. Many batterers plan their assault or foresee it.

MYTH: Battered women are masochistic; they like the violence.
FACT: No one likes to be battered. Women often stay in abusive relationships because they hope their partners will change or because they want their kids to have a father. This does not mean they like the violence.

MYTH: Battering does not produce serious injuries; it is just a part of love.
FACT: Battered women are often severely injured. Not a week passes without news reports of a woman who was battered to death by her partner.

MYTH: Drinking causes men to batter.
FACT: Men batter when sober and when they are drunk. They use the fact that they were drunk only as an excuse: "I didn't know what I was doing." Actually, they get drunk in order to say that they are not responsible for their behavior.

MYTH: Religious faith will prevent him from beating you.
FACT: The fact is, even pastors beat their partners. Religious faith does not stop men from believing that they have a right to beat their wives.

MYTH: Even if he's violent, it is better for the children to have a father.
FACT: Children are very upset and scared by violence. It is better for them to be without a father than to be frightened by their fathers.

MYTH: Long-standing battering relationships can change for the better.
FACT: Without outside intervention, battering tends to repeat itself.

MYTH: Sometimes, women deserve to be beaten.
FACT: Nobody ever deserves violence. Criticisms of abused women, blaming the victims for not leaving the relationship leads to conclusions that they must enjoy being beaten, are nags or drunks, or are mentally ill, and that therefore they, not the perpetrators, are at fault. Attention needs to focus not on why they stay but on why men abuse.

MYTH: Beating a woman can be used to correct her behavior.
FACT: Violence does not change behavior; it is not a problem-solving strategy.

MYTH: Domestic violence does not have bad effects on a child if the child is not hit.
FACT: Child witnesses to domestic violence are more likely to have emotional and behavioral problems. They are also more likely to be abusive in adulthood. Witnessing violence teaches children that violence is normal.

MYTH: Only poor and uneducated women are beaten
FACT: Domestic violence cuts across all

classes.
MYTH: Sometimes, men beat their wives because they love them.
FACT: Violence is not an expression of love.

MYTHS AND FACTS ABOUT RAPE AND SEXUAL ASSAULT/ABUSE

MYTH: Women are raped by strangers in dark places outside the home.
FACT: Most rapes take place at home by someone known to the woman. A woman can be raped anywhere: if she is out alone; if she is with friends; if she is at home or out collecting firewood, going to the market, or tending her garden. Nothing that a woman does gives any man the right to rape her. A woman can be raped by a stranger or by someone she knows. Even when it is someone she knows, it is still rape. The fact that a man might give her money or gifts does not give him the right to have sex with her without her consent.

MYTH: There is no rape in marriage.
FACT: Rape is any act of sexual intercourse without consent. Even if the law doesn't recognize it, rape can still happen in marriage.

MYTH: Women say no when they mean yes.
FACT: No means No. Every woman has the right to refuse, at any time, the sexual advances of any man. The law protects every woman from rape.

MYTH: Men rape because they are overcome by sexual urges.
FACT: Most rapes are planned in advance. Rape is an act of violence, not passion, and the purpose is to make the woman feel bad and the perpetrator feel dominant and in control.

MYTH: Rape happens to women who have loose morals.
FACT: Any woman can be raped: your mother, your sister, your daughter, or your friend. It does not matter how old or young she is. Rape is a reflection of the perpetrator's morals, not the victim's.

MYTH: Women "ask to be raped."
FACT: Rape is a violent crime, a violation of a person's human rights, and a humiliating and terrifying experience. No one asks for it to happen to them.

MYTH: Women provoke rape by the clothes they wear.
FACT: Any woman can be raped, no matter what she wears. It does not matter what a woman is wearing: a long skirt, a short skirt, or a sack. Nothing a woman wears gives a man the right to rape her.

MYTH: Sexual violence is impulsive, done for sexual gratification.
FACT: Most rapes are planned in advance. The rapist stalks a victim or waits for a safe opportunity and finds a victim. Sexual gratification is not the motive for rape; it is an act of anger, aggression, and control, with sex used as a weapon.

THREE FUNCTIONS OF MYTHS

- **Myths provide false security.**
  If we believe the myth that many rape reports are false, then we lower our perceived chance of becoming a victim, and we feel safer.
- **Myths maintain our belief in a just world.**
  We all would like to believe we live in a just world in which people get what they deserve. If a woman or man is raped, then the myth would have us believe that they are bad or that they have done something wrong that makes them deserve it.
- **Myths keep women unequal and controlled by men.**
  We are more likely to blame sex workers

(male and female) for being raped if it happens when they are engaged in actions not considered acceptable for women (e.g., walking alone at night or doing commercial sex work). Even other women often blame survivors when they are raped while not adhering to these restrictions.

ANNEX 4

VIOLENCE PREVENTION AMONG KPS AS A MEANS TO HIV PREVENTION

Slide 1

Violence prevention among key populations as a means to HIV prevention in Kenya

Slide 2

Violence against KPs and the efficacy of HIV programmes

- The focus on structural interventions, especially violence prevention and response, has been low. This may be because the effects of violence against KPs on HIV-programme efficacy have not been fully understood.
- Evidence linking violence and HIV vulnerability have recently become available.
- Given the large numbers of KPs and the importance of HIV programmes, it is imperative that HIV-prevention programmes address violence against key populations.

Slide 3

Violence and unsafe environment are barriers to access to services for key populations[7,8]

Provisions of Article 43(1)(a) of the constitution of Kenya states that every citizen has the right to the highest attainable standard of health. Key population experience high violence and harassment making them unlikely to access health care services

Sexual violence

22% FSWs 17% MSM 8% PWID

Unsafe work environment

44% FSWs 24% MSM 57% PWID

There are direct and indirect intersection of violence and HIV

Indirect: *Fear and constant experience of violence leads to anxiety, depression, loss of self esteem and lower priority to health directly increase vulnerability to HIV*

Direct: *Rape, coercion to have sex without condoms or share needles can directly increase risk to HIV*

Slide 4

Violence against KPs and the efficacy of HIV programmes

- Violence and HIV/AIDS are mutually reinforcing (UN Women 2012).
- Root causes for both include gender discrimination, power imbalances, and harmful social gender norms (WHO 2010).
- Violence against key populations dramatically increases their risk of and vulnerability to HIV.
- Rape, coercion to have sex without condoms with authorities, coercion in intimate relationships to have sex without condoms or to share used needles directly put key populations at risk.

Slide 5

Violence against KPs and the efficacy of HIV programmes

- Fear of violence discourages KPs from coming to places where commodities (condoms/ needles) or services are available, or 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 low concern about health, thereby increasing vulnerability to HIV.

Slide 6

Violence against KPs and the efficacy of HIV programmes

- Violence against key populations is widespread, perpetrated, legitimized, and accepted by many, including law enforcement authorities, gatekeepers , managers, clients, and intimate partners.
- Arrests, raids, and imprisonment are associated with unprotected sex, with STI/HIV symptoms and infections, and with higher frequency of inconsistent condom use with clients.

Slide 7

Violence against KPs and the efficacy of HIV programmes

- Fear of arrest is a barrier to HIV testing, and evidence shows that where key populations move underground to avoid police detection there is greater risk of unprotected sex.
- Police seizure of condoms and syringes prompt unprotected sex and unsafe injecting practices. Syringe confiscation is also associated with HIV.

Slide 8

Violence against KPs and the efficacy of HIV programmes

- Beattie et al. found that sex workers who reported experiencing violence in the past year were significantly less likely to report condom use with clients, to have accessed the HIV-prevention programme, or to have ever visited the project sexual health clinic; and were more likely to be infected by STIs

- Among female sex workers in Mombasa, a study found that high-risk sexual behavior, low control, and frequent violence in relationships with emotional partners heighten FSWs' HIV vulnerability and risk, requiring targeted interventions (Luchsters S et al. 2013)

Slide 9

Violence against KPs and the efficacy of HIV programmes

- 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 (Buller et al. 2013)
- A study in Karnataka, India, found that HIV prevalence among MSM-transgender who reported sexual violence was 20%, compared to 12% among those not reporting sexual violence (Shaw et al, 2014)

Slide 10

Violence against KPs in Kenya

- Sex workers are subject to abuse, harassment and beatings from clients, law enforcers and power brokers. In a study with female sex workers in Kenya, 59% reported having been raped. Police harassment/violence was commonal (FIDA 2008).
- Among SWs surveyed in Coast Province, 66% reported at least one form of sexual violence including being forced to have sex without a condom, beaten, or verbally abused (Tegang et al. 2007).
- Female sex workers reported that stigma, blame, and lack of respect led to their abuse (Schwartz U et al. 2004).

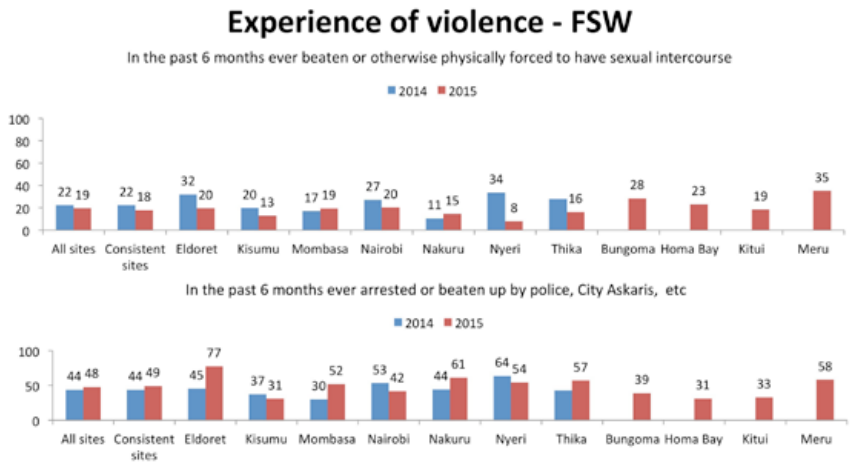
Slide 11

Violence against KPs in Kenya

- Key populations work and live in complex environments dominated by power structures with family, community, workplace and the state.
- Kenyan national laws & by-laws criminalize sex work, same sex relationships and drug use; This exposes KP to punishing behaviour including physical violence, emotional abuse, rape, and extortion from a range of actors, including law enforcement officers and askaris whose role is to protect human rights of the citizens.
- While there has been HIV prevention programmes for key populations in Kenya since 1990, only few have addressed violence against key populations comprehensively.

Slide 12

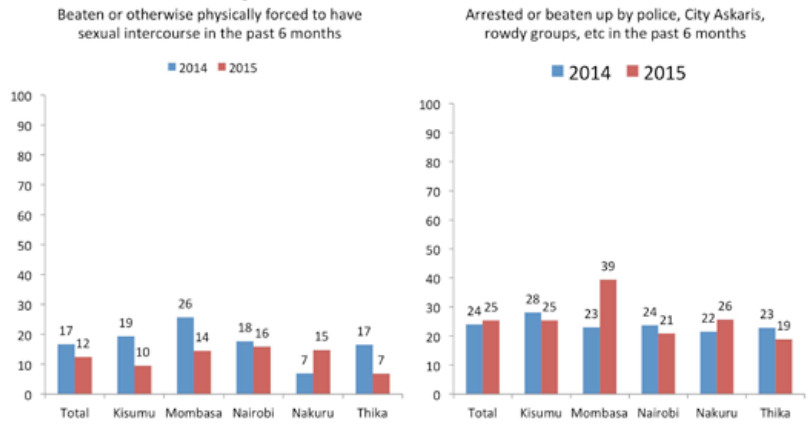
Experience of violence - FSW



- FSWs experiencing violence by law enforcement rose from 44% in 2014 to 48% in 2015, Meru having the highest. Sexual violence, however, declined marginally to 19% from 21% in 2014, Eldoret having the highest.
- No significant differences in 2014 and 2015($p>0.05$)

Slide 13

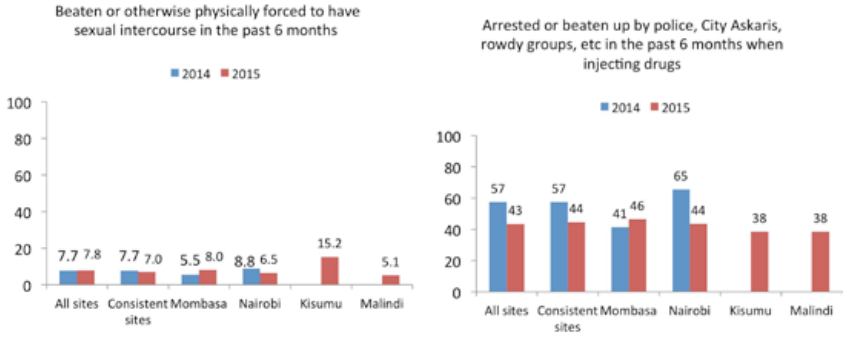
Experience of violence - MSM



- High violence experienced by MSM in most cities by law-enforcement and non-law-enforcement perpetrators from 24% to 25% in 2015.Mombasa leads in cases of violence from law and non-law enforcers ,with a significant increase from 2014. Sexual violence is at 12% from 17% in 2014, Nairobi leading at 16%
- Overall, differences in 2014 and 2015 were not significant(p>0.05).

Slide 14

Experiences of violence - PWID



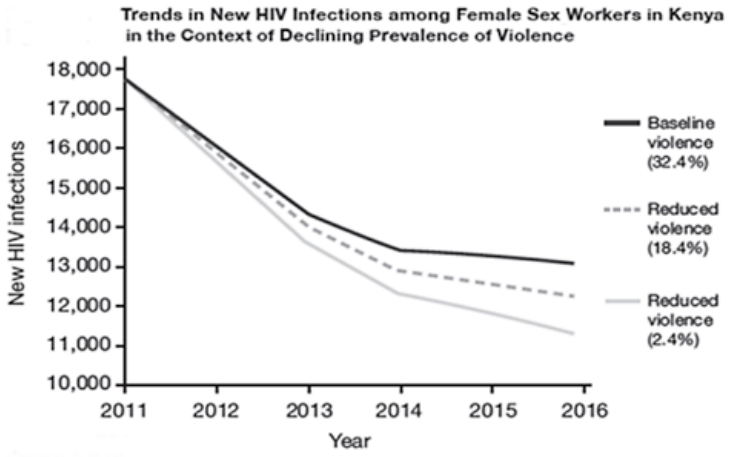
- Overall, 8% of PWID have ever been forced to have sexual intercourse, with Kisumu having more incidences. Women seem to be the major victims, with 16% of them having experienced forced sex.
- 43% of PWIDs have experienced violence by law enforcement and rowdy groups, a decline from 57% in 2014.This appears to be equally shared by both men and women (42% men and 43% women)
- Overall, no major variations across the years(p>0.05).

Slide 15

Violence prevention and response programmes in the context of HIV prevention

- Effective violence prevention and response programmes exist for key populations today.
- A modeling exercise conducted to measure the impact of reducing violence against female sex workers on HIV epidemics in Kenya estimated 25% reduction in incident HIV infections among FSWs when physical and sexual violence was reduced. Cumulative infections averted were 21,200 in Kenya.

Slide 16



Kerringan et al, 2012

Slide 17

Violence prevention and response programmes in the context of HIV prevention

- Beattie et al. found that structural intervention to address violence can be effectively delivered at scale.
- Addressing violence against sex workers was found to be important for preventing the spread of HIV and for protecting their human rights.
- Successful interventions to address violence against key populations include
  - education on rights,
  - community mobilization to respond to violence and discrimination,
  - practical warning systems in sex-work networks,
  - sensitization workshops with police and law enforcement authorities,
  - advocacy at the community and policy levels to promote human rights, and
  - policy change to make the environment safe

Slide 18

Kenyan national guidelines on key populations and the 2013 WHO guidelines

- Community empowerment and education on rights
- Mapping stakeholders and advocacy
- Promoting the safety and security of key populations
- Providing services to key populations who experience violence
- Fostering police accountability
- Collecting evidence and documentation of incidents

Slide 19

ANNEX 5

TYPES OF VIOLENCE EXPERIENCED BY KEY POPULATIONS

- **Physical violence:** any forceful or violent physical behavior that causes harm. It includes plucking out hair, biting, choking, kicking, slapping, burning and shoving.
- **Psychological/emotional violence:** any threat to do bodily harm to a partner, a child, a family member, friends, or oneself. It involves not only injury and anger but also fear and degradation.
- **Socio-cultural violence:** examples include female genital mutilation, widow inheritance.
- **Sexual violence:** entails nonconsensual sexual act or behavior. It includes rape, marital rape, gang rape, attempted rape, and defilement. Rape and other forms of violence are about power and control, where the perpetrator uses his or her position of authority to oppress the vulnerable victim.
- **Economic violence:** examples include limiting a person's access to money, not allowing a woman to work, unequal wages, and a woman's salary being held by her husband.

ANNEX 6

CAUSES AND FACTORS CONTRIBUTING TO VIOLENCE

Root causes of violence	• disrespect or disregard towards key populations • lack of belief in equal human rights for all • cultural/social norms of gender inequality
Contributing factors that perpetuate violence or increase risk of violence, and that influence the type and extent of violence in any setting	• poverty • prostitution or sexual exploitation • alcohol/drug abuse • the need for women to be in isolated areas for food, fuel, wood, or income • boredom; lack of services, activities, programmes • collapse of traditional society and family supports • religious, cultural, and/or family beliefs and practices • design of services and facilities • general lawlessness • geographical location/environment (high-crime area) • lack of laws against forms of violence • lack of police protection • lack of knowledge about human rights and women's rights • legal justice system/laws silently condone gender violence • loss of male power/role in family and community; seeking to assert power • political motives for power/control/fear • lack of education

ANNEX 7

CONSEQUENCES OF VIOLENCE

Survivors of violence are at a high risk of severe health and psychosocial problems, sometimes death, even in the absence of physical assault. Medical, psychological, and social consequences of violence vary, according to the type of violence. Death, either through homicide or suicide, is not uncommon.

The most significant social outcome is stigma, and all societies tend to blame the victim for an incident of violence, especially in cases of rape and other sexual abuses. Survivors of violence often feel extreme shame, and this shame prevents many from disclosing abuse to others and seeking the help they need. When communities blame survivors for their abuse, this compounds their shame and prevents them from telling others about what happened and seeking help. This stigma and blame result in even greater psychological and emotional suffering for the survivor, and often influence the behavior of those who should be helping. The survivor may be considered an outcast in the community and may even be unmarriageable. Survivors of violence are at high risk for further abuse and victimization.

Health consequences

There are serious and potentially life-threatening health outcomes with all types of violence. The exact consequences vary, depending on the type of violence.

Fatal outcomes

- homicide
- suicide
- maternal mortality
- infant mortality
- AIDS-related mortality

Acute physical

- injury
- shock
- disease
- infection

Chronic physical

- disability
- somatic complaints
- chronic infections
- chronic pain
- gastrointestinal problems
- eating disorders
- sleep disorders
- Alcohol/drug abuse

Reproductive

- miscarriage
- unwanted pregnancy
- unsafe abortion
- sexually transmitted infections (STIs), including

	HIV/AIDS • menstrual disorders • pregnancy complications; infertility • gynecological disorders • sexual disorders
Psychological/Emotional consequences Most psychological and emotional after-effects should be viewed as normal human responses to a horrific, terrifying, extreme event. In some cases, however, the survivor experiences mental illness that requires medical intervention.	**Post-traumatic stress** • depression • anxiety, fear • anger • shame, insecurity, self-hate, self-blame • mental illness • suicidal thoughts, behavior, attempts
Social consequences Most societies tend to blame the survivor for the incident, especially in cases of rape. This social rejection results in further emotional damage, including shame, self-hate, and depression. Due to their fear of social stigma and rejection, most survivors never report the incident and never receive proper health care and emotional support. Most incidents of violence are never reported.	**Isolation and ostracism** • blaming the victim • loss of ability to function in community (e.g., earn income, care for children) • social stigma • social rejection • withdrawal from community and life • rejection by husband and family
Economic consequences	**Poverty** • inability to work • lack of income • inability to pay rent or buy food

ANNEX 8

TRAUMA

Examples of traumatic situations: witnessing the violent death of another person; being assaulted, such as in rape or domestic violence.

Doctors have recognized that people who have experienced traumatic situations often experience several common symptoms, which fall under three groups:

Remembering
- Nightmares.
- Flashbacks: sudden remembering of the event, sometimes with the feeling that they can see, feel, hear, and smell what happened. Some describe flashbacks as re-living the event.

Forgetting
- Avoiding any reminders of the traumatic event.
- Avoiding talking about the event.
- Withdrawing socially from people, life, or her/himself.

Anxiety
- Feeling anxious, easily annoyed, irritable, aggressive.
- Sleeping problems.
- Emotional reactions to small frights.
- Physical aches and pains.

Note that each trauma is different for each person, so we have to look at each person's experience individually. Some people will have some of these reactions, and they will feel better after a few weeks or months. Others will feel very affected by what happened, and might feel the trauma for many years.
Traumatic experiences cannot simply be forgotten. Each person needs to process what happened and understand it. Some people need help from mental health workers in order to be able to do this.

When thinking about trauma and healing, we need to always remember that our physical bodies and our emotions and mental health are very closely connected. Sometimes emotional pain or problems can lead to physical pain and problems. For people with these kinds of problems, talking about their experiences and pain with a supportive person can often help them heal their emotional wounds, which can also improve their health in their physical bodies.

Point out that survivors of violence, who can be considered trauma survivors, often benefit greatly from the support of a counselor or mental health therapist. Trauma and experiences of violence are not normal events, and people often need help to work through their feelings after violence. A counselor is someone who is neutral and who supports and listens to a survivor, keeps confidentiality, and does not judge them.

COMMON INDICATORS OF TRAUMA

Traumatized people do not feel safe.
The memory of the experience stays with the person for some time, causing feelings of insecurity and anxiety. They know what kind of horrible things are possible, and they wonder when the next terrible thing will happen to them.

Traumatized people feel out of control.
A traumatizing event almost always reduces or removes the person's sense of control over their own life. This is why it is so important for those of us who are helping survivors to give them back as much control as possible and allow them to make decisions about their life.

Traumatized persons are preoccupied with their traumatic experiences.
Survivors frequently suffer from flashbacks and nightmares and think about their

experiences so much that they have difficulty focusing on anything else.

Traumatized people feel worthless.
Survivors frequently are left with severe feelings of guilt and shame in attempting to control the event and the memories of the event.

Traumatized people feel detached or disconnected.
Survivors often have difficulty expressing feelings or putting energy into their relationships with people they are close to. The experience of trauma can be so overwhelming in terms of so many negative feelings (anger, shame, embarrassment, pain) that people may simply try to turn off all feelings in order to make these feelings go away.

Traumatized persons are vulnerable.
Survivors generally do not function the way they did before the event. Trauma affects their ability to respond and cope with simple daily issues.

ANNEX 9

RESPONDING TO VIOLENCE

Response is providing services and support to reduce the harmful after-effects of violence and prevent further injury, trauma, and harm. Response includes action to

- assist/support the survivor
- provide appropriate consequences to the perpetrator
- restore/maintain security for the survivor and the community
- response, then, includes action in the following sectors/functional areas:
- provide health care
- provide psychosocial assistance
- provide psychological and emotional support
- facilitate social acceptance and reintegration
- ensure security and safety
- pursue legal justice—formal and traditional

All must work in collaboration with one another.

Not all survivors need—or want—all of this help. Our job is to ensure that those affected are linked to services. It is up to the survivor to use the options that are available. The survivor is the expert on their own life, and we must respect their choices.

It is also important to note that we must be very careful about providing assistance to survivors.

If we are not careful, the survivor may face more problems and possibly further trauma and harm. For example, if we go into the home of a survivor and try to persuade the survivor's husband to stop beating her, this may anger the husband and actually cause more abuse, and she may experience even more pressure to keep it secret. This could prevent her from seeking help.

It is our role to allow the survivor to tell us what services she would like; we cannot push her to make decisions or take action unless she is ready.

How to help her:

- Give her emotional support.
- Ask her what her concerns are.
- Ask how you can help her.
- Follow the guiding principles (described in session 3 of module 4 and in **annex 10**) for working with survivors of violence.
- Follow her lead. Offer her options and allow her to make decisions. Understand that she is the expert in her life.
- Ask her if she feels safe or if she needs help with security and would like to report to security personnel.

If the survivor wants to report the crime to the authorities, explain that she has to go to a health center within 72 hours of the incident so that the medical officer can check her and record the findings which will be used as evidence. Evidence that would be collected during the medical examination includes

- injury evidence: physical/genital trauma
- clothing
- foreign material: soil, leaves, grass
- hair: foreign hairs found on survivors' clothes or body
- sperm and seminal fluid from vagina, anus, mouth, body
- swab samples from bite marks, fingernail scraping

Note that if a survivor would like to have a medical exam completed, it is best not to bathe before it is done, because bathing washes away evidence. Many survivors feel dirty after defilement or rape and want to bathe right away. If the survivor has bathed already, do not criticize her. The medical exam can still be completed.

Post-rape care—do's and don'ts after rape

Don'ts after rape	Do's after rape
Do not wash or clean any part of your body.	Report **immediately** to the nearest hospital
Do not comb your hair.	Report to the police
Do not destroy, change, throw away, or wash your clothes.	Take the clothes to the hospital for the health care provider to examine. If possible, carry an extra set of clothing to change.
Do not put your clothes in a plastic bag or newspaper.	Wrap your clothes in a non-polythene paper (e.g., khaki) bag or in clean cotton cloth/leso
Do not discard the condom if one was used.	Submit the condom for clinical examination.
Do not remove/change anything where the rape occurred (crime scene).	Keep all medical records safe.
If possible, do not pass urine or stool or wipe the genital area until you have been examined at the hospital.	If you must pass urine, collect a sample in a clean container and take it to the hospital.

Roles/Services of Various Responders/Service Providers

Service provider/ service delivery point	Roles/services
Hospital	• examination • collection of evidence • laboratory investigations • treatment of injuries • prevention: HIV, pregnancy, STIs, hepatitis, tetanus, • documentation- PRC form and P3 form filling, • counselling • referral • handing over evidence to the police

Police	• recording incident in the Occurrence Book (OB) and issuance of OB number • writing of statement • issuing the Kenya Police Medical Examination P3 Form • escorting the survivor to the hospital • collecting the evidence from the hospital • apprehending the suspect • presenting the suspects to the court • conducting investigations • protecting the crime scene • preserving the evidence • notifying the survivor, witnesses, and health provider on the scheduled court proceedings • prosecuting
Legal/lawyers	• providing legal advice • representing the survivor or the perpetrator in court • cross-examining the survivor and the perpetrator in court
Chief	• creating awareness on violence to the community • arresting the accused perpetrator • referring /escorting the survivor to the service delivery points • recommending cases for rescue i.e. shelters • supporting the police in investigations
Children's Department	• rescuing children from environment in which violence is happening • recommending rescued children to be sent to shelters/rescue homes • supervising the welfare of rescued children • recommending child offenders to borstal institutions
Shelter/rescue homes	• providing shelter to survivors • providing counseling to survivors • providing social support (e.g., education, income generating activities) • facilitating adoption of children born due to rape

ANNEX 10

GUIDING PRINCIPLES FOR RESPONDING TO VIOLENCE

All actors must abide by the guiding principles at all times. No exceptions.

If safety, confidentiality, or respect are breached or compromised in some way by those who are helping, then the helpers will actually be harming the survivor. This must never happen.

Refer often to the following principles in the workshop, as they are at the center of any response to violence.

1. ***Safety***
   Ensuring the safety and security of the survivor should be the primary priority for all actors, at all times. Remember that the survivor may be frightened and may need assurance of her safety. In all cases, ensure that she is not at risk of further harm by the perpetrator or by other members of the community.

   If necessary, ask for assistance from the police or other authorities.

   Be aware of the safety and security of the people who are helping the survivor, such as family, friends, or social workers, and health care staff.

2. ***Confidentiality***
   At all times, respect the confidentiality of the survivor's family.

   Share only necessary and relevant information (not all details), ONLY if requested and agreed by the survivor, with only those people involved in providing assistance.

   Information about violent incidents and violence survivors should never be shared if it includes the individual's name or other identifying information. Information concerning the survivor should be shared with third parties only after seeking and obtaining the survivor's (or their parents,' in the case of children) explicit consent.

   All written information must be maintained in secure, locked files.

   In meetings, there may be times when a specific violence case is mentioned. Ensure that no identifying information is revealed. Disguise details as needed to protect the confidentiality of the survivor.

3. ***Respect***
   All actions taken will be guided by respect for the choices, wishes, rights, and dignity of the survivor. Some examples:

- Conduct interviews and examinations in private settings and with same-sex translators, whenever possible.
- Be a good listener. Maintain a non-judgmental manner. Be patient; do not press for more information if the survivor is not ready to speak about her experience.
- Ask survivors only relevant questions. The prior sexual history or status of virginity of the survivor is not an issue and should not be discussed.
- Avoid requiring the survivor to repeat her story in multiple interviews.
- Do not laugh or show any disrespect for the individual or her culture, family, or situation.

ANNEX 11

THINGS TO SAY AND TO AVOID SAYING WHEN RESPONDING TO SURVIVORS

Some key things to say to survivors that can be helpful:	Some things to avoid saying to a survivor:
• I believe you. • It's not your fault. • You are not alone. • I and others are here to support you. • You are valuable. • You did not deserve this. • You did not cause this to happen.	• You shouldn't think about it. • You shouldn't feel that way. (This is controlling her feelings. She should be able to feel anyway she wants about it.) • Why did you go there alone/let him in/etc? (Blaming her for what happened.) • Why didn't you scream/run/fight harder? • Why were you outside at night? You know that is dangerous. • You should be more careful next time. • You need to go to security right away about this. (Telling her what to do.) • Your children need their father. You need to be a good wife and take care of them. (Imposing your judgment and opinions on her life.) • Why don't you try not to make him angry next time? (Giving her responsibility for what happened, when it was his choice to be violent. Making her feel as if she failed to be in control of the situation.)

ANNEX 12

PREVENTING VIOLENCE

Developing a personal safety plan

People from communities with unique sexualities can protect themselves from violence even if they may not be ready to disclose or report an abusive partner or client. When they have a personal safety plan, they are more able to deal with violent situations. NGO staff or CBO members can review the following points and help key population members to develop their own personal safety plan:

Tips to escape from a violent partner:

- Identify one or more close friends you can tell about the violence, and ask them to seek help if they hear a disturbance in your home or on site.
- If an argument seems unavoidable with the partner, try to have it in a room or an area that you can leave easily.
- Stay away from any room where weapons might be available. Practice how to get out of your home safely. Identify which doors, windows, or staircase would be best.
- Decide where you will go if you have to leave home and have a plan to get there.
- Have a packed bag ready, containing spare keys, money, important documents, and clothes. Keep it at the home of a relative or friend in case of rushed departure.
- Devise a code word to use with your children, family, friends, and the violence response team when you need emergency help or want them to call the police.

Tips to escape from home or from an on-site client:

- Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he is demanding to calm him down. Do not visit the client's place. Instead, ask him to accompany you to your place of choice. At home, you have the right to protect yourself and your family.
- Always carry chili powder to throw in the face of a violent client to cause temporary burning of the eyes and skin.
- Take a self-defense class.

Activities involving society

Health providers and CBOs can

- provide knowledge about physical, sexual, and emotional abuse and explore their own biases, fears, and prejudices;
- organize a self-defense class to teach KPs techniques to protect themselves, for example karate or other martial arts;
- provide supportive, non-judgmental care to survivors of violence; and
- ask community members about abuse in a friendly, gentle way.

Lawyers, police, and others can

- establish policies and procedures to ask clients about abuse,
- establish protocols that clearly indicate appropriate care and referral for survivors of abuse,
- offer free facilities to CBOs and other groups linked to communities with unique sexualities seeking to organize support groups and to hold meetings.

Society and religious leaders can

- urge understanding, compassion, and concern for survivors of violence;
- challenge religious interpretations that justify violence and abuse of women;
- make their houses of worship available as temporary sanctuary for community members in violence;
- provide emotional and spiritual guidance to survivors of violence;
- support the efforts of survivors of violence to end relationships that put them at risk; and
- integrate discussions on healthy relationships and alternatives to violence into religious education programs.

The mass media can

- respect the privacy of survivors of rape by not printing their names without their permission;
- avoid sensationalizing cases of violence against people with unique sexualities, but place events in their proper context, and use them as an opportunity to inform and educate;
- provide free airtime or space for messages about gender violence and announcements of available services;
- reduce the amount of violence portrayed on television;
- develop socially responsible radio and television programming that depicts equitable gender relations.

Parents can

- refrain from arguing in front of their children;
- teach their children to respect others and themselves;
- encourage the health, safety, and intellectual development of their children and encourage their self-esteem;
- avoid hitting their children—use nonviolent forms of discipline instead;
- teach children nonviolent ways to resolve conflicts;
- talk to their children about sex, love, and interpersonal relationships; and
- emphasize that sex should always be consensual.

Members of communities with unique sexualities can

- practice self-discipline; and
- stop violent behavior with friends, community members, and with other stakeholders.

ANNEX 13

THE ARTICLES OF KENYA'S CONSTITUTION AND BILL OF RIGHTS THAT ARE RELEVANT FOR KEY POPULATIONS

Article	Summary	Relevance to KPs	Example
2 (4) Supremacy of the Constitution	Prohibits customary law that is inconsistent with the Constitution.	Cultural practices that increase the risk of infection or make people more vulnerable to infection are rendered unconstitutional.	Any customary practices which contribute to violence or the spread of HIV, such as female genital mutilation, wife inheritance, and disinheritance of widows, can be challenged under the Constitution insofar as they conflict with the rights enshrined in the Constitution.
Article 2(6) Supremacy of the Constitution	Any treaty or law ratified by Kenya shall form part of the law.	Any ratified international treaty that relates to human rights protection is part of Kenyan law and must be complied with.	Relevant international treaties include • the International Covenant on Economic Social and Cultural Rights, • the UN Convention on the Rights of the Child, • the Convention on the Elimination of All Forms of Discrimination Against Women, • the African Charter on Human and People's Rights, and • the African Charter on the Rights and Welfare of the Child. These have all been incorporated into Kenyan law by the Constitution of Kenya 2010.
Article 19 Rights and fundamental freedoms	Rights belong to all individuals.	Key populations have the right to the fundamental freedoms detailed in the Bill of Rights.	Key populations have the right to be treated with dignity and respect. Their human rights shall be upheld and enforced.

Article 20 Application of the Bill of Rights	The Bill of Rights applies to all law and binds all state organs and individuals.		
Article 21 Implementation of rights and fundamental freedoms	It is the duty of the state and every state organ to observe, respect, protect, promote, and fulfill the rights and fundamental freedoms in the bill of rights. The state must enact legislation to ensure the fulfillment of social and economic rights- and also honor international obligations, with particular regard to vulnerable groups.	Key populations can hold the government accountable when it has failed to honor any of its obligations regarding human rights.	These rights include the right to life, the right to health care, the right to family life, and others. The courts may provide relief, including (a) a declaration of rights; (b) an injunction; (c) a conservatory order; (d) a declaration of invalidity of any law that denies, violates, infringes, or threatens a right or fundamental freedom in the Bill of Rights and is not justified under Article 24 of the Constitution; (e) an order for compensation; or (f) an order of judicial review.
Article 22. (1) Every person has the right to institute court proceedings claiming that a right or fundamental freedom in the Bill of Rights has been denied, violated or infringed, or is threatened.	Every person has the right to institute court proceedings claiming that a right or fundamental freedom in the Bill of Rights has been denied, violated or infringed, or is threatened.	KPs have the right to seek justice through the courts if their rights are violated.	If a police officer refuses to register a sex worker's complaint of an assault, then the sex worker has the right to file a case against the police for violating the sex worker's right to register a complaint.

Article 24 Limitation of rights and fundamental freedoms	Details the legal basis on which rights can be limited.	Ensures that the government does not limit rights without justification.	The fundamental rights and freedoms of key populations can be limited only with a reasonable and justifiable cause, based on human dignity, equality, and freedom, and taking into account all relevant factors.
Article 26 Right to life	Guarantees every person the right to life and allows for abortion in cases where a healthcare worker has determined that the mother's life is in danger. It also sets out the basis when life begins.	Ensures that people are not denied the right to live, by either government laws or polices.	Applies where a person is denied access to treatment or access to medicine. For example, where one is denied antiretrovirals (ARVs) because of the existence of a law that classifies ARVs as counterfeit medicine. Without access to affordable ARVs, HIV patients are denied their right to life.
Article 27 Equality and non-discrimination	Promotes equal treatment of men and women; and prohibits discrimination directly or indirectly on the basis of race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language, or birth	Prevents discrimination against key populations because of illness or the work they engage in. Promotes equality between men and women in all spheres. Recognizes the rights of all persons to land, to inheritance, to marry, and to procreate.	Prohibits denying a person work, treatment, or education on the basis of their sex, age, or health status. Prohibits customary property laws that restrict women's ability to own, inherit, or dispose of property, and which leave them economically dependent on their spouses and more vulnerable when they are sick or abused.
Article 28 Human dignity	Emphasizes the right of each	Calls for everyone, including key	Singling out key populations for unfavorable

	person to be treated with dignity.	populations, to be treated with respect and dignity.	treatment is a breach of their right to dignity.
Article 29 Freedom and security of the person	Ensures liberty and protection from cruel, inhuman, or degrading treatment.	Empowers key populations to make their own decisions about medical treatment, and protects them from being treated in a cruel or inhuman manner.	This article was used to challenge cases in which the government jailed TB patients who failed to adhere to their medication.
Article 31 Privacy	Provides for the right to confidentiality regarding personal information.	Relevant in ensuring that information about a person's health status is kept confidential and is not released without his/her consent.	Examples of breach of privacy: • Health care facilities testing pregnant mothers without their consent. • Health care workers failing to maintain the confidentiality of patients' HIV records. • Patients forced to disclose their medical diagnosis to their employer in order to obtain sick leave from work.
Article 35 Access to information	Allow one to access information that is held by the state or by another person and that one requires to exercise their right or to protect such a right.	This is critical for getting information that is held about key populations, such as information held by the Ministry of Health or the Ministry of Education.	It is a breach if the Ministry of Health refuses to give information that is critical to the wellbeing of key populations, such as research findings.

Article 39 Freedom of movement	Allows for people to move freely inside and out of Kenya, without unnecessary restrictions.	The government cannot impose restrictive measures on the movement of anyone, including key populations.	Prohibited: Conducting health screening at borders or requiring disclosure of HIV status as a condition for immigration. Singling out a health condition, such as HIV infection, as a reason for denying longer-term residency, with no similar restrictions on people with other diseases. Screening all migrant workers for HIV and categorically deporting those who test positive.
Article 40 Protection of right to property	Allows for property ownership anywhere in Kenya, irrespective of gender or age, and prohibits repossession, subject to certain conditions.	A person cannot be denied the right to inherit or own property.	Prohibited: A deceased husband's family denies his HIV-positive widow, a sex worker, and her children from inheriting the deceased husband's property.
Article 41 Labour relations	Sets out general working standards for employees, and rights of employers and trade unions.	Ensures that key population members who are living with HIV are reasonably accommodated in their place of work and that their working conditions are fair. Also ensures adequate	Prohibited: • Denying a person the right to work on the basis of his or her HIV status. This article applies to military recruitment as well. • Dismissing an employee from employment because of the employee's HIV infection.

		remuneration irrespective of HIV status.	
Article 43 Economic and social rights	Every individual has the right to health care, sanitation, clean water, housing, social security, education, and emergency medical attention.	The right to health, education, social security, housing, water and food are all important.	The government must take progressive steps to ensure access to anti-retroviral drugs, treatment for opportunistic infections, opioid pain medications for palliative care, and comprehensive TB care for all. The government must take progressive steps to ensure that laws and policies to actualise the social economic rights are enacted and enforced.
Article 45 Family	Guarantees the right to marry and raise a family.	One cannot be denied their right to marry.	It is illegal for the state to • Require HIV testing or proof of HIV-negative status as a condition of marriage. • Force women living with HIV to undergo abortion or sterilization rather than provide information and services to prevent mother-to-child transmission of HIV. • Deny women equal rights in marriage, divorce, or within families, thereby decreasing their ability to negotiate safer sex or leave relationships that pose a risk of HIV.
Article 46 Consumer rights	Consumers have the right to access	Everyone is entitled to	It is illegal to supply substandard medicines

	goods and services for the protection of their health and safety.	adequate drugs and treatment.	and faulty testing kits to government hospitals.
Article 47 Fair administrative action	This highlights the need for administrative action that is expeditious, efficient, lawful, reasonable, and procedurally fair.	If a right or fundamental freedom of a person has been or is likely to be adversely affected by administrative action, then that person has the right to be given written reasons for the action.	Prohibited: The state failing to complete the construction of TB isolation ward despite having funding for it for over 10 years.
Article 48 Access to justice	The state is obligated to ensure that people can get affordable justice.	Many key populations face human rights violations and have difficulty accessing justice.	For many people living in rural areas it is difficult to access the formal court system and to pay the legal fees. In such cases it helps to promote access to customary justice systems, which are much cheaper and often offer more culturally appropriate solutions than the formal court system. Customary justice leaders (i.e., cultural leaders who at times adjudicate on cultural matters as avenues of alternative dispute resolution) must also be provided with human rights training to ensure that their decisions comply with the law.
Article 50 Fair hearing	One can have their case resolved by the	Key populations can go to court and seek	Where a police officer arrests a sex worker and rapes her, the sex worker

	competent court or tribunal.	protection for their rights that have been violated. They cannot be denied this right because of the nature of their work or their sexual preference.	can report the matter to the police for criminal action to be taken against him and also file a civil case to be afforded damages for the acts done. The Victim Protection Act allows the courts to order for the payment of any costs as compensation to a victim from the perpetrator.
Article 51 Rights of persons detained, held in custody, or imprisoned	People who are detained or held in custody retain their rights and fundamental freedoms in the Bill of Rights, except that they are incarcerated.	Key population members arrested for any reason retain their rights. It is unlawful for the police to assault or rape a prisoner, as doing so would violate the prisoner's human rights.	All rights and freedoms exist, apart from those that may be limited by law.

HANDOUTS

HANDOUT 1

PRE-/POST-TRAINING ASSESSMENT QUESTIONNAIRE

Purpose of the Pre/Post-Training Assessment

This survey is designed to inform the facilitation team about your familiarity with the content of the workshop. This will help ensure that the workshop is relevant to your needs.

Please complete the questionnaire and return it to me (the facilitator). Thank you for participating.

[Name of Training] _____

Please tick the appropriate box: Pre-Training ☐ **Post-Training** ☐

NAME (optional): _____

ORGANIZATION: _____ **POSITION:** _____

Survey Questions

Please tick whether you personally agree or disagree with the following statements:

1. Prostitution is a crime.

Agree	Disagree	Not Sure

2. Sex workers are to blame for spreading HIV.

Agree	Disagree	Not Sure

3. Sex workers respond to only physical communication/discipline.

Agree	Disagree	Not Sure

4. Sex workers do not have any human rights.

Agree	Disagree	Not Sure

5. Sex work is immoral.

Agree	Disagree	Not Sure

6. Sex work is the livelihood that sex workers prefer.

Agree	Disagree	Not Sure

7. Sex workers deserve as much respect as other people.

Agree	Disagree	Not Sure

8. Only bad women do sex work.

Agree	Disagree	Not Sure

9. Women in sex work should accept violence as part of their work.

Agree	Disagree	Not Sure

10. Hitting a sex worker is not a crime.

Agree	Disagree	Not Sure

11. Because sex workers perform sex for a living, they cannot claim that they have been raped.

Agree	Disagree	Not Sure

12. A sex worker can help the police fight crime.

Agree	Disagree	Not Sure

13. Arresting a sex worker can reduce diseases in the county/ country.

Agree	Disagree	Not Sure

14. Police and sex workers can work together to reduce the spread of HIV.

Agree	Disagree	Not Sure

15. HIV-positive sex workers deserve to die.

Agree	Disagree	Not Sure

16. Men who have sex with men are criminals.

Agree	Disagree	Not Sure

17. Men who have sex with men are the cause for spreading HIV.

Agree	Disagree	Not Sure

18. Men who have sex with men respond to only physical communication/discipline.

Agree	Disagree	Not Sure

19. Men who have sex with men have human rights protected by the Constitution.

Agree	Disagree	Not Sure

20. Same-sex relationships are unnatural.

Agree	Disagree	Not Sure

21. One should not be bothered about who is having sex with whom and how.

Agree	Disagree	Not Sure

22. Real men do not have sex with men.

Agree	Disagree	Not Sure

23. Men who have sex with men deserve as much respect as other people.

Agree	Disagree	Not Sure

24. It is OK to harass men who have sex with men.

Agree	Disagree	Not Sure

25. Men who have sex with men cannot change their sexual orientation.

Agree	Disagree	Not Sure

26. Assaulting a man who has sex with men is not a crime.

Agree	Disagree	Not Sure

27. A man who has sex with men can never claim that he has been raped.

Agree	Disagree	Not Sure

28. MSM can help the police fight crime.

Agree	Disagree	Not Sure

29. Arresting MSM can reduce diseases in the county/ country.

Agree	Disagree	Not Sure

30. Police and MSM can work together to control HIV.

Agree	Disagree	Not Sure

31. HIV-positive MSM deserve to die.

Agree	Disagree	Not Sure

32. People who inject drugs are criminals.

Agree	Disagree	Not Sure

33. People who inject drugs are the cause for spreading HIV.

Agree	Disagree	Not Sure

34. People who inject drugs respond to only physical communication/discipline.

Agree	Disagree	Not Sure

35. People who inject drugs do not have any human rights.

Agree	Disagree	Not Sure

36. People who inject drugs do so out of choice.

Agree	Disagree	Not Sure

37. People who inject drugs are sick and need medical help.

Agree	Disagree	Not Sure

38. People who inject drugs deserve respect like other people.

Agree	Disagree	Not Sure

39. Good people do not do drugs.

Agree	Disagree	Not Sure

40. People who inject drugs deserve to be treated violently.

Agree	Disagree	Not Sure

41. All people who inject drugs are thieves.

Agree	Disagree	Not Sure

42. Assaulting people who inject drugs is not a crime.

Agree	Disagree	Not Sure

43. People who inject drugs can never claim that they have been raped.

Agree	Disagree	Not Sure

44. A person who injects drugs can help the police fight crime.

Agree	Disagree	Not Sure

45. Arresting a person who injects drugs can reduce diseases in the county/ country.

Agree	Disagree	Not Sure

46. Police and PWID can work together to reduce the spread of HIV.

Agree	Disagree	Not Sure

47. HIV-positive PWID deserve to die.

Agree	Disagree	Not Sure

48. People who inject drugs are irresponsible.

Agree	Disagree	Not Sure

49. Law enforcement agents have unlimited authority, so they are above the law.

Agree	Disagree	Not Sure

50. It is OK for law enforcement officials to use violence against key populations.

Agree	Disagree	Not Sure

51. Key populations engage in behaviour that is against the law, so they have no rights as per the Kenyan Constitution.

Agree	Disagree	Not Sure

52. Key populations cannot do anything to a law enforcement official if he / she does anything that violates a key population member's rights.

Agree	Disagree	Not Sure

HANDOUT 2

PLANNING A VIOLENCE PREVENTION AND RESPONSE INTERVENTION

Successful interventions to address violence against key populations include education on rights, community mobilization to respond to violence and discrimination, practical warning systems in sex work networks, sensitization workshops with police and law enforcement authorities, and community- and policy-level advocacy to promote human rights.[17] The following section details the activities stated in the revised Kenyan national guidelines on key populations in 2014.

1. **Assess the nature of violence experienced by KPs and the need for a violence response system.**

   The implementing partner should organise discussions with the key populations to understand the nature of violence experienced by them. This should include understanding
   1) who perpetrates violence against them,
   2) the types of violence experienced,
   3) the context and time of violence,
   4) factors contributing to violence,
   5) the kind of response system to be developed, and
   6) influencers who need to be sensitised.

   The response system may look different for different sub-populations. Such assessment will enable implementing partners to develop a response system that is based on the needs of the population. This assessment should be done once in a year.

   Resource: **Annex A** - Guide to facilitate consultation with key population on development of a violence response system.

2. **Educate key populations on their rights.**

   The key populations need to know their rights. Although sex work, same-sex relationships, and drug use are illegal, people involved in these practices have human rights. The key populations need to know the laws that affect them and the human rights that protect them. Peer educators of the intervention and the key populations should be trained and educated about the rights of key populations.

   The peers can be trained as trainers to provide such information to the other key populations during peer education. In addition, special group sessions should be organised in DICs or elsewhere to conduct these sessions with the larger key population.

   It is recommended that the peer educators undergo at least two training programmes annually. At least 50% of the key populations registered in the programme should undergo at least one day of sensitisation on rights annually.

   Resource: National AIDS and STI Control Programme (NASCOP) 2015. *Training of Trainers Manual: Guidance for Trainings on Key Populations' Human Rights*. Nairobi: NASCOP, Ministry of Health, Kenya.

3. **Map and sensitise stakeholders.**

   After the assessment (described in point 1) the intervention team provides the outreach team with information that helps the outreach team map stakeholders and influencers who can change the

17 National AIDS and STI Control Programme (NASCOP) 2014. *National Guidelines for HIV/ STI Programming with Key Populations*. Nairobi: NASCOP, Ministry of Health, Kenya. http://nascop.or.ke/index.php/guidelines/

situation. Some of the stakeholders could include bar owners and managers, brothel owners, sex den managers, drug den managers, and so on. The outreach team of the intervention should meet these stakeholders and power holders at least once in a quarter to ensure that they support the key populations when they experience violence and immediately call the peer educator or the outreach team when violence occurs. During this sensitisation the outreach team can also negotiate to set up condom depots in the sites or to paste stickers advertising the project and the helpline. Each mapped stakeholder should be met at least once a quarter during routine outreach.

4. **Set up technical working groups at the county level.**

The implementation partner should support the county government to set up technical working groups at the county government with membership from multiple stakeholders to guide the key population programme. The TWG should include members from the Health Ministry, the implementing partners, the key populations, law enforcement, and religious leaders. This forum can be used as a platform to strategise on violence prevention and response work and to undertake high-level advocacy at the county level, especially with law enforcement or county assembly representatives, the county commissioner, and so on.

Resource: **Annex B** - Terms of reference for county-level KP Technical Working Groups

5. **Establish a violence response system.**

Strategies to promote the safety and security of key populations in their workplaces, hot spots, drug dens, and communities should be developed. A violence response system needs to be developed that can provide immediate support to the key population experiencing violence. The system includes the following steps:

1) **Forming a violence response team** or security committee. These teams can include peer educators, outreach workers, and supervisors. Each team should have at least 3 members, and depending on the size of the intervention there should more than 2-3 teams in each intervention. The teams should be supported by a lawyer (part time) who can be contacted on a 24-hour basis. These teams should be ready to work at night, as most violence related to key populations happens at night. The responsibility of the team is to receive complaints of violence and reach the site of violence within 2 hours, assess the situation, and provide support to the key population.

Roles of violence response team/ paralegals

- Educate the key populations about their rights.
- Be available on spot and report whenever the key populations experience violence.
- Accompany the key population member for medical care.
- Support the KP to register a complaint in a police station.
- Provide avenue for Alternative Dispute Resolution (ADR).
- Link the KPs who experience violence to medical, legal, or psychosocial services.

2) Develop **steps in violence response** for emergency and non-emergency. An SOP (standard operating procedures) should be developed within the project to manage

emergency and non-emergency situations.

3) **Training of the violence response team** is important. Besides knowing the laws and rights (mentioned in activity 2, above), they need extra training to build their paralegal skills in situation assessment and problem solving. The training should include the following topics:

- situation assessment of the event, and response based on the assessment;
- identification of priority issues, and understanding of the institutional levels at which to address them;
- counselling skills;
- communication, negotiation, conflict management skills; and
- record-keeping and documentation.

4) Establish a **communication system** by securing 2 or 3 phone lines which are attended day and night. The violence response teams can manage these calls on a rotational basis. KPs can call into this number to report incidents of violence where they need help.

5) Promote the system, especially the phone numbers, through information, education, and communication (IEC) materials in all the hotspots, and through all the peer educators and events where key populations come together.

Resources:

- Bill & Melinda Gates Foundation 2009. *Community Led Crisis Response Systems: A Guide to Implementation*. New Delhi: Bill & Melinda Gates Foundation. https://docs.gatesfoundation.org/documents/avahan_communityledcrisisresponse.pdf
- National AIDS Control Council (NACC) 2016. *Responding to Violence against Key Populations and Promoting Human Rights in an HIV-Prevention Programme: Training Manual and Handbook*. Nairobi: National AIDS Control Council.
- National AIDS and STI Control Programme (NASCOP) no date. *Learning Site: Violence Prevention and Response*. Nairobi: NASCOP. Ministry of Health. Kenya. http://nascop.or.ke/index.php/case-studies/#

The violence response system in action

- When a key population member calls the crisis number on her/his own behalf or on behalf of another member who has been harassed or abused, the member of the violence response team receiving the call immediately contacts other violence response team members to alert them. Depending on the nature of the crisis and according to the SOP, the violence response team members may inform senior project staff, including the project coordinator and legal resource person.
- The team ensures that at least one person from the violence response team goes to the spot where the crisis has happened and meets the person concerned. Every crisis should be responded to within 30 minutes of being reported. It is important to provide immediate moral support and to demonstrate that the person is not alone in this situation and that the person has support from the project.
- If a police report needs to be filed, or if the situation involves arrest, or if the person affected is at the police station for any other reason, both a team member and a legal resource person should reach the police station within 30 minutes.
- If the KP reporting the crisis needs medical support, then the violence response team should take her/ him to the designated clinic or project clinic.
- Every crisis is documented to record the kind of crisis, the perpetrators, and

the response. A formal documentation system can be used to show an increase or decrease in the number or type of crisis cases, and the nature of responses to crises. This information can be used to review and improve violence response and for public advocacy.

- Weekly debriefing meetings are held with the violence response teams to discuss any crises that happened during the week, followed by collective brainstorming on strategies for improving the violence response.
- The KP experiencing crisis is followed up and, if necessary, linked to other long-term services.

Establish direct or referral services for key populations who experience violence.

Key populations who experience physical, sexual and psychological violence will need psychosocial or medical care in both the short and long term. In Kenya there are gender based violence support centres attached to most major hospitals and therefore the interventions should establish formal linkages with such centers. The service providers in the DICs of implementing partners should also go through sensitivity training so that they can sensitively provide services to KPs who experience violence.

6. **Sensitise law enforcement.**

Working with the police and law enforcement is a key element of efforts to reduce violence against key populations. Activities need to be included at three levels:

1) Special one-to-one advocacy meetings should be done with regional police commanders or county commanders to educate them about the project, the need of key populations to access health, and the barriers and the harassment caused by law enforcement.
2) One-day sensitisation of the police and askaris to orient them on issues of key populations and barriers to access to health services, and to reduce harassment while protecting human rights.
3) Two-day training of in-service police in regional and national police academies to institutionalise the curriculum.

Resource: National AIDS and STI Control Programme (NASCOP) 2016. *Rights-Responsive Law Enforcement: A Manual for Training Trainers to Sensitize Police on Their Role in a Rights-Based Approach to HIV Prevention among Key Populations*. Nairobi: NASCOP, Ministry of Health, Kenya.

7. **Hire legal support.**

Legal support/ lawyers should be available to support key populations when they seek justice. This will require engaging or linking with lawyers or trained paralegals (e.g., key populations trained as paralegals) who can help negotiate with legal and judicial authorities on incidents of violence, advocate on behalf of sex workers, and support training and sensitization of sex workers and others on laws related to sex work. The project may want to also put aside some money for bail or to pay fines for the key populations. Though this is a not a sustainable strategy, this may be kept as an option for very poor KPs, especially PWID.

8. **Establish a key population led advocacy committee.**

Establish a key population led advocacy committee which will plan and monitor the structural interventions within the implementing partners. This committee

should meet regularly to discuss the issues of violence and the action taken by the project, the gaps and concerns of the violence response team, and possible solutions. This committee should also review the data to assess progress and develop plans.

Resource: National AIDS and STI Control Programme (NASCOP) 2014. "Community Committees," pages 67 and 68 of the *National Guidelines for HIV/ STI Programming with Key Populations*. Nairobi: NASCOP, Ministry of Health, Kenya. http://nascop.or.ke/index.php/guidelines/#

9. **Document incidents of violence.**

Each episode of violence should be documented, including the response of the implementing agency towards the incident. This evidence then can be used for planning and advocacy. The violence reporting form in **annex C** can be used for documenting incidents of violence.

Handout 2 - Annex A: Focus Group Guideline for Needs Assessment

1. Could you please tell us about the people who perpetrate violence against people like you? (list the perpetrators and rank them to assess who the key population consider most important.)
2. What are the different types of violence you experience? Could you share some examples?
3. When do such acts of violence take place (day or night), and where do they take place (hot spots, dens, home, etc.)?
4. What are the factors that make people like you vulnerable to violence?
5. How can the project help in such situation of violence?
6. Who are the influencers or change agents who need to be sensitised to stop violence?

Handout 2 - Annex B: Terms of Reference for County-Level Key Population Technical Working Groups

Background Information

Kenya has the third largest population of people living with HIV in sub–Saharan Africa and the highest national HIV prevalence of any country outside of Southern Africa. There is a mixed and geographically heterogeneous HIV epidemic with an estimated adult HIV prevalence of 5.6%. [18]

HIV in Kenya is characterized as a generalized epidemic among the adult population and a concentrated epidemic among key populations. The Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19) defines key populations as "groups who, due to specific higher-risk behaviour, are at increased risk of HIV, irrespective of the epidemic type or local context". The KASF further recognizes that the vulnerability of the KPs to HIV is exacerbated by the legal, cultural, and social barriers related to their behavior. In Kenya the key populations include men who have sex with men, people who inject drugs, and sex workers.

Recent country-wide mapping conducted by NASCOP shows that the significance of key populations in the country is too critical to ignore, as 33% of all new infections in the country are attributed to them (MOT, NACC 2009). According to the Kenya AIDS Epidemic update of 2102 by NACC and NASCOP, HIV prevalence among KPs is high. For instance, prevalence among FSWs is 29.3%, among PWID is 18.3%, and among MSM is 18.2%. The Kenya AIDS Strategic Framework (KASF) 2014/15 – 2018/19 has thus prioritized key populations as one of the priority groups for

18 National AIDS and STI Control Programme (NASCOP) 2014. *Kenya AIDS Indicator Survey 2012: Final Report.* Nairobi, NASCOP. http://www.nacc.or.ke/images/documents/KAIS-2012.pdf

HIV prevention and care.

Barriers to HIV services access by the KPs are common; the most visible forms of barrier are violence and stigma. According to a polling booth survey conducted by NASCOP in 2014, 44% of FSWs, 24% of MSM, and 57% of PWID reported experiencing violence from police and 'askaris' in the last 6 months.[19] A stigma index survey carried out by NACC in 2014 revealed that the key populations face disproportionately higher levels of stigma in society and public institutions, including health facilities.

The KASF has therefore proposed a number of strategies to remove barriers to access of HIV, SRH, and rights information and services in public and private entities for the key populations and other groups. Further, KASF recommends improvement of the legal policy environment at the national and county levels as a means of reducing the stigma, discrimination, social exclusion, and violence which have been identified as some of the biggest impediments to HIV service access by the key populations.

Currently, a Key Population Technical Working Group and a Key Population Advocacy Task Force convened by NASCOP and NACC exist at the national level.

Purpose of the County Key Population Technical Working Groups

In view of the numerous structural challenges which currently impede KPs' access to HIV services, it is imperative that partners from Government and non-governmental agencies galvanize their efforts to collaboratively address these challenges. Additionally, given that health services and HIV response have been devolved to the counties, it is important that a multi-stakeholder forum be convened at the county level to provide technical leadership in harmonizing HIV interventions for key populations in the county and to provide a platform for collective advocacy to address the barriers to HIV services.

The purpose of the Key Population Advocacy Task Force:

The Key Population Technical Working Group will be

1. To provide a platform for harmonizing HIV intervention for KPs in the county.
2. To provide advisory role to the advocacy processes for HIV programming targeting the key populations in the county.
3. To provide support in creating the necessary linkages for effective advocacy at various levels in the county.

Expected outcomes:

- Increased recognition of the importance of KPs in HIV epidemic and hence enhanced resourcing of key populations HIV interventions in the county.
- Increased dialogue and acceptance of the need to address structural barriers that hinder access to HIV and AIDS services by key populations in the county.
- Increased accountability to the constitutional rights of the key populations to access good quality health services.
- Thematic advocacy areas in the county identified and prioritized.
- Resourcing requirements and potential sources of resources for the county advocacy plan mapped and engaged.

Reporting:

The County KP TWG will report to the national KP TWG on quarterly basis. NACC and NASCOP

19 National AIDS & STI Control Programme (NASCOP), Ministry of Health, Kenya. 2014. *National Behavioral Assessment of Key Populations in Kenya: Polling Booth Survey Report.* Nairobi: NASCOP, Ministry of Health, Kenya.

officers in the county and national offices support the County KP TWG with technical support.

Membership and Review:

The county KP-TWG will be open to

i. County Health Directorate officers
ii. County HIV & AIDS coordinators
iii. County AIDS and STI coordinators
iv. Key populations organizations
v. Civil society organization working with KPs
vi. Faith-based organizations
vii. Law enforcement

Frequency of meetings and leadership:

The County KP-TWG meetings shall be held quarterly at a location that will be agreed upon by members. The meetings shall be led by the county chief officer for health or a delegated authority.

Handout 2 - Annex C: Violence Reporting Form

REPUBLIC OF KENYA

MINISTRY OF HEALTH

VIOLENCE REPORTING FORM

County_____ Implementing partner _____

Name of Program staff _____ Date ☐☐ ☐☐ ☐☐☐☐

KP Type _____

1.	Name: _____ Sex(M/F/Transgender):_____ Age:_____ Place of incident: Unique ID:
2.	Date of incident:_____ Time of the incident AM ☐ PM ☐
3.	Was the abuse against: a) An individual: Yes ☐ No ☐ b) Group Yes ☐ No ☐
4.	The form of incident: Harassment ☐ 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 ☐ Clients: Yes ☐ No ☐ School: Yes ☐ No ☐ Local Authority: Yes ☐ No ☐ Neighbors: Yes ☐ No ☐ Community members: Yes ☐ No ☐ Other KP(specify) _____ Mob Justice Yes ☐ No ☐ Yes ☐ No ☐
6.	Date and time the KP team made its first attempt to address the incident through its staff 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 ☐☐ ☐☐ ☐☐☐☐

Program Officer Name : _____ KP Violence Reporting Form - Ver June. 2013

HANDOUT 3

CASE STUDIES

Case 1

On 19 November 2015, 65 female sex workers were arrested in a joint operation between the Kisii county government and police department. After a night in the cells the sex workers were shoved into a police truck and taken to the Kisii teaching and referral hospital, where they were tested for sexually transmitted infections (STIs) without their consent. According to the medical and police officers, 26 of the women tested positive for STIs. Those who tested negative were released. The 26 women who tested positive were taken back to the cells without being offered treatment. Seven of the women were HIV positive and had missed their medication (ART). One woman had a disabled child who was left alone at home.

In the cells, the women were divided into two groups: those who were clean and better dressed were separated from those who were not well dressed. These better-dressed women were held in a cleaner cell which had some form of beddings. The other women were put beside the men's cells in a very dirty place that smelt of urine. The women slept on the cold, dirty cement floor without any mattress, blanket, mat or covering. Most did not have even a sweater. When approached by activists, the Kisii governor's office leading the operation mentioned that their objective was to eliminate sex workers from the county, as there were too many women loitering on the streets of Kisii, and spreading HIV and STIs to married men.

Case 2

According to media reports, around the end of August 2015 more than 400 drug addicts, branded as drug traffickers, were arrested at the Coast, mainly in Mombasa. The police action was part of the drugs, crime, and terror crackdown ordered at the Coast by President Uhuru Kenyatta. Police officers and county inspectorate departments carried out sweeps in parts of Changamwe, Mombasa Island, Kisauni, and Likoni.

On 1 September 2015 The Star newspaper reported that Changamwe police boss Joseph Muthee said 40 suspected drug traffickers and abusers were detained during joint operations. Muthee said police confiscated 34 roles of bhang and 52 sachets of heroin in "well-known notorious dens." In Likoni, 29 suspects were arrested yesterday in parts of Shelly Beach, Mtongwe, and Shika Adabu. Mombasa deputy county commissioner Salim Mohamoud said 43 drug peddlers were arrested in Majengo. Addressing the media after meeting leaders, Mohamoud said several sachets of heroin, cocaine, and rolls of bang were seized. He urged the community to join security agents in the war on drug abuse. According to Mohamoud, "The drug menace is contributing to radicalisation and organised criminal gangs, hence, the need for cooperation from the community. The addicts need to be rehabilitated." [20]

The mass arrest of PWID in Mombasa seriously disrupted the harm-reduction services of various agencies such as MEWA, REACHOUT and the Omari Project. In several instances, outreach workers who were distributing clean syringes in the shooting dens were arrested and branded as traffickers. Mr. Abdallah Badrus, programme manager at MEWA, an organization offering harm-reduction services to PWID at the Coast, observed a significant drop in the number

20 Onsarigo C. 100 arrested in Mombasa raids on drug dens. *The Star*. 1 September 2015. http://www.the-star.co.ke/news/100-arrested-mombasa-raids-drug-dens#sthash.Rofu2abx.dpuf

of PWID coming to the drop-in centers for harm-reduction services. Service providers also reported that provision of basic services such as needle and syringe exchange became impossible when the PWID went into hiding. It was feared that, without access to sterile injecting equipment, addicts would share used needles and syringes, which increases the risk of HIV infection.

The raids and arrests that drove addicts into hiding reversed major gains in harm reduction that had taken years of work!

Case 3

Phelister, a 21-year-old transgender sex worker, has been living in Nairobi for the last five years. She survives by engaging in sex work, the only option available. At around 8 p.m. on 18 June 2004, while she was waiting for clients she was raped by 10 men who forcefully took her to the grounds beside Lenana Road. They threatened to kill her if she wouldn't have sex with them. She was forced to have oral and anal sex with all of them. While she was being sexually assaulted, two policemen arrived. Most of the perpetrators fled, but the police caught two. Phelister told the police about the sexual assault. Instead of registering a case against the perpetrators and sending Phelister for medical examination, the police harassed her with offensive language and took her along with the captured perpetrators to the nearby police station. The police did not allow Phelister to put on her trousers and forced her to be naked for seven hours. At the police station Phelister was subjected to brutal torture. They took her to a room, stripped her naked, and handcuffed her hands to a window. Six policemen, allegedly drunk, hit her with their hands and lathis and kicked her with their boots. At around 5 a.m. they released her, threatening to shoot her if she ever mentioned what happened at the police station. Phelister went home and now suffers mental illness from the trauma she experienced.

Case 4

Japheth is a 23-year-old man who works in a bank. He is an active homosexual who regularly has contact with other homosexuals on interactive web sites. The manager of the bank where Japheth works also visits these web sites and one day sees Japheth's profile. The next day he calls Japheth into his office and says he knows about Japheth's homosexuality. He threatens Japheth to have sex with him or else he will tell everyone at the bank that Japheth is a homosexual. Japheth is forced to have sex with the manager. Japheth thought this crisis was over, but after one week the manager again approached Japheth for sex, threatening him with exposure if he refused. Japheth is afraid. He does not want to have sex with the bank manager. He gives an excuse and tells the bank manager that he will see him tomorrow. Japheth goes home very depressed. The next day Japheth did not come to work. The news then reached the bank manager that Japheth had committed suicide.

HANDOUT 4

SETTING UP A VIOLENCE RESPONSE SYSTEM

What Is Community-Led Violence Response?

Community-led violence response is a simple concept:

- A community member confronted with violence can summon rapid, on-the-spot support by calling a phone number staffed by another KP who is part of the violence response system.
- A team of trained community members assesses the nature and urgency of the crisis, takes steps to address any immediate danger, and provides counseling, access to medical services, and other relevant support.
- In cases where there appears to have been a wrongful arrest of a community member, a volunteer lawyer may assist in intervening with the police. As the violence response system matures, community members may do this effectively themselves. The team aims to respond immediately, and it works to resolve the crisis over the longer term if necessary. The violence response system involves documentation of each incident, including the number of people involved, to improve future responses and monitor trends in violence against KPs (both locally and at the regional and national levels).

An Overview of Violence Response

Violence response addresses immediate incidents of violence as well as incidents that are ongoing or require a longer-term approach:

1. **Responding to incidents of violence.** At a minimum, this involves reaching the scene of the incident within a short time (usually less than 30 minutes in urban areas or within a few hours in rural areas); verifying the details of what has occurred; activating legal support where required; and counseling the affected individual to ensure he/she has adequate psychosocial, medical, and resource support in the immediate term.
2. **Resolution of crises with families, communities, and intimate partners.** Violence against KPs by family members, intimate partners, or the local community is commonplace. Violence against KPs by members of the same group can also be a problem. Violence response systems try to resolve these incidents and prevent future violence by
   - counseling individuals and families,
   - using lawyers and other respected local leaders to advocate on behalf of affected, and
   - doing community-led advocacy to strengthen public opinion.
3. **Advocacy and sensitization work with stakeholders.** A violence response system should be part of a larger effort to equip communities to tackle the broader issues of legal and social discrimination that make them vulnerable to violence and to HIV infection. This requires training and resources.

Because of the limited resources available to HIV programs, violence response systems must mobilize support from other groups, organizations, and stakeholders. These include

- Lawyers, human rights groups, and other advocacy groups that can help communities when a major crisis occurs. Over time they might train, mentor, and form coalitions with violence response teams.
- Existing social welfare schemes that provide subsidized food, savings and income-generation programs, literacy training for children and adults, safe houses, and counseling.
- Organizations that conduct sensitization work with the police.
- Media groups or mass media efforts that

work to improve HIV knowledge and address HIV-related stigma.

Why Is Violence Response Important for HIV Prevention?

Without a support system, KPs who face actual or threatened violence may suffer increased vulnerability to HIV. The criminalization of sex work and homosexual behavior may lead perpetrators of violence to believe there will be no consequences to their action. Those who experience violence may be afraid to report it for fear of public exposure. They may also suffer low self-esteem, and their ability to negotiate safer sex may be limited, putting them at greater risk of HIV and making them harder to reach with HIV interventions.

Violence response systems can make KPs feel safer and can also support the HIV-prevention work of peer educators. The reassurance that they can call someone if they encounter a threatening situation can help KPs assert their personal and collective right to safety. This is critical for sex workers, for whom the threat of violence may arise when negotiating condom use.

Community members' support for one another in crisis situations may be a stepping stone for them to take action on other fronts. It may prompt the formation of formal and informal community groups. This may be a more sustainable and effective way for them to organize and advocate for their rights.

HANDOUT 5

CASE STUDY OF GRUESOME MURDERS OF SEX WORKERS IN NAKURU

In October 2015 a series of murders terrified Nakuru's sex worker community. The murders seemed systematic; all three victims were sex workers, and the murders happened within the same locality. One of the victims had her faced carved and eyes gorged out in what looked like a ritual killing.

Particularly intriguing was the police laxity in dealing with the cases. Despite the fact that the police removed the bodies from the murder scenes, the crimes were not recorded in the police records. It took joint intervention by government agencies and civil society organizations to get the cases recorded in the occurrence book (OB). As a result, the cases were recorded in the OB a week after the murders.

Also intriguing was the speed at which the police developed theories surrounding the murders. For the case of the lady whose eyes were gorged out, even before a post mortem was undertaken the police blamed the mutilation on stray dogs. In another case, the police said the girl died while attempting to terminate a pregnancy. In the third case, which seemed straightforward because the girl was murdered in the client's house, the police claimed that the owner of the house lent it to a third party who committed the murder and ran away. They reported that the suspect committed suicide in Mombasa as the police were closing on him, and therefore the case was closed.

The reactions of the relatives of the murdered sex workers surprised many. Most of the relatives were not interested in justice and were eager to bury the deceased before the post-mortem. The Nakuru murders triggered a frenzy of media reporting, albeit long after the crimes. It was mysterious that the media did not investigate these crimes which appeared to be the work of a serial killer.

Response: The role of the County KP TWG

The most encouraging thing about the Nakuru murders was the collaborative efforts initiated by the County Key Population Technical Working Group (KP TWG). The KP TWG, NACC, and NASCOP were able to initiate immediate measures to follow up on the cases. The TWG got an audience with the County Police commander, Mr. Hassan Barua, who pledged action and indeed followed up with the OCS Bondeni to ensure that the cases were properly recorded and investigated. The KP TWG, NACC, and NASCOP also jointly rallied partners to support a series of sensitization events to hasten the response, pushing for action on the murders and enhancing the safety of the KPs.

Sensitization meetings were held with KP reps, CSOs working with KPs, the police, and hotel and lodges owners. The outcome has been a well-coordinated multi-stakeholder network in constant communication through a WhatsApp mailing group that constantly shares information on issues around the security and safety of KPs.

Actions and steps taken by the Nakuru KP Technical Working Group

- The listed members of the TWG met in the early morning of 12 Oct. 2015 and booked an 11:00 a.m. appointment with the Nakuru County Commander. Unfortunately, by 11:00 a.m. he had left his office, and he rescheduled the meeting to 3:00 p.m.
- The team proceeded to the sites of the murders and interviewed key informants, including bar attendants, fellow sex workers, and peer educators working within the HIV-prevention programme.
- Unfortunately, the murder cases were reported by the local media, and the tension for a demonstration increased.

By the time of compiling the report, the sex workers had already staged a peaceful demonstration. The team trailed the demonstration as it happened and confirmed that sex workers and representatives of some key HIV-prevention programmes were present.

Participants in the demonstration included sex workers, Kenya Sex Workers Alliance (KESWA), Bar Hostesses and Sex Workers Empowerment Programme (BHSEP), and HOYMAS.

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