Pehchan Training Curriculum
MSM, Transgender and Hijra Community Systems Strengthening

Facilitator Guide
Trauma and Violence
Pehchan Consortium Partners

India HIV/AIDS Alliance (www.allianceindia.org)

Pehchan Focus: National coordination and grant oversight
Based in New Delhi, India HIV/AIDS Alliance (Alliance India) was founded in 1999 as a non-governmental organisation working in partnership with civil society and communities to support sustained responses to HIV in India. Complementing the Indian national program, Alliance India works through capacity building, technical support and advocacy to strengthen the delivery of effective, innovative, community-based interventions to key populations most vulnerable to HIV, including men who have sex with men (MSM), transgenders, hijras, people who use drugs (PWUD), sex workers, youth, and people living with HIV (PLHIV).

Alliance India Andhra Pradesh

Pehchan Focus: Andhra Pradesh
Alliance India supports a regional office in Hyderabad that leads implementation of Pehchan in Andhra Pradesh and serves as a State Lead Partner of the Bill & Melinda Gates Foundation.

The Humsafar Trust (www.humsafar.org)

Pehchan Focus: Maharashtra, Madhya Pradesh, Goa, Gujarat and Rajasthan
For nearly two decades, Humsafar Trust has worked with MSM and transgender communities in Mumbai, Maharashtra. It has successfully linked community advocacy and support activities to the development of effective HIV prevention and health services. It is one of the pioneers among MSM and transgender organisations in India and serves as the national secretariat of the Indian Network for Sexual Minorities (INFOSEM).

Pehchan North Region Office

Pehchan Focus: Punjab, Delhi, Uttar Pradesh and Bihar
Alliance India supports a regional implementing office based in Delhi that leads implementation of Pehchan in four states of North India.

Solidarity and Action Against The HIV Infection in India (SAATHII) (www.saathii.org)

Pehchan Focus: West Bengal, Manipur, Orissa and Jharkhand
With offices in five states and over 10 years of experience, SAATHII works with sexual minorities for HIV prevention. SAATHII works closely with the West Bengal's State AIDS Control Society (SACS) and the State Technical Support Unit and is the SACS-designated State Training and Resource Centre for MSM, transgender and hijra.

South India AIDS Action Programme (SIAAP) (www.siaapindia.org)

Pehchan Focus: Tamil Nadu
SIAAP brings more than 22 years of experience with community-driven and community development focussed programmes, counselling, advocacy for progressive policies, and training to address HIV and wider vulnerability issues for MSM, transgender and hijra community.

Sangama (www.sangama.org)

Pehchan Focus: Karnataka and Kerala
For more than 20 years, Sangama has been assisting MSM, transgender and hijra communities to live their lives with self-acceptance, self-respect and dignity. Sangama lobbies for changes in existing laws that discriminate against sexual minorities and for changing public opinion in their favour.
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About this Module

This module is designed to help training participants: 1) deepen their understanding of trauma and violence; 2) identify different forms of violence; 3) understand the connection between violence and exploitation; 4) learn strategies to address violence; and 5) develop an action plan to respond to trauma and violence in their local context. In the Pehchan programme, this module is used to introduce basic principles of trauma and violence to CBO Counsellors and Outreach Workers.

About Pehchan

With financial support from the Global Fund, Pehchan is building the capacity of 200 community-based organisations (CBOs) for men who have sex with men (MSM), transgenders and hijras in 17 states in India to be more effective partners in the government’s HIV prevention programme. By supporting the development of strong CBOs, Pehchan addresses some of the capacity gaps that have often prevented CBOs from receiving government funding for much-needed HIV programming. Named Pehchan, which in Hindi means ‘identity’, ‘recognition’ or ‘acknowledgement,’ this programme will reach 453,750 MSM, transgenders and hijras by 2015. It is the Global Fund’s largest single-country grant to date, focused on the HIV response for vulnerable sexual minorities.

Training Curriculum Overview

In order to stimulate the development of strong and effective CBOs for MSM, transgender and hijra communities and to increase their impact in HIV prevention efforts, responsive and comprehensive capacity building is required. To build CBO capacity, Pehchan developed a robust training programme through a process of engagement with community leaders, trainers, technical experts, and academicians in a series of consultations that identified training priorities. Based on these priorities, smaller subgroups then developed specific thematic components for each curricular module.

Inputs from community consultations helped increase relevance and value of training modules. By engaging MSM, transgender and hijra (MTH) communities in the development process, there has been greater ownership of training and of the overall programme among supported CBOs. Technical experts worked on the development of thematic components for priority areas identified by community representatives. The process also helped fine-tune the overall training model and scale-up strategy. Thus, through a consultative, community-based process, Pehchan developed a training model responsive to the specific needs of the programme and reflecting key priorities and capacity gaps of MSM, transgender and hijra CBOs in India.
Preface

As I put pen to paper, a shiver goes down my spine. It is hard to believe that this day has come after almost five long years! For many of us, Pehchan is not merely a programme; it is a way of life. Facing a growing HIV epidemic among men who have sex with men (MSM), transgender, and hijra communities in India, a group of development and health activists began to push for a large-scale project for these populations that would be responsive to their specific needs and would show this country and the world that these interventions are not only urgently needed but feasible.

Pehchan was finally launched in 2010 after more than two years of planning and negotiation. As the programme has evolved, it has never stepped back from its core principle: Pehchan is by, for and of India’s MSM, transgender and hijra communities. Leveraging rich community expertise, the Global Fund’s generous support and our government’s unwavering collaboration, Pehchan has been meticulously planned and passionately executed. More than just the sum of good intentions, it has thrived due to hard work, excellent stakeholder support, and creative execution.

At the heart of Pehchan are community systems strengthening. Our approach to capacity building has been engineered to maximise community leadership and expertise. The community drives and energises Pehchan. Our task was to develop 200 strong community-based organisations (CBOs) in a vast and complex country to partner with state governments and provide services to MSM, transgender and hijra communities to increase the effectiveness of the HIV response for these populations and improve their health and wellbeing. To achieve necessary scale and sustain social change, strong CBOs would require responsive development of human capital.

Over and above consistent services throughout Pehchan, we wanted to ensure quality. To achieve this, we proposed a standard training package for all CBO staff. When we looked around, we found there really wasn’t an existing curriculum that we could use. Consequently, we decided to develop one not only for Pehchan but also for future efforts to build the capacity of community systems for sexual minorities. So began our journey to create this curriculum.

Building on the experience of Sashakt, a pilot programme supported by UNDP that tested the model that we’re scaling up in Pehchan, an involved process of consultations and workshops was undertaken. Ideas for each module came from discussions with a range of stakeholders from across India, including community leaders, activists, academics and institutional representatives from government and donors. The list of modules grew with each consultation. For example in Sashakt, we had a single training module on family support and mental health; in Pehchan, we decided that it would be valuable to split these and have one on each.

Eventually, we agreed on the framework for the modules and the thematic components, finding a balance between individual and organisational capacity. Overall, there are two main areas of capacity building: one that is directly related to the services and the other that is focused on building capable service providers. Then we began the actual writing of the curriculum, a process of drafting, commenting, correcting, tweaking and finalising that took over eight months.
Once the curriculum was ready to use, trainings-of-trainers were organised to develop a cadre of master trainers who would work directly with CBO staff. Working through Pehchan’s four Regional Training Centers, these trainers, mostly members of MSM, transgender and hijra communities, provided further in-service revisions and suggestions to the modules to make them succinct, clear and user-friendly. Our consortium partner SAATHII contributed particularly to these efforts, and the current training curriculum reflects their hard work.

In fact, the contributors to this work are many, and in the Acknowledgements section following this Preface, we have done our best to name them. They include staff from all our consortium partners, technical experts, advocates, donor representatives and government colleagues. The staff at India HIV/AIDS Alliance, notably the Pehchan team, worked beautifully to develop both process and content. That we have come so far is also a tribute to vision and support of our leaders, at Alliance India and in our consortium partners, Humsafar Trust, SAATHII, Sangama, and SIAAP, as well as in India’s National AIDS Control Organisation and at the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva.

We would like to think of the Pehchan Training Curriculum as a game changer. While the modules reflect the specific context of India, we are confident that they will be useful to governments, civil society organisations and individuals around the world interested in developing community systems to support improved HIV and other health programming for sexual minorities and other vulnerable communities as well.

After two years of trial and testing, we now share this curriculum with the world. Our team members and master trainers have helped us refine them, and seeing the growth of the staff in the CBOs we have trained has increased our confidence in the value of this curriculum. The impact of these efforts is becoming apparent. As CBOs have been strengthened through Pehchan, we are already seeing MSM, transgender and hijra communities more empowered to take charge, not only to improve HIV prevention but also to lead more productive and healthy lives.

**Sonal Mehta**
Director: Policy & Programmes
India HIV/AIDS Alliance

New Delhi
March 2013
General Acknowledgements

The Pehchan Training Curriculum is the work of many people, including community members, technical experts and programme implementers. When we were not able to find training materials necessary to establish, support and monitor strong community-based organisations for MSM, transgenders and hijras in India, the Pehchan consortium collectively developed a curriculum designed to address these challenges through a series of community consultations and development workshops. This process drew on the best ideas of the communities and helped develop a responsive curriculum that will help sustain strong CBOs as key element of Pehchan.

We would like to take this opportunity to acknowledge the contributions of those who helped in taking this process forward, including (in alphabetical order): Ajai, Praxis; Usha Andewar, The Humsafar Trust; Sarita Barapanda, IWW-UK; Jhuma Basak, Consultant; Dr. V. Chakrapani, C-Sharp; Umesh Chawla, UNDP; Alpana Dange, Consultant; Brinelle D’Sourza, TISS; Firoz, Love Life Society; Prashanth G, Maan AIDS Foundation; Urmija Jadav, The Humsafar Trust; Jeeva, TRA; Harleen Kaur, Manas Foundation; Krishna, Suraksha; Monica Kumar, Manas Foundation; Muthu Kumar, Lotus Sangama; Sameer Kunta, Avahan; Agniva Lahiri, PLUS; Meera Limaya, Consultant; Veronica Magar, REACH; Magdalene, Center for Counselling; Sylvester Merchant, Lakshya; Amrita Nanda, Lawyers’ Collective; Nilanjana, SAFRG; Prabhakar, SIAAP; Priti Prabhughate, ICRW; Nagendra Prasad, Ashodaya Samithi; Revathi, Consultant; Rex, KHPT; Amitava Sarkar, SAATHII; Dr. Maninder Setia, Consultant; Chetan Sharma, SAFRG; Suneeta Singh, Amaltas; Prabhakar Sinha, Heroes Project; Sreeam, Ashodaya Samithi; Suresh, KHPT; Sanjantie Veul, JHU; and Roy Wadia, Heroes Project.

Once curricular framework was finalised, a group of technical and community experts was formed to develop manuscripts and solicit additional inputs from community leaders. The curriculum was then standardised with support from Dr. E.M. Sreejit and streamlined with support from a team at SAATHII, led by Pawan Dhall. This process included inputs from Sudha Jha, Anupam Hazra, Somen Achrya, Shantanu Pyne, Moyazzam Hossain, Amrita Sarkar, and Debjyoti Ghosh Dhall from SAATHII; Cairo Araijo, Vaibhav Saria, Dr. E.M. Sreejit, Jhuma Basak, and Vahista Dastoor, Consultants; Olga Aaron from SIAAP; and Harjyot Khosa and Chaitanya Bhatt from India HIV/AIDS Alliance.

From the start, the Government of India’s National AIDS Control Organisation has been a key partner of Pehchan. In particular, Madam Aradhana Johri, Additional Secretary, NACO, has provided strong leadership and steady guidance to our work. The team from NACO’s Targeted Intervention (TI) Division has been a constant friend and resource to Pehchan, notably Dr. Neeraj Dhingra, Deputy Director General (TI); Manilal N. Raghvan, Programme Officer (TI); and Mridu, Technical Officer (TI). As the programme has moved from concept to scale-up, Pehchan has repeatedly benefitted from the encouragement and wisdom of NACO Directors General, past and present, including Madam Sujata Rao, Shri K. Chandramouli, Shri Sayan Chatterjee, and Shri Lov Verma.

Pehchan is implemented by a consortium of committed organisations that bring passion, experience, and vision to this work. The programme’s partners have been actively engaged in developing the training curriculum. We are grateful for the many contributions of Anupam Hazra and Pawan Dhall from SAATHII; Hemangi, Pallav Patnaik, Vivek Anand and Ashok Row Kavi from the Humsafar Trust; Olga Aaron and Indumati from SIAAP; Vijay Nair from Alliance India Andhra Pradesh; and Manohar from Sangama. Each contributed above and beyond the call of duty, helping to create a vibrant training programme while scaling up the programme across 17 states.
India HIV/AIDS Alliance’s Pehchan team has been untiring in its contributions to this curriculum, including Abhina Aher, Jonathan Ripley, Yadavendra (Rahul) Singh, Simran Shaikh, Yashwinder Singh, Rohit Sarkar, Chaitanya Bhatt, Nunthuk Vungholhkim, Ramesh Tiwari, Sarbeshwar Patnaik, Ankita Bhalla, Dr. Ravi Kanth, Sophia Lonappan, Rajan Mani, Shaleen Rakesh, and James Robertson. A special thank-you to Sonal Mehta and Harjyot Khosa for their hard work, patience and persistence in bringing this curriculum to life.

Through it all, the Global Fund to Fight AIDS, Tuberculosis and Malaria has provided us both funding and guidance, setting clear standards and giving us enough flexibility to ensure the programme’s successful evolution and growth. We are deeply grateful for this support.

Pehchan’s Training Curriculum is the result of more than two years of work by many stakeholders. If any names have been omitted, please accept our apologies. We are grateful to all who have helped us reach this milestone.

The Pehchan Training Curriculum is dedicated to MSM, transgender and hijra communities in India who for years, have been true examples of strength and leadership by affirming their pehchán.
Module Acknowledgments: Trauma and Violence

Each component of the Pehchan Training Curriculum has a number of contributors who have provided specific inputs. For this component, the following are acknowledged:

**Primary Authors**
M.L. Prabhakar and Dr Indumathi Ravishankar, SIAAP

**Compilation**
Dr. E. M. Sreejit, Consultant

**Technical Input**
Aditya Bandopadhyay, Adhikaar; Debiyoti Ghosh, SAATHII

**Coordination and Development**
Vahista Dastoor, C4D Consultant
Pawan Dhall, SAATHII

**References**
About the Trauma and Violence Module

<table>
<thead>
<tr>
<th>No.</th>
<th>D2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Trauma and Violence</td>
</tr>
</tbody>
</table>
| **Pehchan Trainees** | • Project Managers  
• Counsellors  
• Outreach Workers (ORW) |
| **Pehchan CBO Type** | Pre-TI and TI Plus |
| **Training Objectives** | By the end of this module, the participants will:  
• Understand the concepts of trauma and violence;  
• Understand the link between violence and vulnerability to HIV; and  
• Develop action plans to address trauma and violence in their respective settings. |
| **Total Duration** | One day. A day’s training typically covers 8 hours. |

Module Reference Materials

All the reference material required to facilitate this module has been provided in this document and in relevant digital files provided with the Pehchan Training Curriculum. Please familiarise yourself with the content before the training session.

**Attention:** Please do not change the names of file or folders, or move files from one folder to another, as some of the files are linked to each other. If you rename files or change their location on your computer, the hyperlinks to these documents in the *Facilitator Guide* will not work correctly.

If you are reading this module on a computer screen, you can click the hyperlinks to open files. If you are reading a printed copy of this module, the following list will help you locate the files you need.

**Audio-visual Support**
1. PowerPoint presentation ‘Trauma and Violence’  
2. Short-film titled ‘Domestic Violence – Isn’t It Time Someone Called Cut?’

**Annexures**
Annexure 1 on “Crisis Response Team under Pehchan – A Guide”  
# Activity Index

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity Name</th>
<th>Time</th>
<th>Material</th>
<th>Audio-visual Resources</th>
<th>Take-home material</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction to Module</td>
<td>1 hour</td>
<td>N/A</td>
<td>Short-film titled ‘Domestic Violence – Isn’t It Time Someone Called Cut?’</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>Typology and Forms of Violence</td>
<td>2 hours</td>
<td>Chart papers and markers</td>
<td>Refer to the slides titled ‘Typology and Forms of Violence’ from the PowerPoint presentation ‘Trauma and Violence’</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>Impact of Violence: An Introduction to Trauma</td>
<td>1 hour</td>
<td>N/A</td>
<td>Short-film titled ‘Domestic Violence – Isn’t It Time Someone Called Cut?’</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>Violence and Vulnerability to HIV</td>
<td>1 hour</td>
<td>N/A</td>
<td>Refer to the slides titled ‘HIV and Violence’ from the PowerPoint presentation ‘Trauma and Violence’</td>
<td>N/A</td>
</tr>
<tr>
<td>5</td>
<td>Violence and the MTH Community</td>
<td>1 hour</td>
<td>N/A</td>
<td>Refer to the slides titled ‘Violence and the MTH Community Some Facts’ from the PowerPoint presentation ‘Trauma and Violence’</td>
<td>N/A</td>
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<tr>
<td>6</td>
<td>Strategies to Address Trauma and Violence</td>
<td>2 hours</td>
<td>Chart papers and markers</td>
<td>N/A</td>
<td>Annexure 1 on ‘Crisis Response Team’</td>
</tr>
</tbody>
</table>

1 Overhead projector, laptop, sound system and whiteboard should be provided at every training.
Activity 1: Introduction to Violence

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
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<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Articulate the objectives of this module.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
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<tr>
<td>Audio-visual Support</td>
<td>Short-film titled ‘Domestic violence: Isn’t It Time Someone Called Cut?’</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

Ask the participants to sit comfortably in their chairs, close their eyes, relax, and take deep breaths. Once you feel the participants have settled down, tell them that you will be playing a tape for them, and they should listen to this carefully, keeping their eyes closed throughout the tape.

Play only the audio of the film titled ‘Domestic violence: Isn’t it time someone called cut?’

At the end of the film, allow the participants to sit still with their eyes closed for a minute or two, and then ask them to open their eyes.

Ask the participants to put in words what they felt was going on in the film based on the sounds they heard. Use the following questions to help them respond:

• What sounds did you hear?
• What do you think was going on?
• What feelings were you going through?
• How do you feel right now?

Then show the film with both the audio and visuals. Use the following questions to help link the earlier responses of the participants to the experience of watching the violence in the film:

• Describe what you saw in the film.
• What do you think is the first point of violence in the film?
• When do you think the victim in the film first felt fear?
• What was the victim afraid of?
• What are the types of violence displayed in the film?
• What do you think the victim was feeling?
• What do you think the victim did next?
• Why do you think the perpetrator was being violent?
• What do you think the victim can do to stop the violence?
• What are the words you associate with violence?

At this point, debrief the participants on the objectives of the module.

Note to Facilitator

Trauma and Violence are topics that involve human situations which cannot be easily generalised, as they differ from situation to situation and person to person. The module has been designed to trigger cognitive and emotional responses from participants; some of the responses may stem from their own experiences of violence. Allow these responses to guide the course of the activities. However, be prepared for some participants to get emotionally distressed. Depending on how the participants respond, the sessions may become unstructured. Therefore, at the end of every activity, sum up the key learning points.

At the beginning of this activity, tell the participants that the film being shown and the subsequent discussion may evoke unpleasant memories and strong negative emotions.

Tell them that such emotions are natural and are shared by countless others who have faced or witnessed violence. Reassure them that violence and its aftermath can be tackled and that this module offers ways to deal with the adverse effects, as well as find ways to bring an end to violence.
Activity 2: Typology and Forms of Violence

<table>
<thead>
<tr>
<th>Time</th>
<th>2 hours</th>
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<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will able to:</td>
</tr>
<tr>
<td></td>
<td>• Articulate a definition for violence;</td>
</tr>
<tr>
<td></td>
<td>• Identify forms of violence and their manifestations; and</td>
</tr>
<tr>
<td></td>
<td>• Understand that violence occurs at various levels, ranging from the individual to societal.</td>
</tr>
<tr>
<td>Materials</td>
<td>Chart papers and markers.</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>Refer to the slides on ‘Typology and Forms of Violence’ from the PowerPoint presentation ‘Trauma and Violence’.</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

Divide the participants into four groups and assign one of the following forms of ‘violence’ to each group:

• Physical violence;
• Sexual violence;
• Psychological (including mental, emotional, verbal and blackmail) violence; and
• Deprivation or neglect.

Give chart papers and pens to each group and ask them to list five examples of violence in each of the following settings:

• Family and intimate partner violence: violence which largely takes place between family members and intimate partners, usually at homes.
• Community violence: violence between individuals who may or may not know each other, generally taking place outside the home.
• Collective violence: violence committed by larger groups of individuals or by governments.

Provide 30 minutes for this discussion, and if necessary, extend it for another 10 minutes. Use the following leading questions:

• Is poverty violence? If yes, where does it feature?
• Is there any overlap in the different types of violence?
• Can violence be inflicted on oneself? If so, give examples.
• Are particular groups of people subjected to more violence than others? Introduce the term ‘gender-based violence’ here.
• What are the power dynamics between the perpetrator and the victim?
• Is there any intentionality from the perpetrators side?

Note to Facilitator

Types of violence that may come up during the discussion:

• Hate crimes
• Molestation
• Forced sex work and trafficking
• Sexual harassment
• Stalking
• Incest
• Rape
• Custodial violence
• Poverty-related violence
• Sexual assault within marriage
• Violence against men/women in areas of armed conflict
• Displacement of persons during war/forced migration

In cases where more insidious or invisible forms of violence are not being mentioned, work with participants to describe them out and ask participants to categorise them under the larger groups.
Ask the participants about their learnings from the Legal and Human Rights Module (D1) regarding rights and privileges. In this context, ask them if they think abuse of power can lead to violence in special settings mentioned below:

- Teacher and student;
- Parent and child; and
- Employer and employee.

Point out that no one has an absolute right of power over anyone. A parent may admonish a child but cannot go beyond a line which may be lead to physical or emotional abuse. Using the slides titled ‘Typology and Forms of Violence’, sum up the discussion by asking the participants to construct a definition of violence.

Conclude the activity by reviewing types of violence, and discuss the implications of power and its potential for violence. *(World Health Organization, 2002)*

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**Defining Violence**

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, mal-development or deprivation.

*World Health Organisation*
**Activity 3: Impact of Violence – An Introduction to Trauma**

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
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<tbody>
<tr>
<td><strong>Learning Outcomes</strong></td>
<td>By the end of this activity, the participants will learn:</td>
</tr>
<tr>
<td></td>
<td>• What is trauma and how it is related to violence;</td>
</tr>
<tr>
<td></td>
<td>• How prolonged exposure to violence can lead to trauma; and</td>
</tr>
<tr>
<td></td>
<td>• How prolonged trauma might cause destructive behaviour.</td>
</tr>
<tr>
<td><strong>Materials</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Audio-visual Support</strong></td>
<td>Short-film on ‘Domestic violence: Isn’t it Time Someone Called Cut?’.</td>
</tr>
<tr>
<td><strong>Take-home Material</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Methodology**

Screen a section of the short-film titled ‘Domestic violence: Isn’t it time someone called cut?’ again, from the scene where the man comes towards the victim till the scene where she gets thrown to the ground.

Ask the participants to put themselves in that situation and try to elicit their feelings. Use the following scenario to get more responses from the participants:

‘Imagine a person being physically and verbally abused almost on a daily basis’ (play the last part of the clip again now, where the victim is kicked after being knocked down).

Ask them, would they be:

- Afraid?
- Developing a feeling of hatred towards the perpetrators?
- Angry? If yes, they would be angry against whom?
- Hating themselves for ‘inviting’ violence (or feel that they are responsible)?
- Fighting back?
- Experiencing physical reactions (e.g. sweating, racing pulse, frozen with fear, choking in the throat, heaviness in the legs, etc.)?
- Feeling despaired, if they experienced these emotions and bodily sensations day after day without hope of respite?

Note down their responses on a whiteboard or a flip-chart. At this point, introduce the topic of trauma by telling the participants that prolonged and/or frequent exposure to violence can lead to trauma. State that (psychological) trauma is caused as people get stuck in different responses and live with the feeling of helplessness, numbness, pain or fear, which in the long run, leads to physical ailments, mental health issues and/or influences their relationship with others (since behaviour gets altered). Point out that in the long run if these symptoms continue even after the episodes of violence have stopped, it is known as Post Traumatic Stress Disorder (PTSD).
Sum up the session by pointing out that:

- Trauma is not necessarily a result of prolonged exposure to violence. Trauma can also be caused by a single event.
- An event experienced as traumatic by one individual may not be traumatic for another; the experience of trauma depends on the person's coping skills and perceived loss of bodily integrity and psychological control. Thus, it is an individual's subjective experience that determines whether or not an event is traumatic.
- Trauma can influence an individual’s behaviour and make him/her more vulnerable to self-destructive behaviour (including not taking preventive measures against HIV), and can also negatively impact relationships with others. Therefore, it is essential to understand trauma and deal with it appropriately.

Remind the participants that when they come across a client who seems to be undergoing any of the symptoms discussed, the participant’s primary work would be to refer the client to a trained psychologist (in case the CBO does not have any in-house psychologists).

**Background Information**
*(Allen, 1995)*

**What is Trauma?**

Trauma is caused when people get ‘stuck’ in a particular situation and have to live with the feeling of helplessness, numbness, pain and fear, which in the long run leads to physical ailments, mental health issues and/or influences their relationship with others (behaviour gets altered). Traditionally, the focus of trauma is on the mind and solutions also involve approaches that focus on the mind. Both body and mind need to be focused to understand and heal trauma better. Environmental issues too need to be addressed to handle trauma better.

Trauma needs special attention; hence, a timely intervention through appropriate referral becomes the key to addressing it. Mapping of resources within a geographical area with regard to support for trauma is essential for working with communities.

**What is Emotional and Psychological Trauma?**

It is the result of stressful events that affect your sense of security, making you feel helpless and vulnerable. Traumatic experiences generally involve a threat to life or safety. However, any situation that leaves you feeling overwhelmed and lonely can be traumatic, even if there is no physical harm. It is the subjective emotional experience of an event, not the objective facts, that determine whether an event is traumatic. The more frightened and helpless one feels, the more likely one is to feel traumatised.

**When is Something Traumatic?**

- When it happens unexpectedly.
- When one does not have the means to fight it.
- Someone does something harmful on purpose.
- One is unprepared for it.
- When it happens repeatedly.

*Note to Facilitator*

Jon Allen, a psychologist at the Menninger Clinic in Houston, Texas, USA, and the author of *Coping with Trauma: A Guide to Self-Understanding* (1995), reminds us that there are two components to a traumatic experience – the objective and the subjective:

'It is the subjective experience of the objective events that constitutes the trauma... The more you believe you are endangered, the more traumatized you will be... Psychologically, the bottom line of trauma is overwhelming emotion and a feeling of utter helplessness. There may or may not be bodily injury, but psychological trauma is coupled with physiological upheaval that plays a leading role in the long-range effects.' *(p. 14)*
Signs that Help Identify a Person is Under Trauma:
- Emotional symptoms
- Shock, denial, or disbelief
- Anger, irritability, mood swings
- Guilt, shame, self-blame
- Feeling sad or hopeless
- Repeatedly talking about the traumatic incident
- Confusion, difficulty concentrating
- Anxiety and fear
- Withdrawing from others
- Feeling lonely, disconnected or numb
- Physical symptoms
- Loss of sleep or bad dreams
- Palpitation (racing heartbeat)
- Aches and pains
- Fatigue
- Agitation
Activity 4: Violence and Vulnerability to HIV

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning Outcomes</strong></td>
<td>By the end of this activity, the participants will:</td>
</tr>
<tr>
<td></td>
<td>• Understand the link between violence and vulnerability to HIV.</td>
</tr>
<tr>
<td><strong>Materials</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Audio-visual Support</strong></td>
<td>Refer to the slides on ‘HIV and Violence’ from the PowerPoint presentation ‘Trauma and Violence’.</td>
</tr>
<tr>
<td><strong>Take-home Material</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Methodology**

Start an interactive discussion on the association between violence and vulnerability to HIV, and list the points made by the participants on a whiteboard or flip-chart. In order to steer the discussion along the desired lines, point out how:

- Violence plays a big role in causing HIV infection among MTH community members as coercive sexual acts may directly increase risk of HIV through physiological trauma and less protection;
- In India, stigma, discrimination, and violence makes MSM and transgender communities particularly vulnerable to HIV infection;
- In an abusive relationship, the victim may be more vulnerable to HIV, as abusive partners are more likely to have sexual partners other than the victim;
- Fear of violence can keep the MTH victim from insisting on precautions such as condoms and prevent them from seeking treatment for STIs; and
- MTH persons are not motivated to get tested for HIV or get the results because they are afraid that sharing their HIV positive status may result in more physical violence.

Using slides titled ‘HIV and Violence’ from the PowerPoint presentation ‘Trauma and Violence’, discuss ‘Circle of Stigma and Vulnerability’ in the light of the above points.
Reference Material
(Chakrapaniet al., 2007)

Circle of Stigma and Vulnerability

Structural Level

Discriminatory Practices

Indirect
- Police
  - False arrest
  - Refusing to offer protection
  - Harassment of community workers
- Community Members
  - Stigma against homosexuality & HIV/AIDS
  - Taboos against homosexuality
  - Pressures to marry and have children
- Family Members
  - Blame for conflict and family stress
  - Shame regarding sexual orientation
- Community Members
  - Social exclusion by peer groups and other Kothis
- Family Members
  - Arranged marriage
  - Expectations to maintain family lineage
  - Taboos around sex and same-sex behaviours
- Health Care Providers
  - Insensitive practice
  - Inadequate training
- Health Care System
  - Lack of services with competency in working with MSM
  - Inaccessibility to MSM

Direct
- Police
  - Verbal and physical harassment
  - Sexual assault and violence
- Community Members
  - Physical violence and blackmail by ruffians
- Family Members
  - Violence from parents and siblings
  - Forced out of the house
- Health Care Providers
  - Refusal of service
  - Verbal harassment

Legal System
- Criminalisation of sex between men

Vulnerability to HIV & AIDS

Stigma

Police
- False arrest
- Refusing to offer protection
- Harassment of community workers

Community Members
- Stigma against homosexuality & HIV/AIDS
- Taboos against homosexuality
- Pressures to marry and have children

Family Members
- Blame for conflict and family stress
- Shame regarding sexual orientation

Community Members
- Social exclusion by peer groups and other Kothis

Family Members
- Arranged marriage
- Expectations to maintain family lineage
- Taboos around sex and same-sex behaviours

Health Care Providers
- Insensitive practice
- Inadequate training

Health Care System
- Lack of services with competency in working with MSM
- Inaccessibility to MSM
Activity 5: Violence and the MTH Community

**Time** | 1 hour
---|---
**Learning Outcomes** | By the end of this activity, the participants will:
- Understand the importance of learning about violence in the context of the MTH community.
**Materials** | N/A
**Audio-visual Support** | Refer to the slides on ‘Violence and the MTH Community Some Facts’ from the PowerPoint presentation ‘Trauma and Violence’.
**Take-home Material** | N/A

**Methodology**

Conduct an interactive discussion about different types of violence faced by MTH communities and why there might be a higher prevalence of violence among these communities compared to other population groups. Link the responses of participants to the discussions in preceding activities, and identify:

- The perpetrators of violence against individuals belonging to the MTH community; and
- The perpetrators of collective violence against the MTH community.

Discuss the impact of such violence, both at an individual level as well as at the community level. Using the slides titled ‘Violence and the MTH Community: Some Facts’ from the PowerPoint presentation ‘Trauma and Violence’, briefly describe the types of violence and give some facts about violence against MTH communities.
Activity 6: Strategies to Address Trauma and Violence

<table>
<thead>
<tr>
<th>Time</th>
<th>2 hours</th>
</tr>
</thead>
</table>
| Learning Outcomes | By the end of this activity, the participants will:  
• Develop action plans to address trauma and violence in their respective settings. |
| Materials    | Chart papers and markers. |
| Audio-visual Support | N/A |
| Take-home Material | Annexure 1 on ‘Crisis Response Team under Pehchan -A Guide’. |

**Methodology**

Facilitate a discussion on the following questions:

- Is it realistic to work towards ending such violence?
- Why do we want to end this violence?
- Who needs to put a stop to this violence?

Present the structural violence model shown in the above section to the participants and instruct them to individually write a personal plan with their understanding of trauma and violence.

Ask them how they can prevent/address violence towards them and how would they deal with those who perpetrate acts of violence towards others. Encourage the participants to write/draw their ideas on a piece of paper.

Divide the participants into three groups, and ask each group to discuss and prepare points on how to establish a crisis intervention team in their area or organisation. Ask them to ponder over the following questions:

- What will be the objectives of crisis intervention team?
- What will be the constitution of the crisis intervention team?
- What should be the rationale behind the interventions designed by the team?
- How can the intervention services be made more accessible and available for the community when they are needed?
- How can they document the various aspects of these processes?

Ask participants in each group to map all the resources in their area which they feel can make for a good resource in crisis response. Discuss their strategies in the larger group.

After the discussion, lead them into another discussion on current strategies, the key players and best practices. On a whiteboard/flip-chart, draw three concentric circles; the innermost circle representing the people closest to the victim of violence to whom the news has been conveyed (a PE, ORW, and the Counsellor), the second circle representing all the other people within the CBO (the project manager, other ORWs, PEs, etc.), and the third circle representing the various referral services and linkages with which they can address such acts of violence, such as the police, local clubs, lawyers, doctors, etc.
Conclude the group work activity by explaining how programmes such as Pehchan are addressing the issues of trauma and violence:

- Addressing the problem of trauma and violence should involve concrete, easy-to-implement, effective crisis management techniques in combination with local advocacy programmes;
- Creating an enabling environment for effective MTH HIV prevention programmes would build their self-esteem, which will help them focus more on their physical and mental health and well-being, specifically in relation to STIs and HIV; and
- In programmes such as Pehchan, trauma and violence responses will rely on creating Crisis Response Team (refer to Annexure 1) to assist victims for medical care and legal recourse, training community-friendly lawyers, beat-level police, and CBO staff to provide support for filing first-incident reports.

Wrap-up by giving a quick go-through of the day’s learnings on violence, different types of violence, perpetrators, victims, trauma, HIV, and violence and crisis management.
Annexure 1: Crisis Response Team under Pehchan – A Guide

Background and Objective

It is well documented and known that men who have sex with men (MSM), transgender and hijra (MTH) population are vulnerable to violence due to their identity and non-confirmative gender expressions.

The perpetrators can include law enforcement agencies, local goons, healthcare providers, clients, family and community members. The violence may take several forms, most common being verbal and physical abuse and sexual assault. Therefore, to tackle such cases of violence setting up of Crisis Response Team (CRT) has been initiated under the Pehchan programme at the CBO-level.

The objectives of setting up of CRT are:

- To support MTH populations in cases of crisis;
- To build, sustain and strengthen relationships with relevant stakeholders such as law enforcement agencies; and
- To be champions for creating awareness on human rights issues of MTH populations.

For crisis management to be effective, it is essential to have:

- Trained and committed staff members who are willing to be ‘on call’ 24 hours a day and respond immediately when a crisis happens.
- Effective communication mechanisms.
- Availability of information about crisis response to community members.
- Experienced and committed lawyers and healthcare providers who are willing to provide assistance 24 hours a day.
- Networking, alliance-building, and sensitisation work with local stakeholders (especially MTH populations) through regular meetings and education as appropriate. This includes community-level legal literacy sessions.
- Close alliances with other civil society organisations, activists and local media who can advocate on behalf of the community when necessary.
- Reflections on crisis management cases to improve and build internal capacities.
- One member from TG hijra community and led by either community Project Manager or Project Director of the CBO.
Crisis Response Team in CBOs of Pehchan Programme

- The Crisis Response Team is established with representations from each site through community volunteers, outreach staff, programme staff and legal resource person familiar with the legal issues surrounding harassment of MTH populations.
- The team needs to establish detailed protocols for staffing and procedures for handling the crisis.
- Information about CRT should be widely circulated and discussed during the outreaches and events.
- The CRT should meet regularly ideally once in a quarter besides and emergency meeting. These meeting should be well documented.
- Funds available under Emergency legal aid may be used for local transport for handling crisis situation, post crisis meetings of CRT and legal aid. Also CRT needs to map additional resources for its long term sustainability.
- The meeting of CRT should be held at the hotspots so as to increase its visibility amongst the community members.
- CRT members should also be part of local sensitisation meetings carried out by the CBO.

The team may have 5 – 15 members, depending on need (i.e., frequency of incidents, size of area to be covered).

Crisis Response in Action

- When a community member informs on one’s behalf or on behalf of another member who gets harassed or abused, the member of the crisis team responding to the information gets in touch with other crisis team members to apprise them of the situation.
- The team ensures that at least one person from the crisis response team goes to the spot where the crisis has happened and meets the person concerned. It is important to provide immediate moral support and give the message that the person is not alone in this situation and the person has support from the programme.
- If a police report needs to be filed or it the situation any kind of police action, a team member and a lawyer should reach the police station immediately.
- If a person reports any physical injuries healthcare provider should be immediately contacted to provide first-aid and/or hospitalisation.
- Every crisis should be documented. This information can be used both to strategise for improving crisis response and for public advocacy. Also when this data is analysed over a period of time, it can reveal trends in the nature and frequency of these incidents.
- Immediate meeting for all the crisis team members should happen within 24 hours.
Capacity Building

Following the formation of the CRT team at the CBO level, there is a need to build their capacities to handle and document the crisis situation. Advocacy officers (AO) along with Training Officers (TO) will make sure that this training happens at the CBO within a week of the formation of the team. Pehchan modules on ‘Human and Legal Rights’, ‘Violence & Trauma’ and ‘Trangender and Hijra Communities’ should be used for training CRT members. After three months, CRT members should be trained on ‘Mental Health’ and ‘Community Preparedness for Sustainability’ module. Refresher training should be organised every six months. AO should prepare the training calendar and share it with the team at SR and PR level.

Documentation and M&E Indicators

Often violence is under reported and not talked about. It is important to document it effectively and use the data for advocacy with relevant authorities. Some indicators and method for good reporting include:

<table>
<thead>
<tr>
<th>Outcome Indicator</th>
<th>Percentage of MSM reporting cases of violence by law enforcement authorities/police</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale/Purpose</strong></td>
<td>MTH face high levels of stigma and discrimination and are often suspected of spreading HIV/AIDS. Pehchan uses advocacy strategies to address stigma and discrimination, particularly in situations where stigma prevents member MTH from seeking services or using condoms or accessing social security measures etc. Common forms of violence (physical, mental &amp; social harm) faced by MTH include:</td>
</tr>
<tr>
<td></td>
<td>• Harassed (verbally and physically) in public settings by police &amp; other law enforcers;</td>
</tr>
<tr>
<td></td>
<td>• Harassment, blackmail, extortion and forced sex by the police, denial of legal redress by police &amp; lawyers (many times police don’t register complain); and</td>
</tr>
<tr>
<td></td>
<td>• Unjustifiable arrests.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of MTH responded to the question related to the violence.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of MTH surveyed.</td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>MSM, Transgender, Hijra.</td>
</tr>
<tr>
<td>Measurement Tool</td>
<td>Study at Baseline, Midline and End line</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Method of Measurement</td>
<td>The indicator will be measured during baseline and then again would be monitored during the midline and finally during the end line assessment to see the improvement in the situation after the programme implementation. In the survey of a sample of men who have sex with men, respondents will be asked about violence at the hand of the law enforcers in the preceding six months.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Number of incidents of violence and harassment reported</td>
</tr>
</tbody>
</table>
| Rationale/Purpose | MTH face high levels of stigma and discrimination generally and in the context of being suspected of spreading HIV/AIDS. Pehchan for MTH use advocacy strategies to address stigma and discrimination, particularly in situations where stigma prevents members MTH from seeking services or using condoms or accessing social security measures etc. Common forms of violence (physical, mental & social harm) faced by MTH include:  
  • Harassed (verbally and physically) in public settings by police & other law enforcers;  
  • Harassment, blackmail, extortion and forced sex by the police;  
  • Denial of legal redress by police & lawyers (many times police don’t register the complains); and  
  • Arrests (unjustifiable) without clear IPC section defined.  
The indicator also will be measured during baseline and then again would be monitored during the midline and finally during the end line assessment to see the improvement in the situation after the programme implementation. |
| Data collection frequency | Quarterly  
Monthly  
Capture the data as when in the crisis management register as an when an incident is reported  
Baseline & End line |
<p>| Measurement Tool | Crisis management register, survey tool |
| Method of Measurement | As and when an incident of violence is reported to CRT it is documented in the Crisis management register |
| Interpretation | This indicator measures the experiences of MTH in the effectiveness of efforts to reduce stigma and discrimination. It also to identify individuals who experience hostility on a regular basis. |</p>
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number of incidents of violence and harassment addressed within 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale/Purpose</td>
<td>As a part of the strengthening the response to address needs of the community a rapid response system will be developed to address the immediate and long-term impact of trauma and violence faced by the community from various sources.</td>
</tr>
</tbody>
</table>
| Data collection frequency | Quarterly  
Monthly  
Capture the data as when in the crisis management register as an when an incident is reported |
| Measurement Tool   | Crisis management register |
| Method of Measurement | As and when an incident of violence is reported to the CRT it is documented in the Crisis management register |
| Interpretation     | Fear of encountering stigma and discrimination can substantially alter the risk behaviour and service utilisation of High Risk Groups(HRGs). Immediate response by the team is required so that this does not get repeated again and the MTH are not harassed, abused or denied access to services or venues because of their association or membership in a particular group. Thus immediate response to the incident from the Pehchan team is essential to not allow the incident to get repeated and give support immediately to the MTH who has faced the violence. At the point of reporting the incident to the crisis response team and the first level of plan of action developed and immediate emotional / coping support for trauma and violence is provided then it will be treated as ‘addressed’ for recording purpose. |
Annexure 2: PowerPoint Presentation – Trauma and Violence

Training on
Trauma and Violence

Trauma and Violence
Forms of Violence
The Nature of Violence

- Physical
- Sexual
- Psychological
- Involving deprivation or neglect

All four can be part of gender-based violence.

Violence at Different Levels

- Societal
- Community
- Family and intimate partner
- Self

Defining Violence

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, mal-development or deprivation.

—The World Health Organization, 2002
Defining Violence

Power

Intentionality

Is Abuse of Human Rights an Act of Violence?
Trauma and Violence

HIV and Violence

Defining Violence

Trauma and Violence

Violence and MTH Community
Fact 1

Forty-two per cent of MSM reported that they have been sexually assaulted or raped. Seventy-five per cent of MSM reported being sexually assaulted or raped by either policemen or goons. They thought it happened because they were effeminate.


Fact 2

There is widespread violence experienced by MSM outside intimate partner relations which is characterised by homophobia and is accompanied by various forms of discrimination.

Fact 3

Studies indicate that violence experienced by MSM and TG worldwide is most commonly perpetrated by the police and is done in an extreme and at times barbaric manner.
Fact 4

The violence experienced by TG, including physical and verbal abuse, is even more severe and is mostly perpetrated by others in the MTH community, family, and even friends.

Fact 5

Forms of violence against TG/hijras range from sexual assault and violence by police in Nepal to beatings by family members in Bangladesh, to even murder as witnessed in Guatemala.

References


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Pehchan Training Curriculum
MSM, Transgender and Hijra
Community Systems Strengthening

**CG**
- Curriculum Guide

**module A**
- A1 Organisational Development
- A2 Leadership and Governance
- A3 Resource Mobilisation and Financial Management

**module B**
- B Basics of HIV Prevention and Outreach Planning (Pre-TI)

**module C**
- C1 Identity, Gender and Sexuality
- C2 Family Support
- C3 Mental Health
- C4 MSM with Female Partners
- C5 Transgender and Hijra Communities

**module D**
- D1 Human and Legal Rights
- D2 Trauma and Violence
- D3 Positive Living
- D4 Community Friendly Services
- D5 Community Preparedness for Sustainability
- D6 Life Skills Education

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