★ New modules for health managers

Caring for women subjected to violence: A WHO training curriculum for health care providers.
Revised edition, 2021

Slide Deck

World Health Organization

Table of contents

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Orientation and introductions

Why are we here? Objectives

Participants will be able to demonstrate:

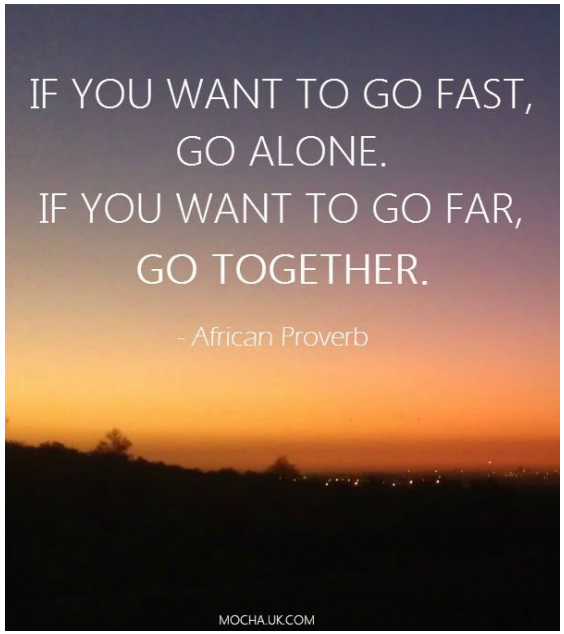
1. General knowledge of VAW as a public health problem
2. Behaviours and understand values that contribute to safe & supportive service cultures
3. Clinical skills to respond to VAW
4. Knowledge of how to access resources & support for patients & for oneself

Training overview

- Agenda
- Housekeeping
- Expectations of participants?
- Training approach: mix of didactic & participatory
- Sensitivity to survivors in our midst
- Ground rules

Ground rules

- ✓**Timeliness**
- ✓**Learn & work together**
- ✓**Respect each other**
  - Listen with an open mind
  - Let everyone participate
  - Express disagreements respectfully
  - Give feedback constructively
  - ✕ Interrupting others
- ✓**Safe space**
  - Respect confidentiality, personal info stays in the room
- ✓**Be present**
  - ✕ Use of electronics
- ✓**Suggestions to improve are welcome!**



Exercise:
Fears and Motivations in a Hat

Learning objectives for the exercise

- To acknowledge and understand providers‘ concerns about caring for survivors of intimate partner and sexual violence
- To build on providers‘ motivations and strengths in addressing intimate partner and sexual violence

Exercise:
Fears and Motivations in a Hat

- Each participant will write:
  - One thing that motivates them to respond to intimate partner or sexual violence
  - On a second piece of paper, one fear they have about responding to intimate partner or sexual violence
- Fold the piece of paper and put them in two hats: one for motivations, one for fears
- Discuss

Exercise:
Fears and Motivations in a Hat

Take-away points

- Many providers have **concerns** about raising the topic of violence with their patients, as it may trigger their own memories of experiencing or witnessing abuse, or they may feel inadequate.
- However, data suggest that responding to women with empathy can be a **source of healing** for survivors.
- Many of us are passionate about providing care and assuring health and justice for our clients. This positive **energy** can fuel how we apply this training in our clinical practice.

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 1

Understanding violence against women as a public health problem

Learning objective

Demonstrate general knowledge of VAW as a public health problem

Competencies

- Know the epidemiology of VAW
- Describe the health consequences of VAW
- Understand the role and limitations of providers in responding to VAW
- Know about WHO guidelines and tools to respond to VAW

Violence against women: Strengthening the health system response

https://www.youtube.com/watch?v=Qc_GHITvTmI

Definitions and forms of VAW

Any public or private act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty with the family or general community

Violence against women

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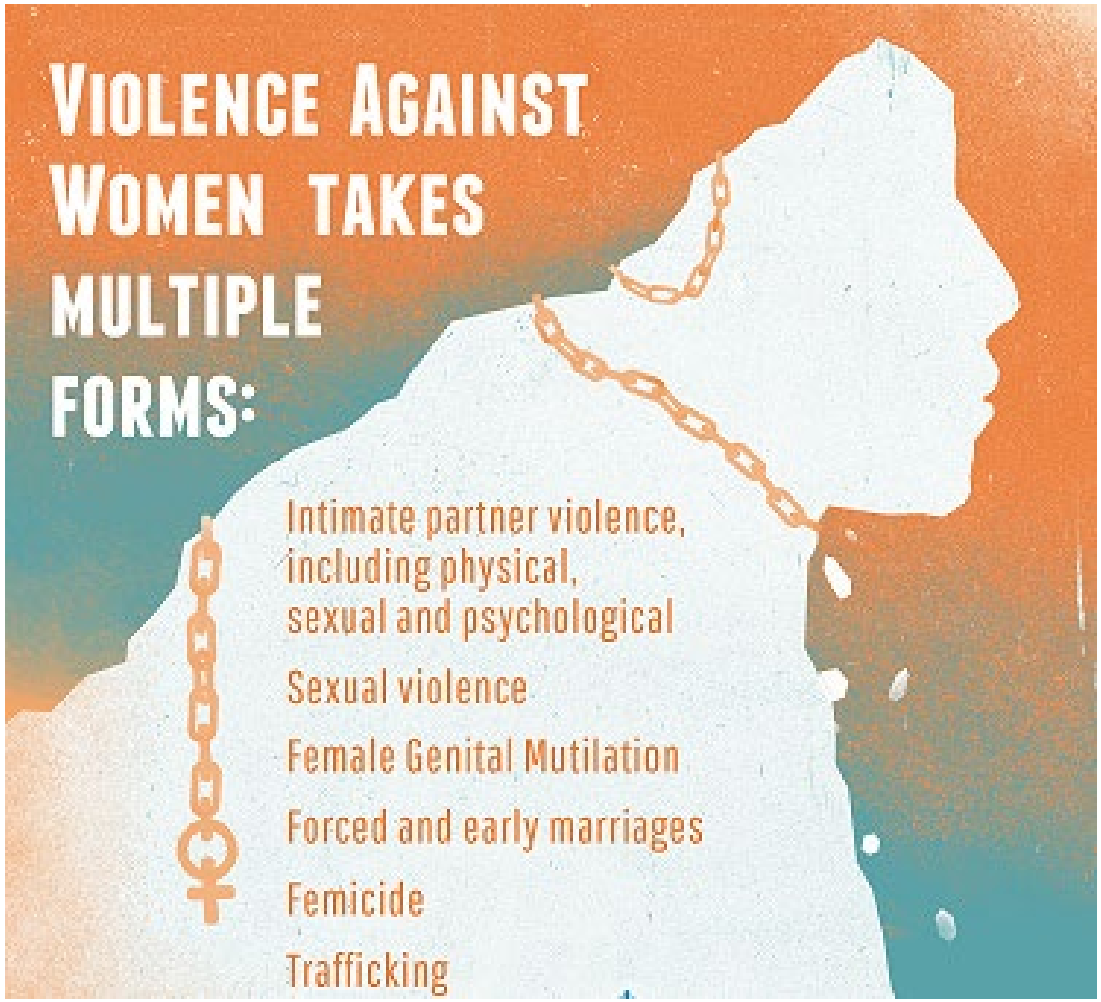
Violence against women…

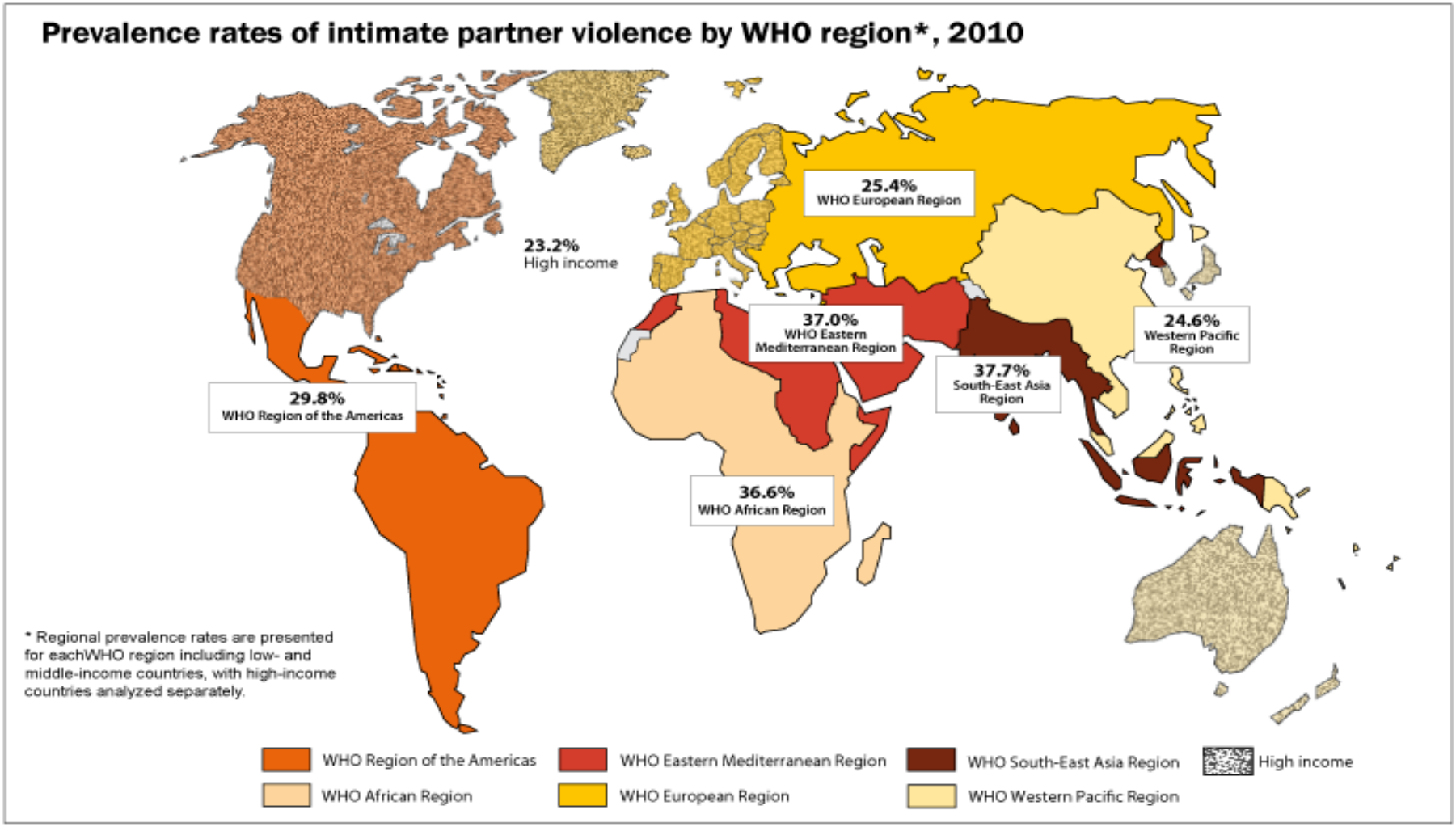
…takes many forms



Domestic/ intimate partner violence:
the most common form of violence experienced by women

Prevalence of VAW

30% globally have experienced physical &/or sexual violence by their partner



Data Source: *Global and regional estimates of violence against women*. WHO, 2013.

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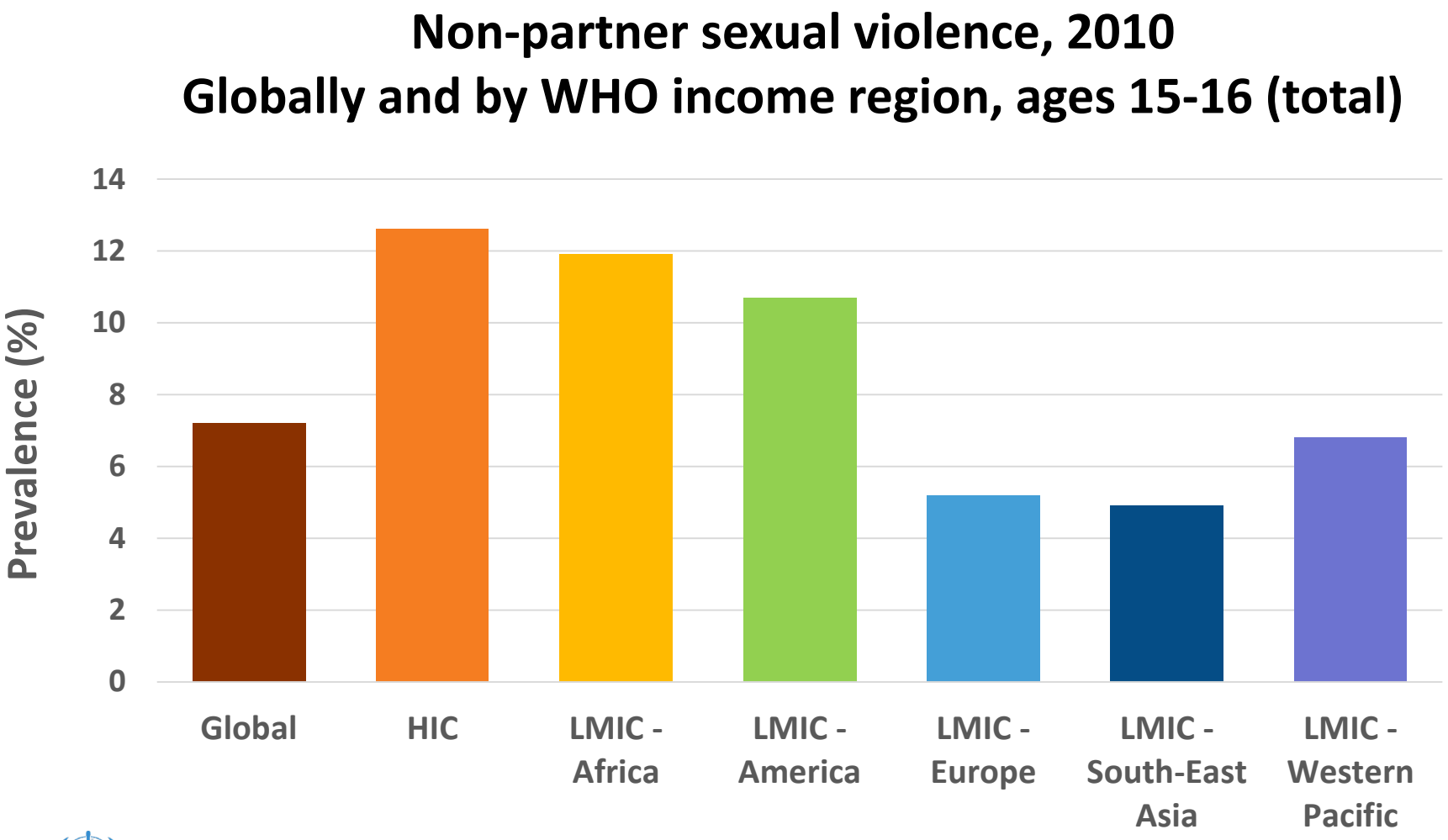
7% ♀ globally have experienced sexual violence



[Add local prevalence data]

Violence starts early in women's lives

Age group, years	Prevalence, %	95% CI, %
15 – 19	29.4	26.8 to 32.1
20 – 24	31.6	29.2 to 33.9
25 – 29	32.3	30.0 to 34.6
30 – 34	31.1	28.9 to 33.4
35 – 39	36.6	30.0 to 43.2
40 – 44	37.8	30.7 to 44.9
45 – 49	29.2	26.9 to 31.5
50 – 54	25.5	18.6 to 32.4
55 – 69	15.1	6.1 to 24.1
60 – 64	19.6	9.6 to 29.5
65 – 59	22.2	12.8 to 31.6

Lifetime prevalence of partner violence by age

HIGH levels of VIOLENCE during pregnancy

"

**He hit me in the belly and made me miscarry two babies….
I went to the hospital with heavy bleeding and they cleaned me up.**

– Woman interviewed in Peru

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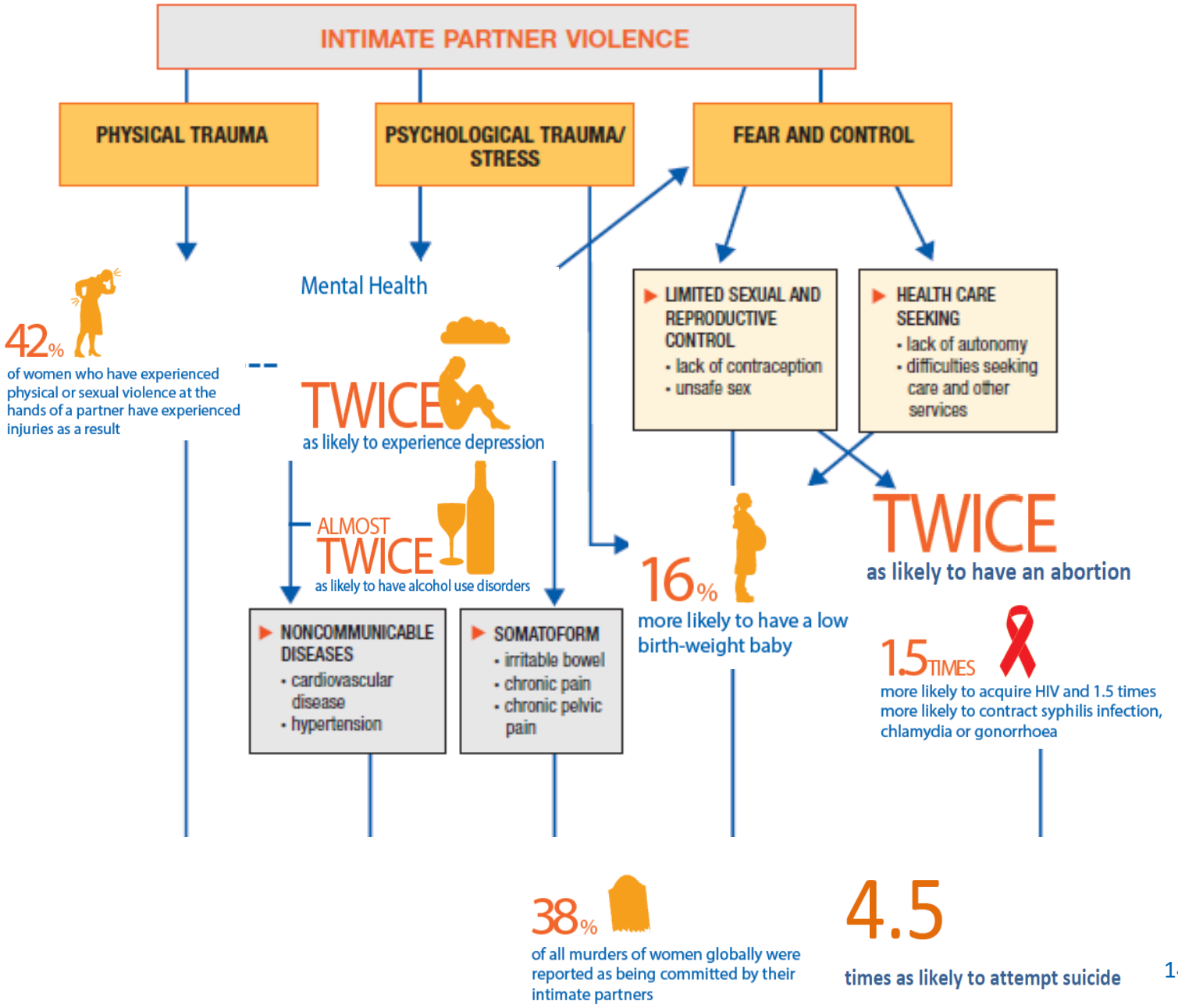
Health and socio-economic consequences

Pathways & health effects



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Inter-generational & socio-economic consequences

Effects on children	• Higher rates of infant mortality • Behaviour problems • Anxiety, depression, attempted suicide • Poor school performance • Experiencing or perpetrating violence as adults • Physical injury or health complaints • Lost productivity in adulthood
Effects on families	• Inability to work • Lost wages and productivity • Housing instability
Social and economic effects	• Costs of services incurred by victims and families (health, social, justice) • Lost workplace productivity and costs to employers • Perpetuation of violence

Role of health-care providers

Health providers and health systems have a critical role in supporting women, minimizing the impact of violence and preventing violence

Why health systems?

- Women and girls experiencing violence are more likely to use health services
- Health-care providers are often women's first point of professional contact
- All women are likely to seek health services at some point in their lives

Why is the VAW response different? No magic pill

Needs may include:

- Emotional support
- Reassurance
- Physical health care
- Safety may be an ongoing concern
- Referrals for other resources that the health system cannot provide
- Help to feel more in control and able to make her own decisions

Role of health-care providers

- ✓ Do no harm
- ✓ Identify violence
- ✓ Empathic response
- ✓ Clinical care
- ✓ Referrals as needed
- ✓ Documentation
- ✓ Medico-legal evidence
- ✓ Advocacy as community role models

Providers are NOT responsible for

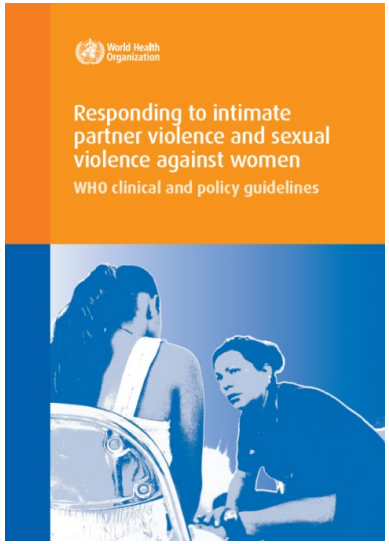
- Solving violence-related issues
- Addressing all violence-related needs
- Addressing all aspects of treatment, care & support in one consultation

Ignoring violence can do harm

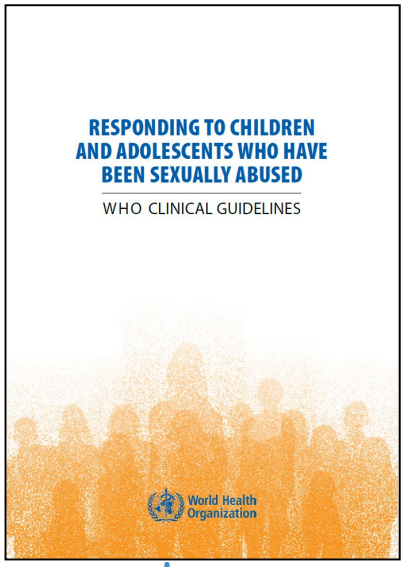
Provider behaviour	Possible consequences
• Blames or disrespects women or girls	• Inflicts additional emotional distress or trauma
• Doesn't recognize VAW behind chronic or recurring conditions	• Woman receives inappropriate or inadequate medical care
• Fails to provide post-rape care or address VAW in FP, STI/HIV care	• Unwanted pregnancy, STIs, HIV, unsafe abortion, more violence
• Breaches privacy or confidentiality	• Partner or family member becomes violent after overhearing information
• Ignores signs of fear or emotional distress	• Woman is later injured, killed or commits suicide

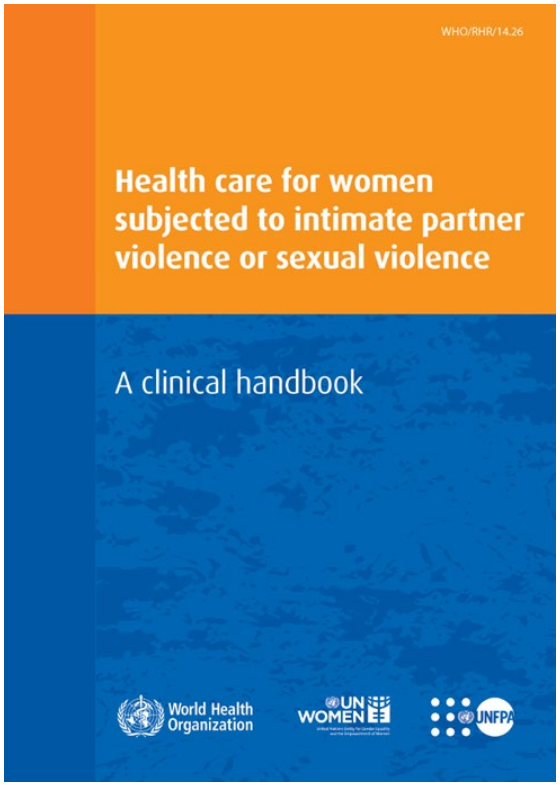
WHO guidelines & tools to assist providers

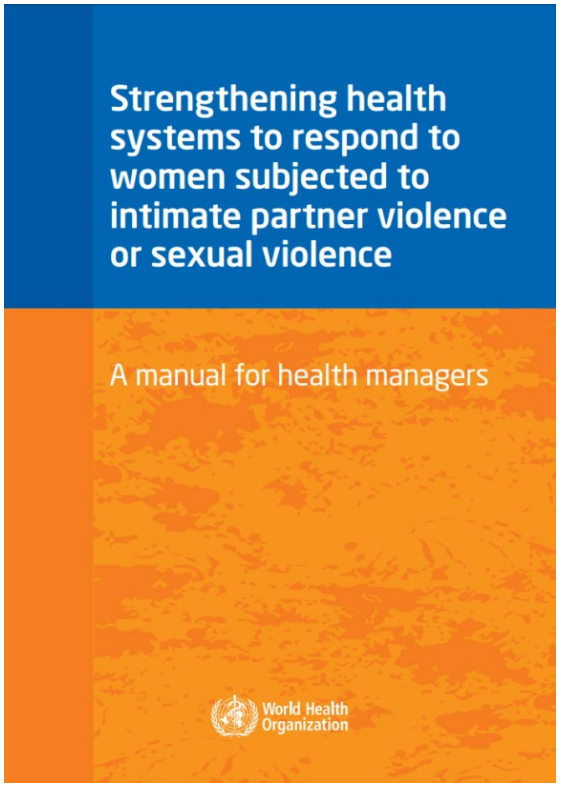
WHO guidelines & implementation tools



"What"







"How"

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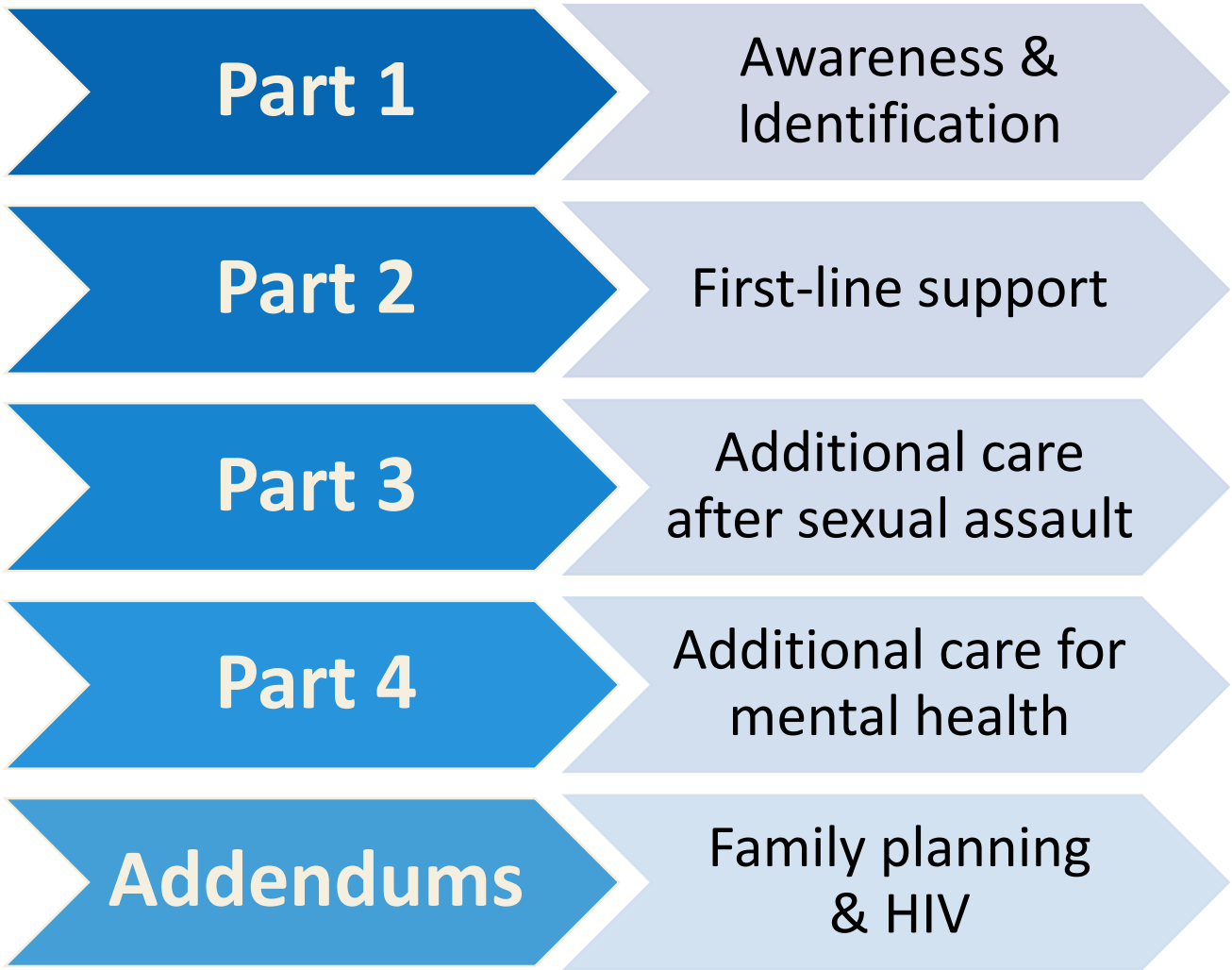
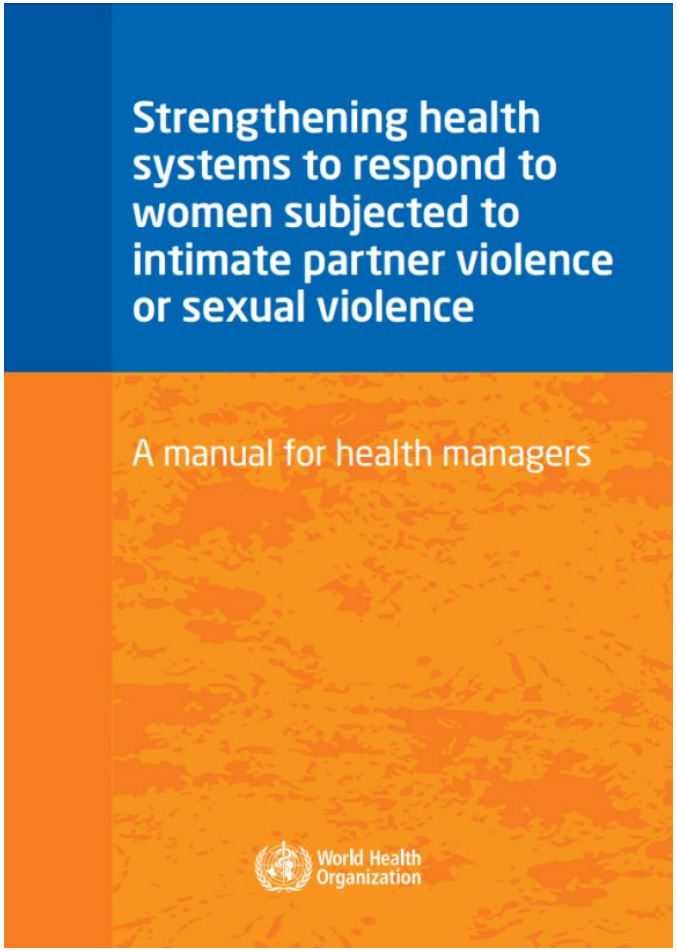
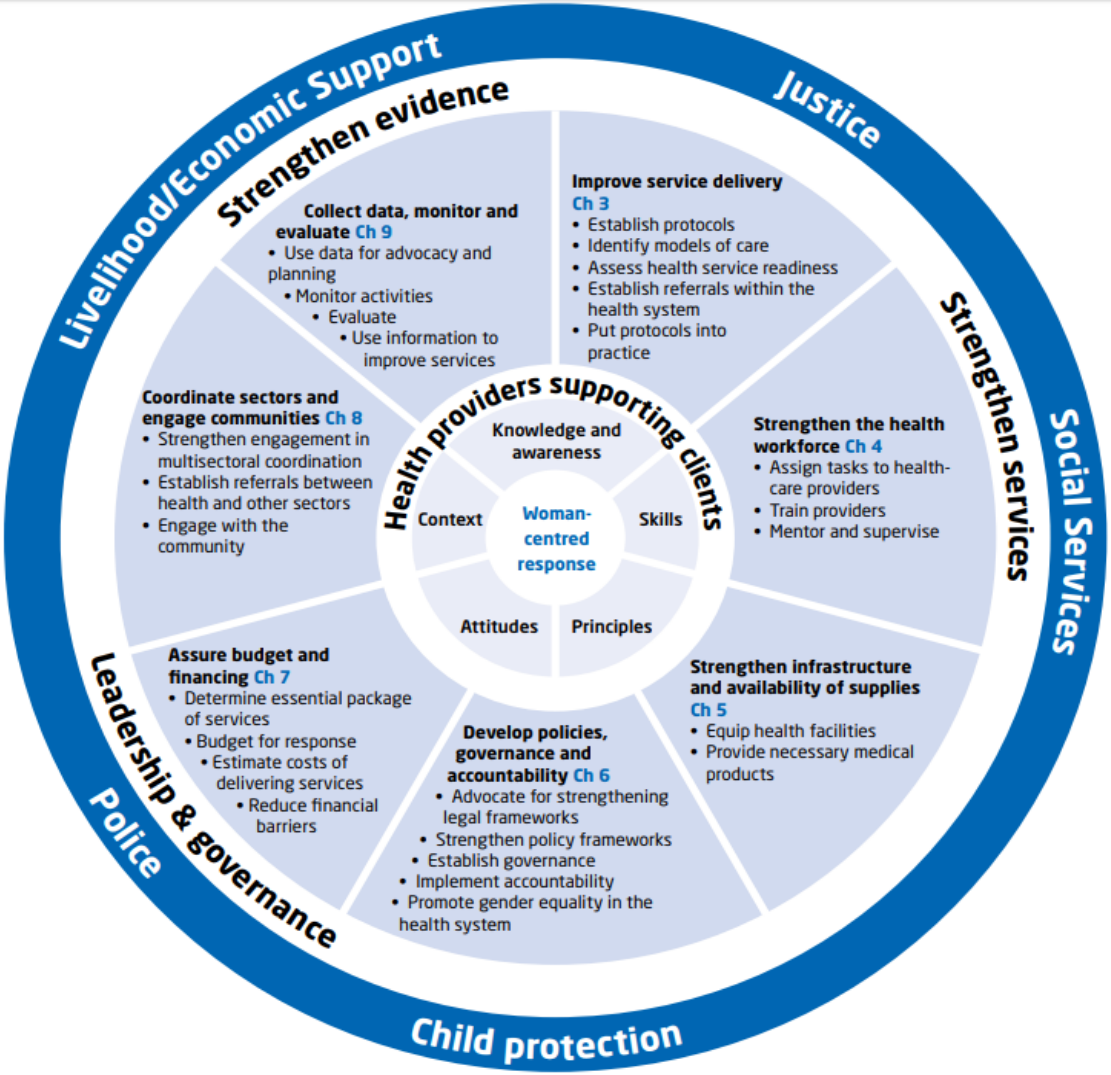
Contents of clinical handbook



Health managers' manual: contents





Key messages

- Violence against women takes **many forms**
- Health impact can be **short- and long-term** consequences for health and well-being
- While not disclosing abuse spontaneously, many women **seek treatment** for conditions or complications caused by violence
- Therefore, health-care providers have a central role to **identify and support** survivors

Small changes make a BIG difference

"The doctor helped me feel better by saying that I don't deserve this treatment, and he helped me to make a plan to leave the house the next time my husband became violent ."

— Salvadoran woman

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 2

Understanding the survivor's experience and how providers' values and beliefs affect the care they give

Learning objective

Demonstrate behaviours and understand values contributing to a **safe** & **supportive** service culture

Competencies

- Demonstrate self-awareness of one's beliefs, assumptions, potential biases and emotional response,
- Understand the circumstances and the barriers that women experiencing violence face
- Recognize the importance of empathy with survivors

Exercise 2.1 A: Myth or Fact?

Learning objective for the exercise: To critically reflect on our perceptions and beliefs that affect the care that we provide to women survivors

- The facilitator will read a statement
- Consider whether it is a myth or a fact
- Be ready to explain your reasons to the group if asked

Exercise 2.1 B: Voting with Your Feet

Learning objective for the exercise: To critically reflect on our perceptions and beliefs that affect the care we give survivors

- Please form a straight line in the middle of the space
- The facilitator will read a statement
- Depending on your opinion, move toward the sign "Agree" or the sign "Disagree".
- If you strongly agree or disagree, move close to the sign. If you mildly agree or disagree, move only part way toward the sign.

Take-away points: Exercises 2.1 A&B

- It is important for us to be aware of our own beliefs and attitudes, especially if they might harm survivors
- If we are aware of our negative beliefs, we can better avoid communicating them to survivors of violence
- Changing mindsets takes time, but it can be done. Self-reflection is healthy.

Choose EITHER 2.2A or 2.2B !

Exercise 2.2 A: Blanketed by Blame

Learning objectives for the exercise

- Increase awareness of and empathy for the difficulties that women who experience violence face when seeking support
- Highlight how gender norms can affect women's ability to seek help and access care
- Encourage thinking about what you can do as providers to offer an empathic response

Exercise 2.2 A: Blanketed by Blame

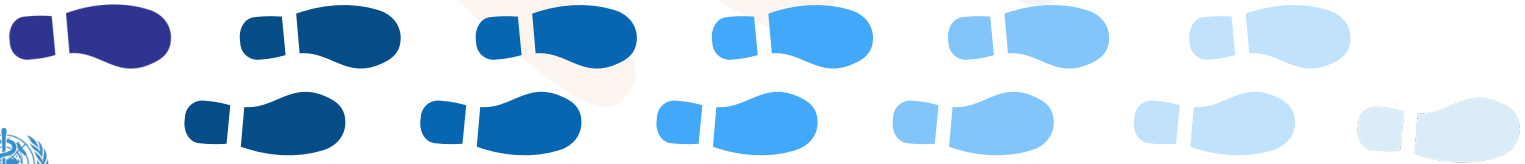
- 12 participants are needed to play roles in this exercise
- 1 person will play “Maya”, a survivor of violence (choose name according to setting)
- The rest will play people whom Maya asks for help
- We will see how each one responds to Maya

Exercise 2.2 B: In Her Shoes

Choose EITHER 2.2A or 2.2B !

Learning objectives for the exercise

- Increase awareness of and empathy for the difficulties that women who experience violence face when seeking support
- Highlight how gender norms and behaviours can affect women's ability to seek help and obtain care
- Encourage thinking about what you can do as providers to offer an empathic response to survivors of violence



Exercise 2.2 B: In Her Shoes

This exercise will enable us to walk in the shoes of a woman who has experienced violence. In small groups, we will follow a unique story of one of 10 women survivors where we have to make decisions as if we were the survivor as the story develops – we will 'walk in her shoes'.

- In small groups (3–5 people), we will adopt the character of a women subjected to violence
- Each group will visit each of the stations marked by the signs on the walls
- Situation cards for each survivor describing a part of the story for that woman are found in each station
- The group will discuss and make the decision that their character faces at that station

Take-away points: Exercises 2.2 A&B

- Survivors of violence face many hard decisions
- Women often have few options, many barriers
- Where violence is considered normal, women can feel they must stay in violent situations
- NEVER blame her for violence or her decisions
- Health-care providers can help in many ways

– continued –

Take-away points: Exercises 2.2 A&B

– continued –

- Putting ourselves in the survivor's shoes helps us empathize and understand
- It is important to reflect on our own values and NEVER blame women for violence
- Given the barriers to leaving, safety is a long-term goal
- We encourage women to look for options, and we support their decision-making

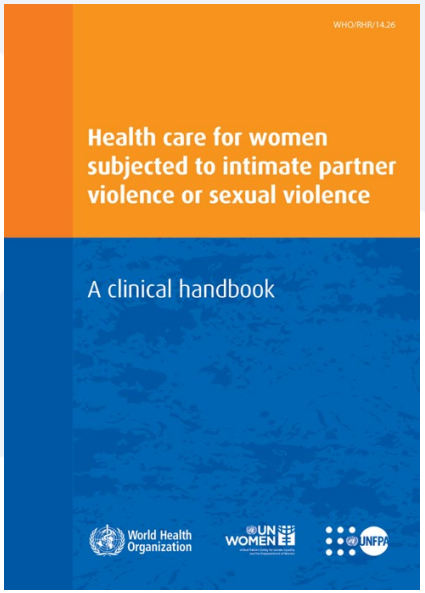
Key messages

- By putting ourselves in the shoes of the survivor, we can empathize and understand her situation
- Know our own values and beliefs and, if they might cause harm, set them aside
- NEVER blame the woman
- Safety is a long-term goal, not quickly achieved
- Encourage women to look for options and support them to make decisions right for them

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 3

Guiding principles and overview of the health response to violence against women



Learning objective

Demonstrate behaviours and understand values contributing to a safe & supportive service culture

Competencies

- Know the guiding principles of woman-centred care
- Understand how to apply the guiding principles in your practice

Guiding principles

Guiding principles

- **Two fundamental principles:**
  - Respect for **human rights**
  - Promotion of **gender equality**

Guiding principles

- **What does it mean to respect human rights?**
  - Autonomy
  - Freedom from fear & violence
  - Highest attainable standard of health
  - Non-discrimination

Guiding principles

- **What does it mean to promote gender sensitivity/equality?**
- Be aware of **power** differences
- Avoid reinforcing **unequal power** dynamics
  - Reinforce her **value as a person**
  - Respect her **autonomy and dignity**
  - Provide **information** and **counselling** that help her to make her **own decisions**
  - **Listen**, **believe** and take what she says seriously
  - **Do not blame** or **judge**

Privacy and confidentiality

Privacy, safety and confidentiality must drive:

- When and where violence is discussed
- Documentation
- Referral processes

Discussion: What do confidentiality & privacy entail in practice?

Additional considerations for child & adolescent-centred care

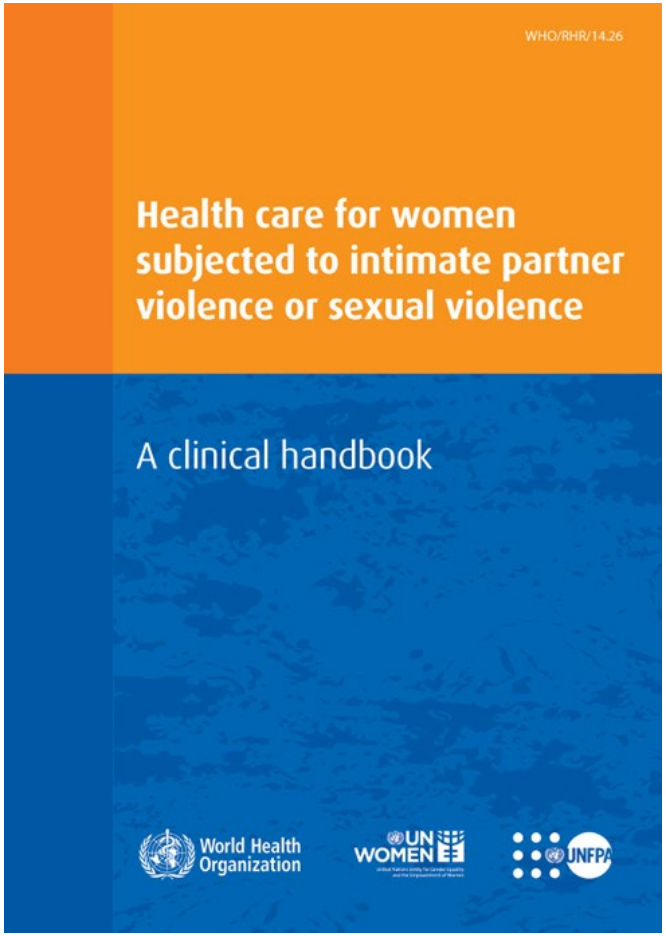
Best interests of the child

- Empower non-offending care-givers
- Create child friendly environment

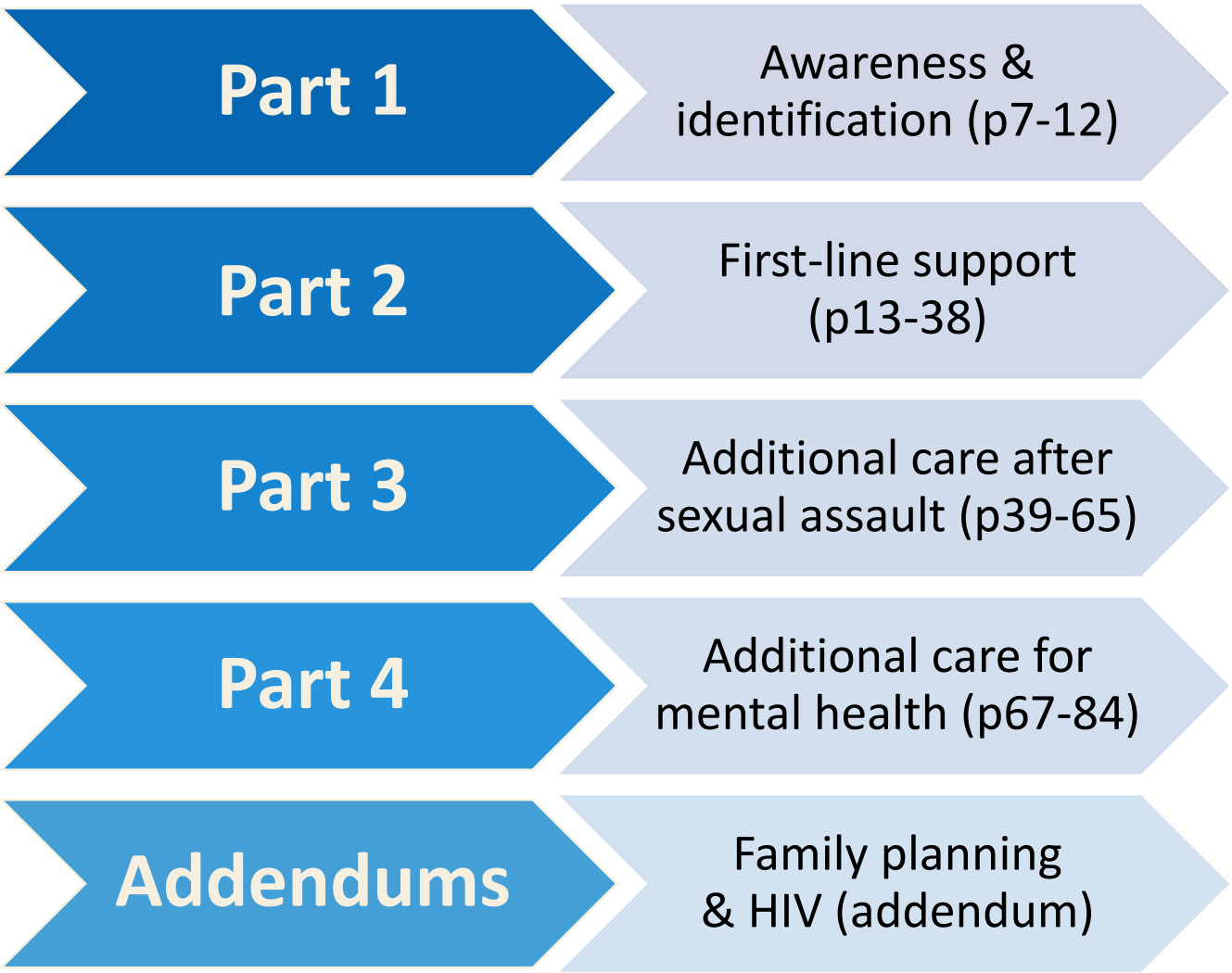
Evolving capacities

- Provide age-appropriate information
- Seek informed consent, as appropriate
- Ask child's or adolescent's opinions

Clinical handbook contents overview



Contents of clinical handbook



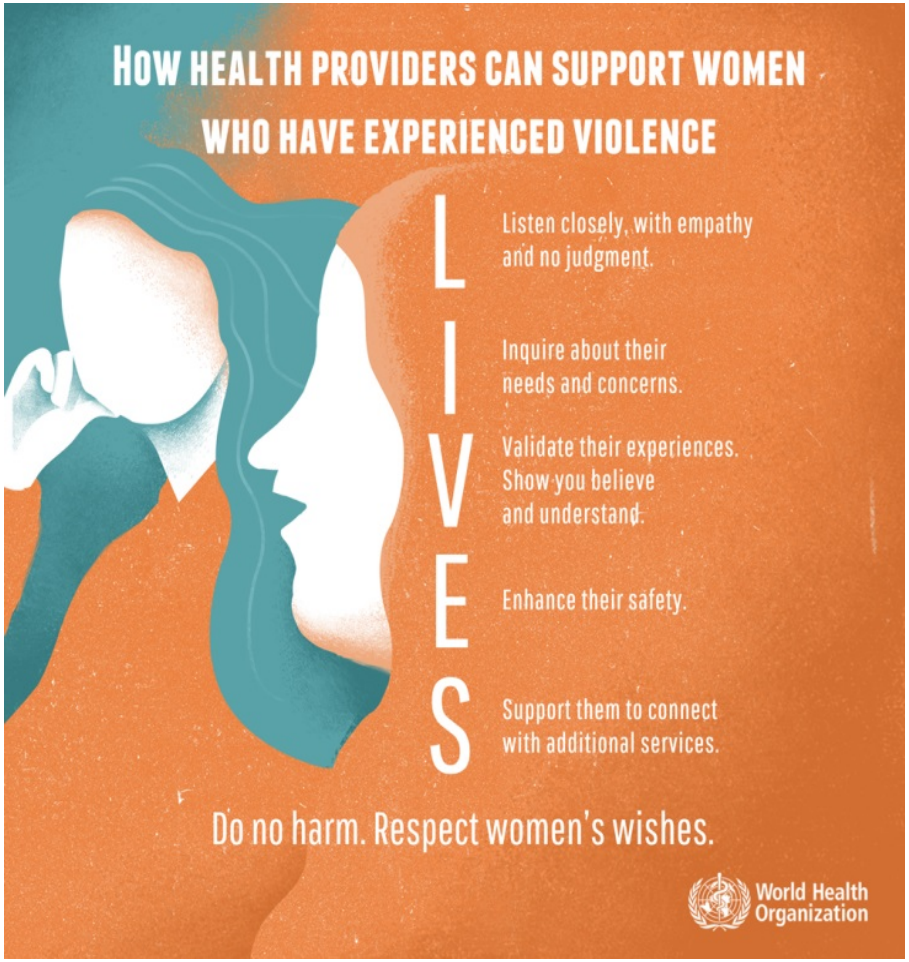
Possible entry points for health care

- Maternal health (antenatal or postnatal)
- Family planning services
- Post-abortion care
- STI or HIV care
- Child health & early childhood development
- Adolescent health
- Mental health
- Substance abuse

Clinical inquiry to identify IPV

- **NOTE:** Universal screening NOT recommended
- Instead, discuss violence if the woman brings it up or her signs and symptoms suggest violence.
- **Asking about violence**
- Ask only when the woman is alone
- Make no judgements
- Use appropriate language

First-line support – job aid



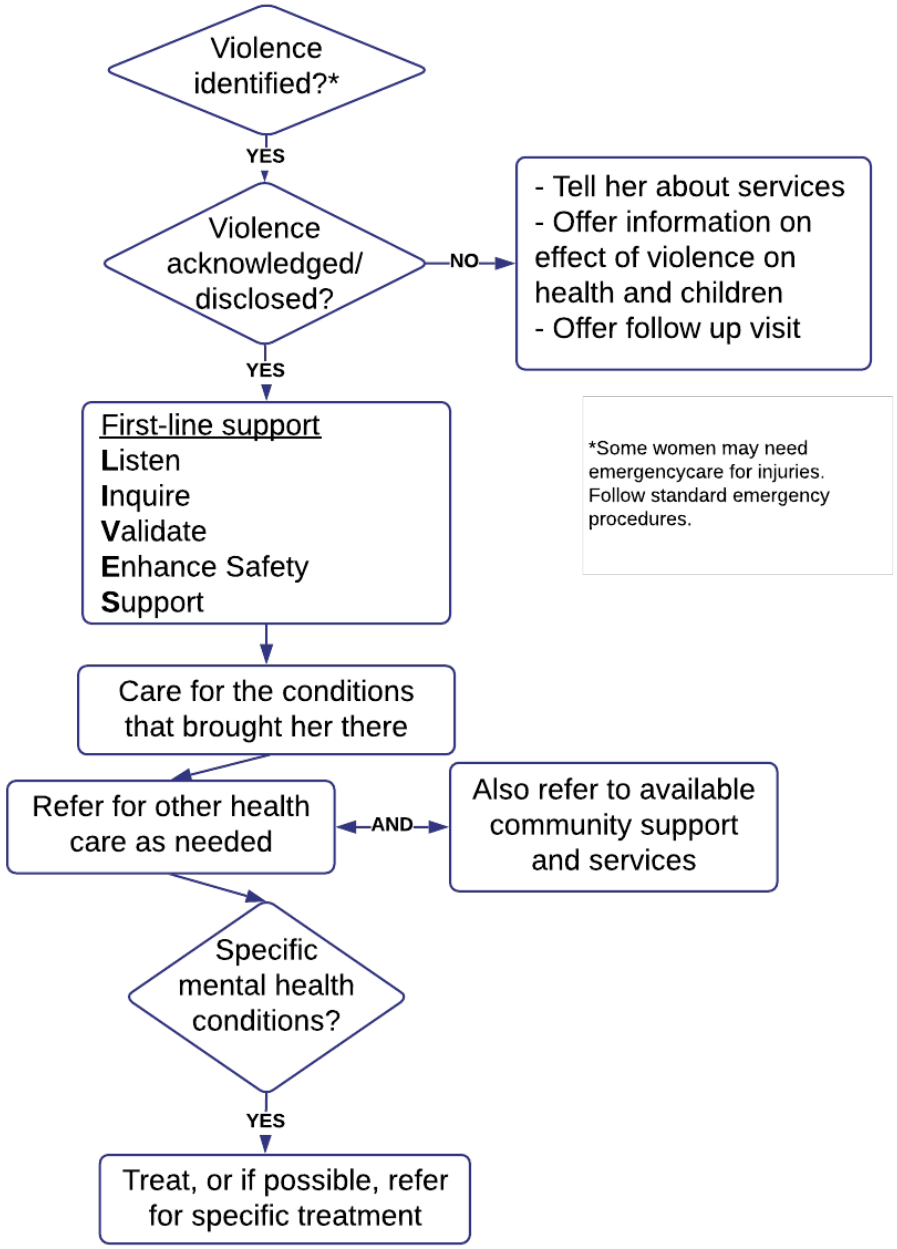
Learn to listen with your

Eyes – giving her your undivided attention

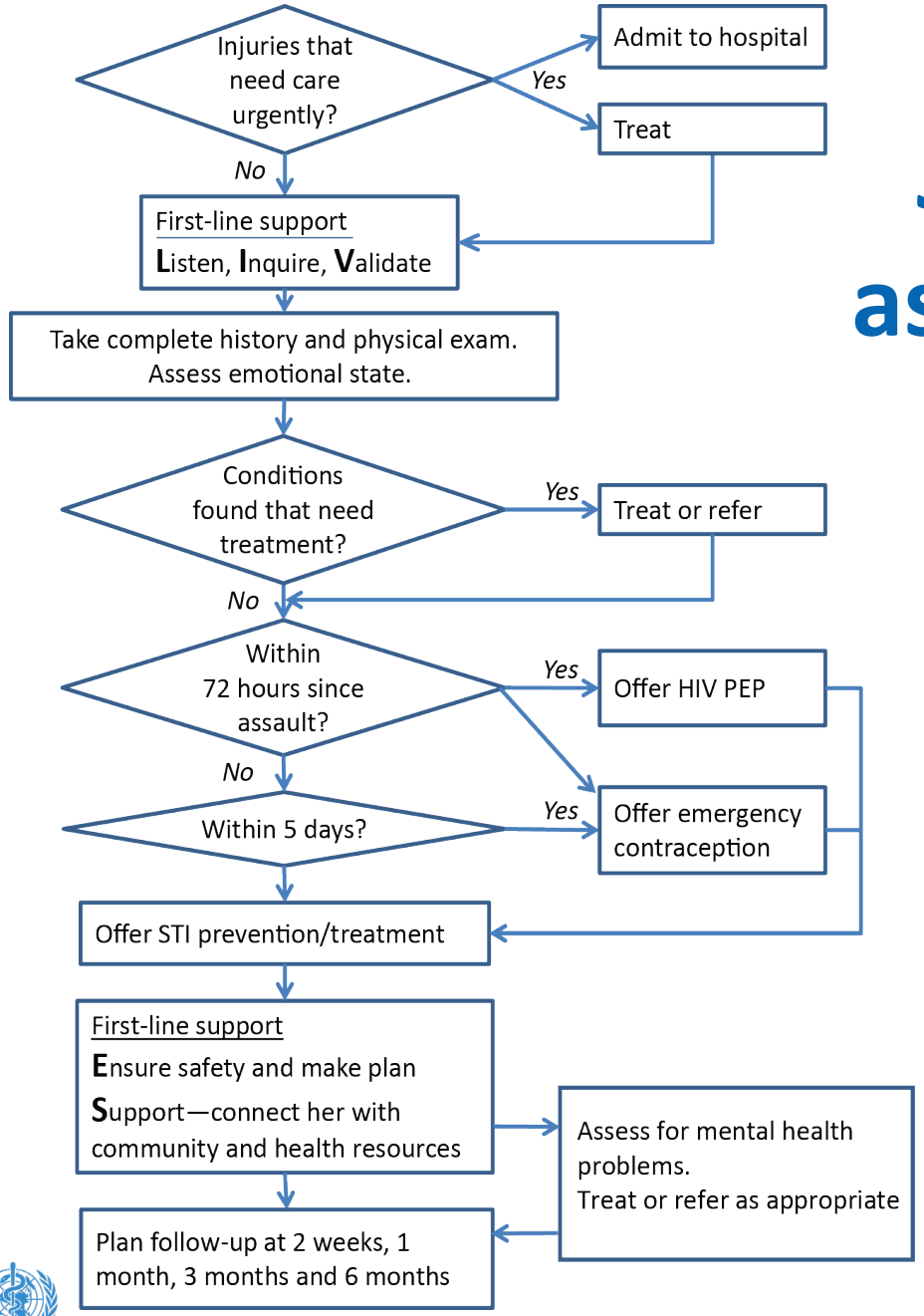
Ears – truly hearing her concerns

Heart – with caring and respect

Job aid: Intimate partner violence summary protocol (page 38)



Job aid: sexual assault summary protocol (page 65)



Mental health care: Basic psychosocial support

- Help strengthen **positive coping methods**
- Explore availability of **social support**
- Teach **stress reduction** exercises
- Make regular **follow-up** appointments
- Assess for moderate–severe **depression or PTSD**

Considerations for family planning & HIV

Family planning

- Understand reproductive coercion
- Assess barriers to FP in context of violence
- Facilitate appropriate method choice

HIV

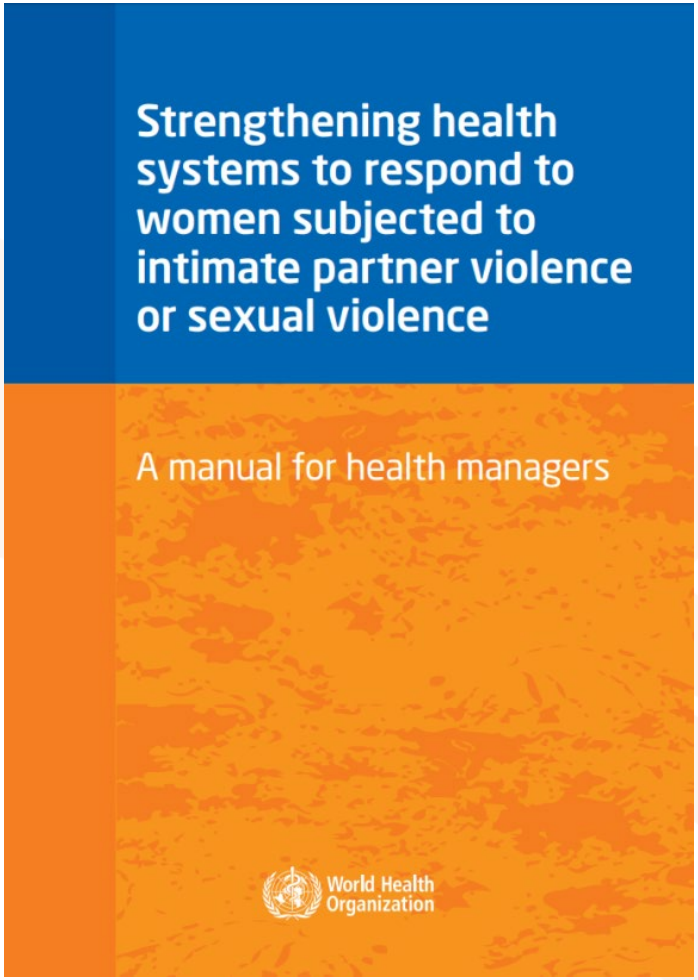
- Risks & benefits of disclosure
- Counselling on disclosure of HIV status
- Planning for safe HIV status disclosure

Reporting violence & Enabling health systems

Reporting considerations

- For **women:** mandatory reporting NOT recommended
  - Offer to report if woman wants
  - If required, tell the woman at the outset
- For **child** sexual abuse**,** where obligation to report:
  - Assess health, safety & well-being implications of reporting
  - Inform about limitations on confidentiality before consultation

Necessary system-wide changes



- Assure **supervision and feedback**
- Improve **infrastructure**
- Strengthen **referrals**
- **Document**
- **Monitor and evaluate**

Key messages

- The health system response should be based on respect for **human rights** and promotion of **gender equality**
- This training covers skills in the 5 parts of the WHO **clinical handbook**
- An **enabling health system** is key to helping providers put training into practice

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Session 4

Provider–survivor communication skills

Learning objective

Demonstrate behaviours and understand values that contribute to a safe and supportive service culture

Competency

- Communicate empathically and effectively with patients/survivors

Active listening

Use verbal and nonverbal means to show support and communicate understanding

Ask questions:

- open-ended
- focused
- closed

Use good body language:

- posture
- eye contact

Avoid

- leading questions
- compound questions

How does active listening look? "SOLER"

S – sitting position

O – open posture

L – leaning forward

E – eye contact

R – relaxed

Exercise 4.1: Active listening

Learning objectives of the exercise: Appreciate and practice active listening

- Turn to your neighbour and form a pair
- Recall a challenging situation in your life (not related to violence) and take about 5 minutes to describe it to your partner
- The listener should practice active listening
- Then switch, and listen to your partner telling you about a challenging situation in her or his life

Discussion

- What did your partner do to show she/he was listening attentively to you?
- What did your partner say that showed active listening?
- What did your partner NOT do or say – both good and bad?
- How did you feel afterwards?

Key messages: Empathic & effective communication

- Allows survivors to be heard – an important step towards healing
- Empathic and effective communication takes place throughout the meeting.
- Use both verbal and non-verbal skills
- Start with open-ended questions

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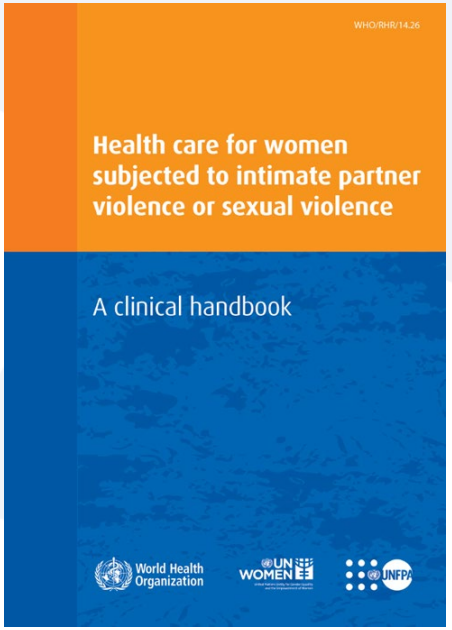
Session 5

When and how to identify intimate partner violence



Learning objective

Demonstrate clinical skills to respond to VAW that are appropriate to one's profession and specialty

Competencies

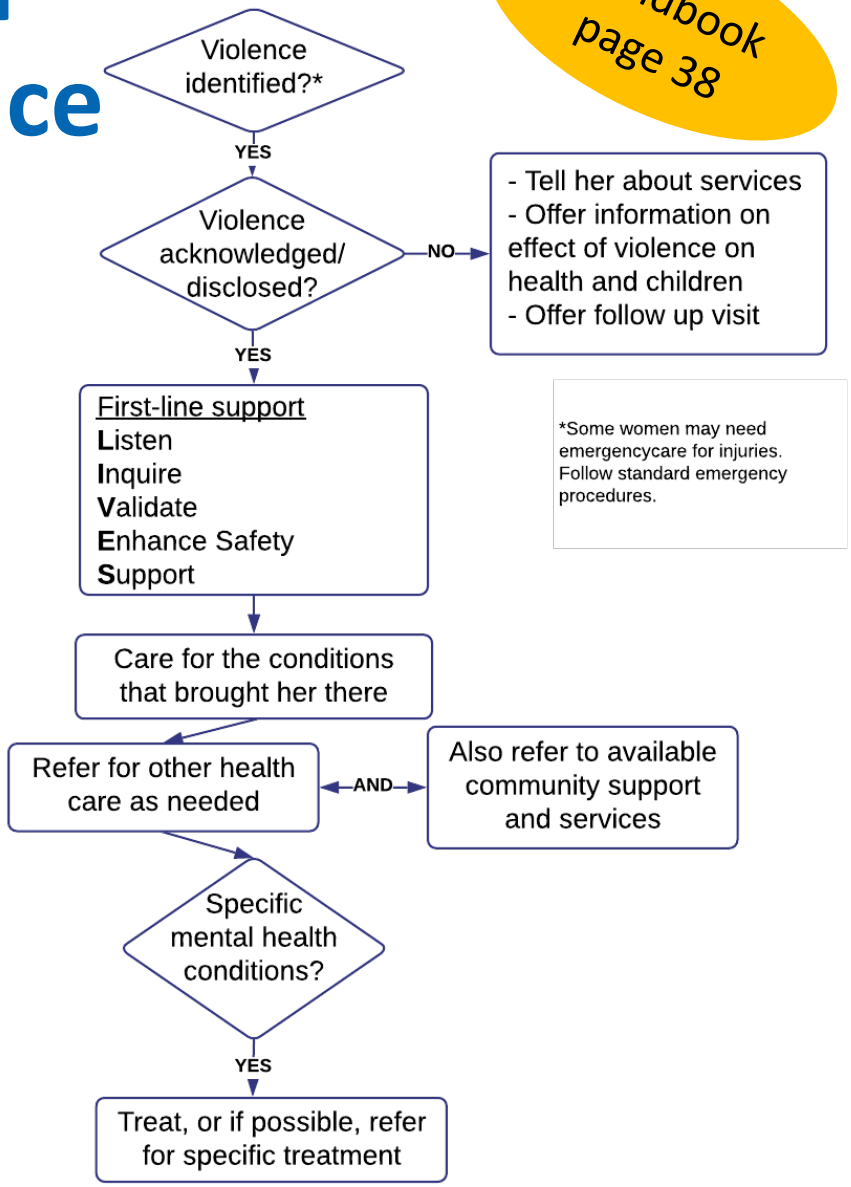
- Know minimum standards for asking about and responding to IPV
- Recognize signs and symptoms that suggest violence
- Understand how to ask about IPV
- Demonstrate appropriate ways to ask about IPV

Summary protocol for intimate partner violence

Handbook page 38

1. Identify partner violence
2. First-line support: Listen, Inquire, Validate (LIV)
3. Treat health conditions that brought her to the facility
4. First-line support: Enhance safety, offer Support (ES)
   a. Assess and plan for safety
   b. Refer for other support services

5. Assess for mental health conditions
   a. Manage or refer for moderate to severe mental health conditions



Minimum system requirements for asking about IPV

- ✓ Training on how to ask and on minimum first-line response
- ✓ A protocol/standard operating procedure
- ✓ Private setting
- ✓ Confidentiality ensured
- ✓ System for referral in place

Identifying partner violence

NOTE: Universal screening is NOT recommended

- **Clinical enquiry** IS recommended, and health-care providers should be sensitized and have a low threshold for asking, as answers can improve diagnosis and treatment
- Printed information on services for partner violence should be available in private areas (with cautions about taking it home)
- Posters with general information on partner violence can be displayed in waiting areas.

Clinical inquiry: suspect violence if:

- ✓ On-going stress, anxiety or depression; substance misuse
- ✓ Thoughts, plans or acts of self-harm or (attempted) suicide
- ✓ Injuries that are repeated or not well explained
- ✓ Repeated STIs
- ✓ Unwanted pregnancies

– continued –

Clinical inquiry: suspect violence if:

– continued—

- ✓ Unexplained chronic pain or conditions
- ✓ Repeated health consultations with no clear diagnosis
- ✓ Partner or husband is intrusive during consultations
- ✓ Often misses health-care appointments
- ✓ Children have emotional and/or behavioural problems

Asking about violence

Raise the topic indirectly first. For example:

- "Is everything okay at home?"
- "I have seen other women with problems like yours."
- "Many women have problems with their husbands."

Asking about violence

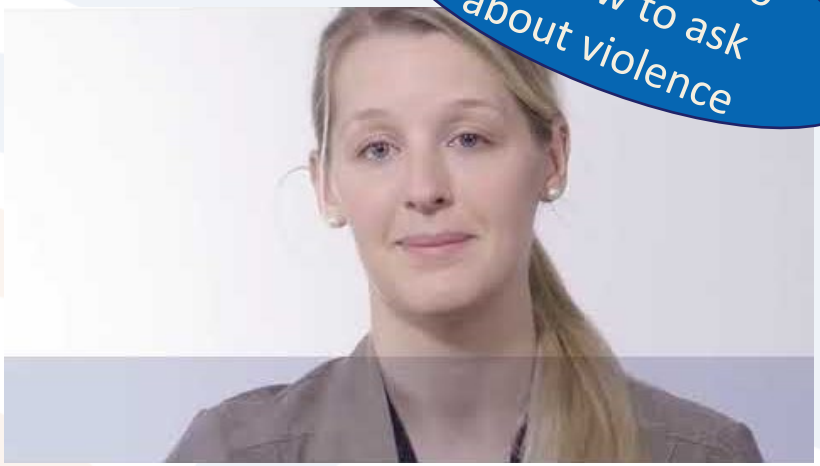
Then ask direct questions. For example:

- "Has your husband ever threatened to hurt you or your children?"
- "Are you afraid of your husband?"
- "Does your husband bully or insult you?"
- "Does your husband try to control you – for example, not letting you have money or go out of the house?"
- "Has your husband forced you into sex?"
- "Has your husband threatened to kill you?"

"What if I suspect violence, but she doesn't disclose?"

- Do NOT pressure her
- Tell her of available services
- Offer information
- Offer a follow-up visit

Optional video on how to ask about violence



https://youtu.be/Hu06nVCzih0?t=543

Exercise 5.1 A: Role plays on identification of IPV

Learning objective for the exercise

To practice appropriate ways to raise the topic of violence and to ask about violence from a partner/husband

Exercise 5.1 A: Role plays on identification of IPV

Form groups of 3. One plays a patient. One plays a health-care provider. The third observes.

- "Patients": Please follow the scenario hand-out
- "Providers": Please ask questions that suit the scenario
- Observers: Provide feedback to your group after the role play

Time: 10 minutes for role play, 5 minutes for feedback and discussion, then switch roles

Exercise 5.1 B: Case reviews for identifying IPV

Learning objective for the exercise

- To recognize signs and symptoms that suggest violence
- To practice appropriate ways to raise the topic of violence and to ask about violence

Exercise 5.1 B: Case reviews for identifying IPV

- Please read the 3 cases in the handout
- In groups of 4 or 5, for each case, please agree:
  - Do you think this person may have experienced violence?
  - What makes you think this?
  - How would you raise the topic?
  - What questions would you ask? (Please write)

– continued –

Exercise 5.1 B: Case reviews for identifying IPV

– continued –

- The facilitator(s) plays the role of the patient in each case
- Participants play the role of providers and ask the questions that you have written
- Then we will discuss what questions and approaches work best in each case

Time: 10 minutes

Providers' frequent questions

Handbook pages 34–37

1. "Why not offer advice?"
2. "Why doesn't she just leave him?"
3. "How did she get herself into this situation?"
4. "What can I do when I have so few resources and so little time?"
5. "That isn't the way we were taught."
6. "What if she decides not to report to the police?"

– continued –

Providers' frequent questions

– continued –

Handbook pages 34–37

7. "How can I promise confidentiality if the law says I have to report to the police?"
8. "What if she starts to cry?"
9. "What if you suspect violence but she doesn't acknowledge it?"
10. "What if she wants me to talk to her husband?"
11. "What if the partner is one of my clients, too?"
12. "What if I think her partner is likely to kill her?"

Key messages

- To identify IPV, stay alert to **clinical cues**
- **Ask compassionately**, without judging
- **Verbal and non-verbal skills** are important
- **Active listening** provides important support
- Your **skills** will improve with practice

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 6

First-line support using LIV(ES), part 1: Listen, Inquire, Validate

Learning objective

Demonstrate clinical skills appropriate to one's profession and specialty to respond to VAW

Competencies

- Know the content of first-line support (LIVES)
- Demonstrate skills in offering the first three elements of first-line support – **L**isten, **I**nquire, **V**alidate

What is first-line support?

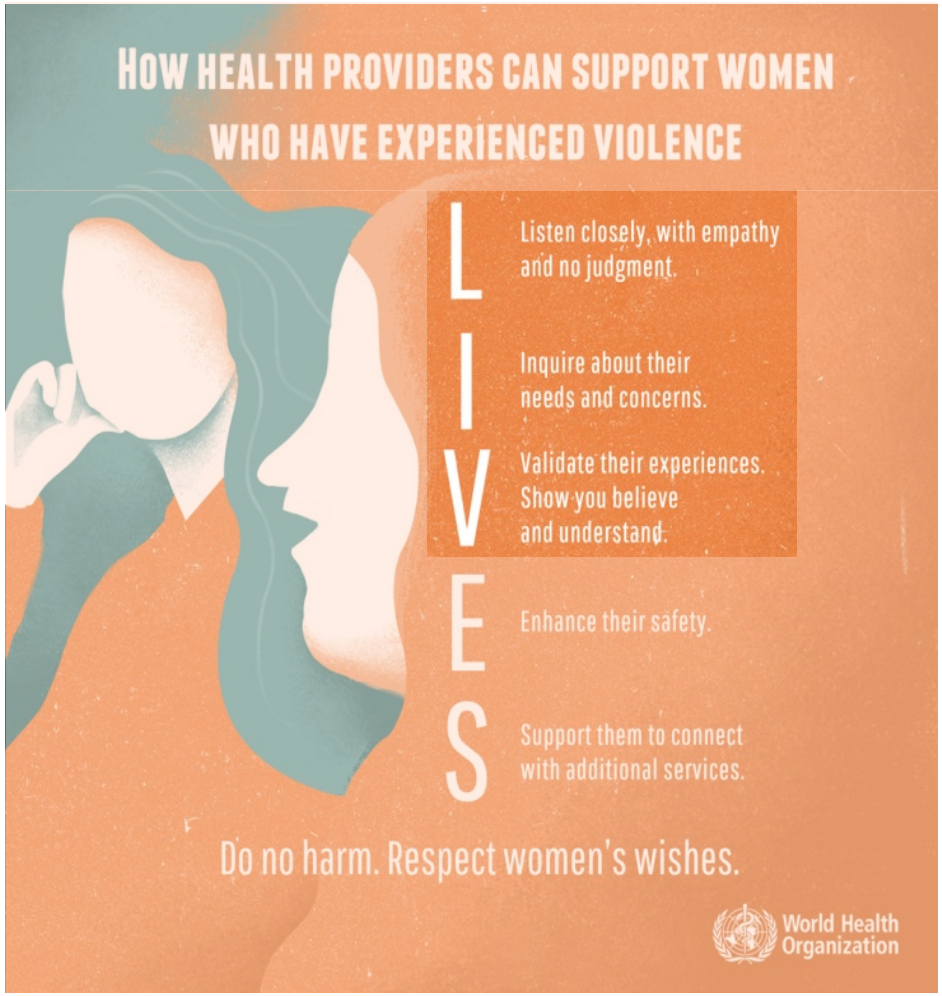
DO

- ✓ identify needs and concerns
- ✓ respond to emotional, physical, safety and support needs
- ✓ listen & validate experiences & concerns
- ✓ help her feel connected to others, calm and hopeful
- ✓ empower her to feel able to help herself and to seek help explore options respect her wishes

DON'T

- × try to solve her problems
- × try to convince her to leave a violent relationship
- × try to convince her to go to the police or courts
- × ask questions that force her to relive painful events
- × ask her to analyse what happened or why
- × pressure her to tell you her feelings & reactions

First-line support – job aid



Learn to listen with your

Eyes – giving her your undivided attention

Ears – truly hearing her concerns

Heart – with caring and respect

Listen

Active listening dos and don'ts	
Dos ✓	**Don'ts X**
How you act	
Be patient and calm.	Don't pressure her to tell her story.
Let her know you are listening; for example, nod your head or say "hmm…"	Don't look at your watch or speak too rapidly. Don't answer the telephone, look at a computer or write.
Your attitude	
Acknowledge how she is feeling	Don't Judge what she has or has not done, or how she is feeling. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived," or "Poor you".
What you say	
Give her the opportunity to say what she wants. Ask, "How can we help you?"	Don't assume that you know what is best for her.
Encourage her to keep talking if she wishes. Ask, "Would you like to tell me more?"	Don't interrupt. Wait until she has finished before asking questions.

Listen

Active listening dos and don'ts	
Dos ✓	**Don'ts X**
Allow for silence. Give her time to think.	Don't try to finish her thoughts for her.
Stay focused on her experience and on offering support.	Don't tell her about someone else's story or talk about your own troubles.
Acknowledge what she wants and respect her wishes.	Don't think and act as if you must solve her problems for her.

Inquire about needs and concerns

Phrase your questions as **invitations to speak.**	"What would you like to talk about?"
Ask **open-ended questions** instead of yes or no questions.	"How do you feel about that?"
Check your understanding (repeat what she says).	"You mentioned that you feel very frustrated."
Reflect her feelings.	"It sounds as if you are feeling angry about that…" , "You seem upset."
Explore as needed.	"Could you tell me more about that?"
Ask for **clarification** if you don't understand.	"Can you explain that again, please?"
Help her to **identify and express** her needs and concerns.	"Is there anything that you need or are concerned about?"
Sum up what she has expressed.	"You seem to be saying that…."

Validate

Job aid, handbook page 24

Important things that you can say:

- "It's not your fault. You are not to blame."
- "It's okay to talk."
- "Help is available." [Say this only if it is true.]
- "No one deserves to be hit by her husband."
- "You are not alone. Unfortunately, many other women have faced this problem, too."
- "What happened has no justification or excuse."
- "Your life, your health, you are of value."
- "Everybody deserves to feel safe at home."
- "I am worried that this may be affecting your health."

Video on Listening, Inquiring about needs, Validating (LIV)

https://youtu.be/Hu06nVCzih0?t=520

Watch from 8:40 until 20:36

Exercise 6.1: Role-play LIV(ES)

Learning objective for the exercise: Develop skills for the LIV elements of first-line support

- Form groups of 3. In each group choose roles: patient, health-care provider or observer
- *Patients* and *observers*: Choose one of the scenarios
- *Patients* and *health-care providers*: Act out the role-play (20 minutes)
- Then, observers give feedback to their team (5 minutes)

Key messages

- Effective listening and LIVES can be powerful healing tools. For some, they are sufficient.
- When meeting a patient, minimize distractions and focus on her
- Later, find a colleague and practice the LIV elements of LIVES, using your own words

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Session 7

Know your setting: identify referral networks and understand the legal and policy context

Learning objective

Demonstrate knowledge of how to access resources and support for patients and for oneself

Competencies

- Understand the roles of other services
- Know community resources
- Know legal and policy context including providers' legal obligations
- Collaborate with referral partners to help survivors obtain services

Principles for referral pathways

Referral pathways should:

- respect **self-determination**
- **minimize points of care** and retelling of the story
- maintain **safety** of the woman and **confidentiality** of her information

Establishing referral pathways

Make referral agreements with known resources

- Identify and map available **community services**
  - — police/law enforcement
  - — justice/legal services
  - — social services
  - — economic/livelihood support
  - — child protection
- Make a **referral directory** (job aid on next slide)
- **Agreements** can be formal or informal
- Specify how you will learn **whether the woman reaches** the referral resource
- **Monitor** referrals and coordination mechanisms

Annex 6. Sample referral directory form

Job aid, manager's manual, page 141

Need	Name of agency &/or contact person	Contact	Responsible for follow-up	
Victim advocate/Family protection unit/Social worker		Phone: E-mail:		
Counselling/Crisis centre/		Phone: E-mail:		
Support groups		Phone: E-mail:		
Mental health care		Phone: E-mail:		
Reproductive health care		Phone: E-mail:		
Laboratory services		Phone: E-mail:		
Child care		Phone: E-mail:		
Child protection		Phone: E-mail:		
Police		Phone: E-mail:		
Need	**Name of agency &/or contact person**	**Contact**	**Responsible for follow-up**	**Form**
Forensics		Phone: E-mail:		
Shelter/housing		Phone: E-mail:		
Financial aid		Phone: E-mail:		
Legal aid		Phone: E-mail:		
Livelihood/ employment		Phone: E-mail:		
[Other]		Phone: E-mail:		
[Other]		Phone: E-mail:		

Job aid: Referral directory

What does it mean to "know" a resource?

- **Know at least one person** at that service
  - Be able to refer to these people by name
- Know **what services are provided**, so that you can tell patients
- **Maintain relationships** through
  - hosting cross-trainings
  - sharing information

Provide “warm referrals”

Warm referral practices help women reach further care

1. Ask: “What would **help most** if we could do it now?”
2. Help her **identify and consider** referral and social support options
3. Explain how the referral service can **meet her need**
4. Give her **contact details** – location, how to get there, names

— continued —

Provide "warm referrals"

– continued –

5. Offer to help **make an appointment**, if it helps
   - Offer to call on her behalf OR
   - Offer to make a call with her OR
   - Offer a private place where she can call
6. Help her **solve any practical problems** that might interfere – for example, no transportation, no childcare

Know the legal & policy context

Know the law & policy that affects the care you give (content to be developed by country)

- Laws that cover:
  - **sexual violence**, including rape, sexual harassment, child sexual abuse
  - **intimate partner violence**

– continued –

Know the legal & policy context

— continued —

What laws & policies say about:

- **abortion** services for survivors of violence
- **limits to access** to abortion, emergency contraception
- age of **sexual consent**
- age of **parental consent** for adolescents' care

— continued —

Know the legal & policy context

— continued —

What are the legal or policy **obligations**

- — requiring **health care** for survivors
- — mandatory **reporting** to police
- — who is authorized to perform **forensic exams** and testify in court?
- — **confidentiality** of information and data sharing

Exercise 7.1: The Web of Referrals

- **Learning objective for this exercise:**
  Appreciate how uncoordinated systems and too much specialization can make referrals burdensome for the survivor

Exercise 7.1: The Web of Referrals

- In this role play we will follow “Rose” as she seeks help for intimate partner violence
- We need 10 volunteers. Will one please volunteer to play “Rose”? The others will play people she visits and who refer her to others.
- Rose will ask each person she visits to take hold of the string that she carries

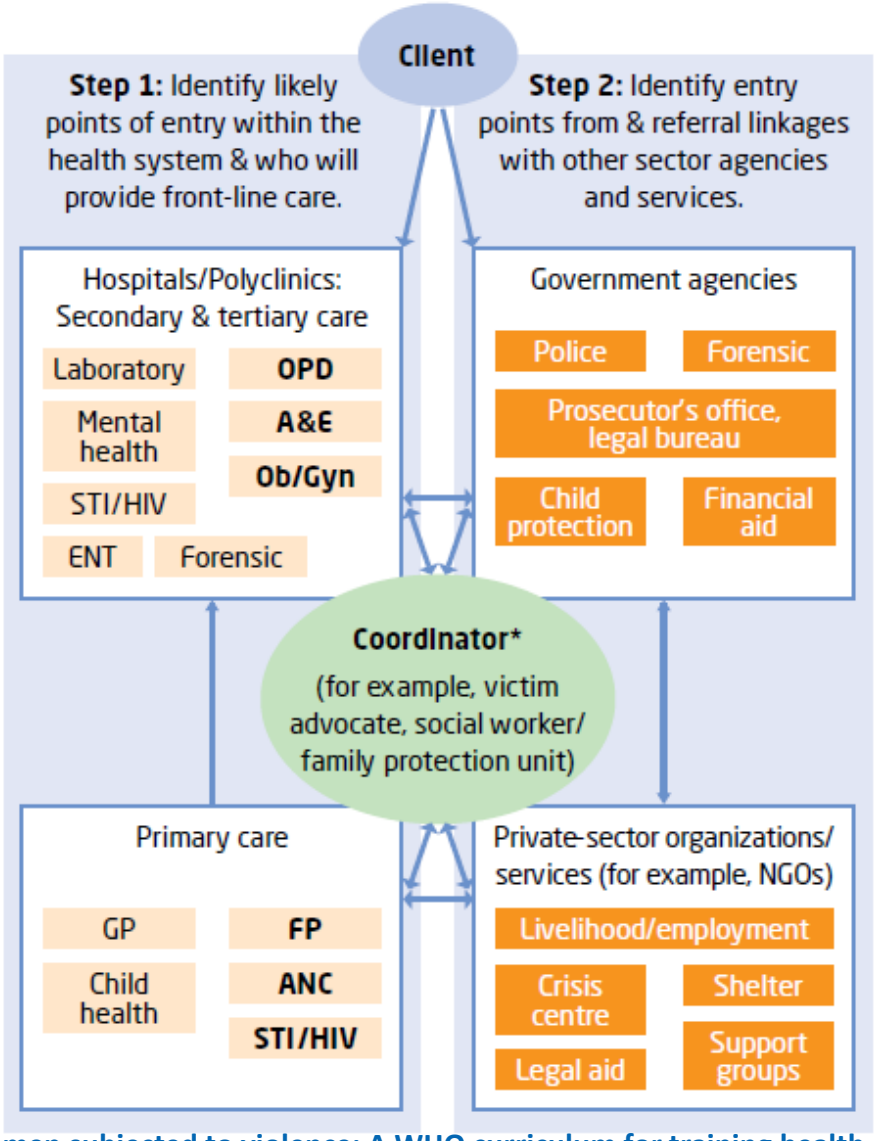
Exercise 7.2: Drawing the ideal referral pathway

Learning objective for this exercise: Think through how to draw a referral pathway for your locality.

1. Brainstorm what services/supports a woman might need and identify what formal and informal support is available
2. Specify possible referral paths

Job aid 8.1

Steps for developing your referral pathways for care of women subjected to violence



Job aid, manager's manual pages 91–93

Step 3: Identify the person/unit responsible for coordinating* access to care and services and the contact details.

*See Annex 4 for coordinator's role and responsibilities including terms of reference/job description.

The services that are highlighted in bold are the likely entry points within the health system for providing front-line care.

Job aid, manager's manual pages 91–93

Step 4: Specify roles and responsibilities, name, contact details, and forms to be used between referring and receiving unit.[1]

Role of referring unit (i.e. Health Facility)

- maintains an updated referral directory with contact details of referral services[2]
- identifies client
- provides ongoing treatment
- refers client for services not provided onsite
- follows up with client and receiving organization
- documents referral activity[3]
- conducts quality assurance.

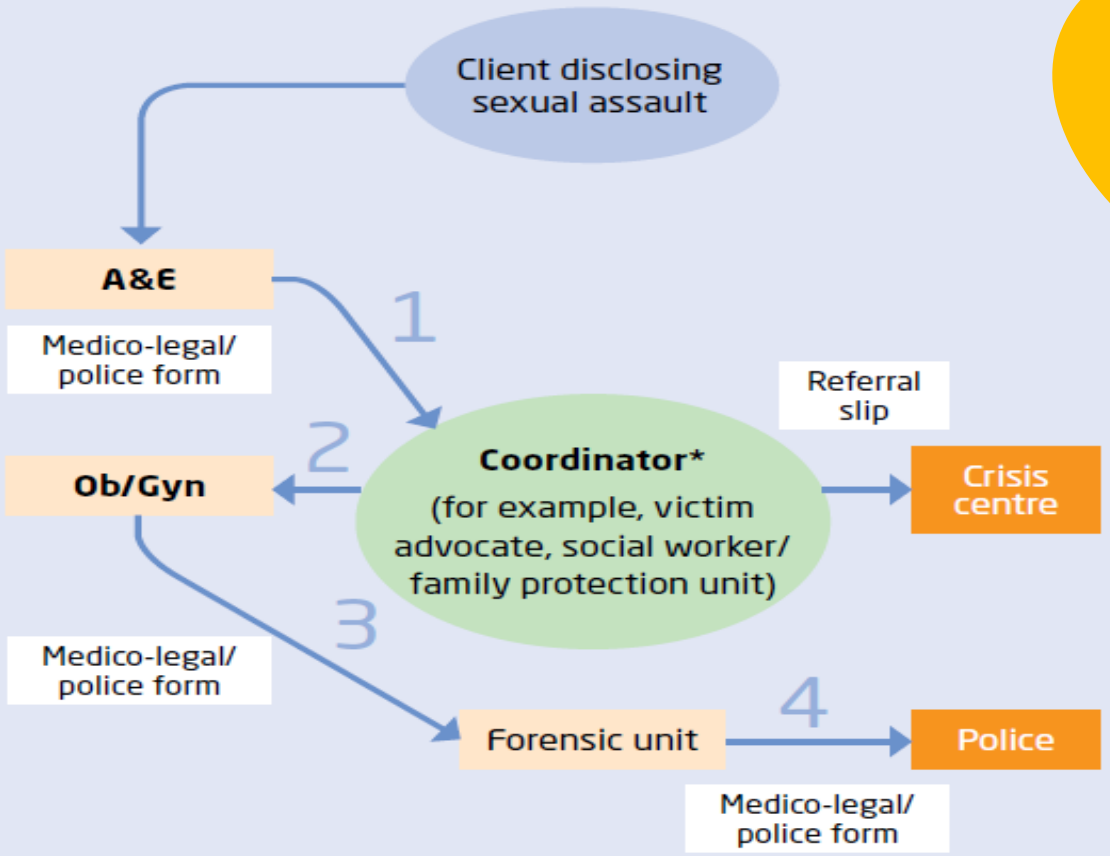
Role of receiving unit

- receives client
- provides service
- documents service
- refers clients to other needed services.

Roles & Responsibilities can be formalized in an MOU[4] &/or protocols/SOPs

Step 5: Specify the sequence in which referrals will be provided to other services (for example, for sexual assault survivors — from accidents and emergencies to coordinator to gynaecologist to forensic unit to police. See example below.) This sequence may be different for survivors of intimate partner violence.

Step 6: Specify the forms that will be shared/passed between services (for example, police/medico-legal forms, referral slips/ forms).



Job aid, manager's manual pages 91–93

Key messages

- Active and up-to-date **referral networks** and **warm referral practices** help women reach care
- Make referral agreements with **known resources**
- Referral pathways should:
  - respect **self-determination**
  - **minimize points of care** and retelling the story
  - maintain **confidentiality and safety**
- Know the relevant **laws & policies**

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Session 8

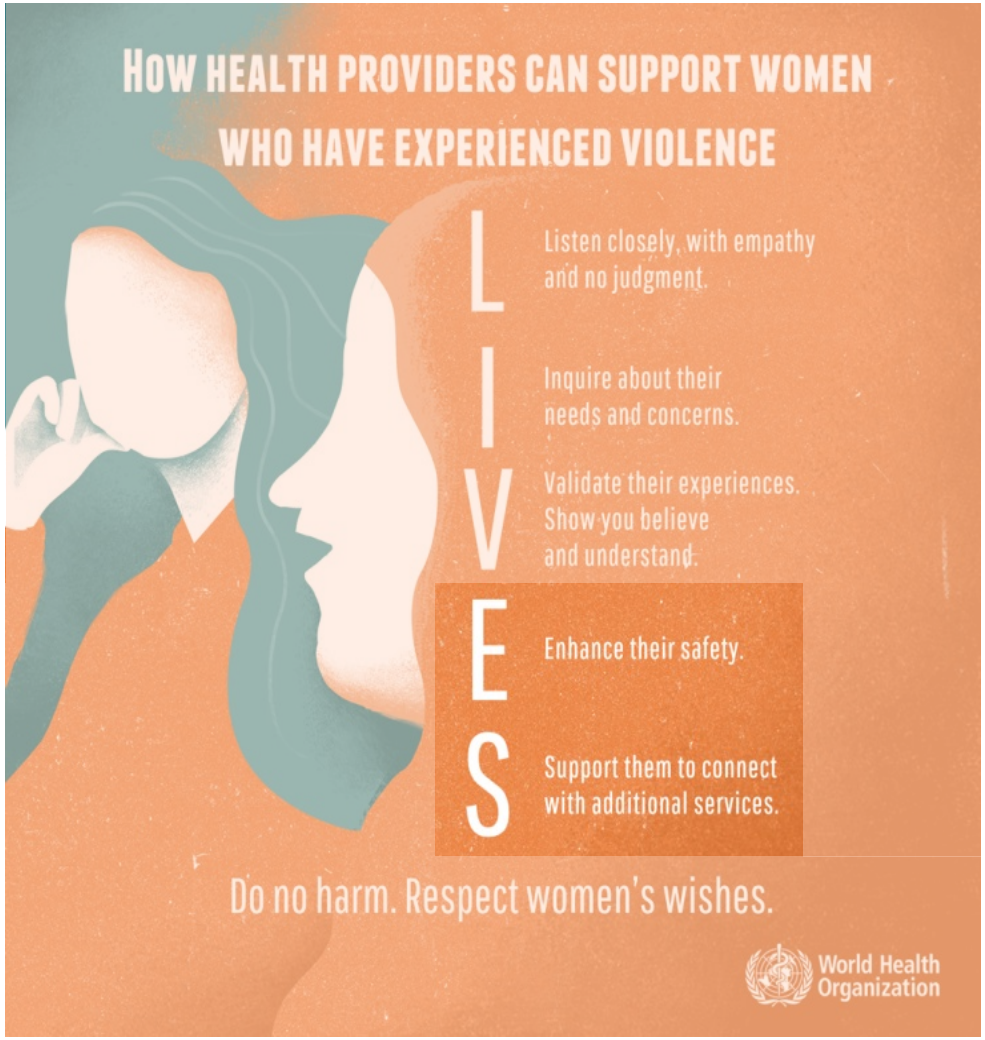
First-line support using (LIV)ES, part 2: Enhancing safety and providing Support

Learning objectives

Objective 4: Demonstrate knowledge of how to access resources and support for patients and for oneself

Competencies

- Demonstrate the skills to assess immediate risk/safety and to support safety planning
- Know what resources are available in the community
- Know how to collaborate with referral partners to help survivors obtain other services
- Demonstrate skills to provide warm referrals



Learn to listen with your

Eyes – giving her your undivided attention

Ears – truly hearing her concerns

Heart – with caring and respect

Enhance safety

Assess safety after sexual assault or episode of partner violence

- Discuss whether it is safe to go home

Assess immediate risk of partner violence

- Find out whether there is immediate risk of serious injury or it is safe to go home (see next slide)

Assess safety after partner violence

Job aid, handbook page 26

Questions to assess immediate risk

Women who answer **"yes" to at least 3** of these questions may face especially high immediate risk

1. Has the violence happened **more often or gotten worse** over the past 6 months?
2. Has he ever used a **weapon** or threatened you with a weapon?
3. Has he ever tried to **strangle** you?
4. Do you believe he could **kill** you?
5. Has he ever beaten you when you were **pregnant**?
6. Is he violently and constantly **jealous** of you?

Enhance safety after partner violence

If NOT safe:

- help make a **safety plan**
- make **referrals** (for example, shelter, safe housing) or help identify a **safe place** where she can go

See safety plan **job aid**, handbook, page 27

Enhance safety

Avoid putting her at risk

- Talk about abuse only when you and she are alone
- Maintain confidentiality of health records
- Discuss how she will explain where she has been and what to do with any paperwork that she will take home

Facilitating social support

- Help her to identify and consider her options, and what is most important to her
- Use and update a referral directory
- Discuss her social support – she may prefer to rely on her informal network
- Connect her to resources through warm referrals

See slides 7& 8 in Session 7

Exercise 8.1: Enhance safety facilitate Support

Learning objective for this exercise

Develop skills in providing the E and S elements of LIVES first-line support

Exercise 8.1: Role play: Enhance safety, facilitate Support

- Divide into groups of 3. In each group choose roles: patient, health-care provider and observer.
- **Patient:** Read the scenario to yourself. Don't tell the others the details. When asked, read aloud the part **"Explain to provider"**. Describe your situation and answer the provider's questions.
- **Health-care provider:** Listen to the patient's disclosure and provide first-line support – **E**nhance safety and access **S**upport
- **Observer:** Provide feedback to the provider
- Then, switch roles in your group and role-play the other scenario

Time: 10 minutes for each role play, 5 minutes for feedback and discussion

Key messages

- Risk assessment gauges immediate safety needs
- Trust your patient when she says that she faces severe danger
- Linking her to support services is a core activity
- Referrals should always respond to her stated needs
- As much as possible, make warm referrals
- Empathic, active communication is the most effective and comfortable for both of you

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Session 9

Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination

Learning objective

Demonstrate clinical skills appropriate to one's profession and specialty to respond to VAW

Competencies

For care of sexual assault/abuse survivors,

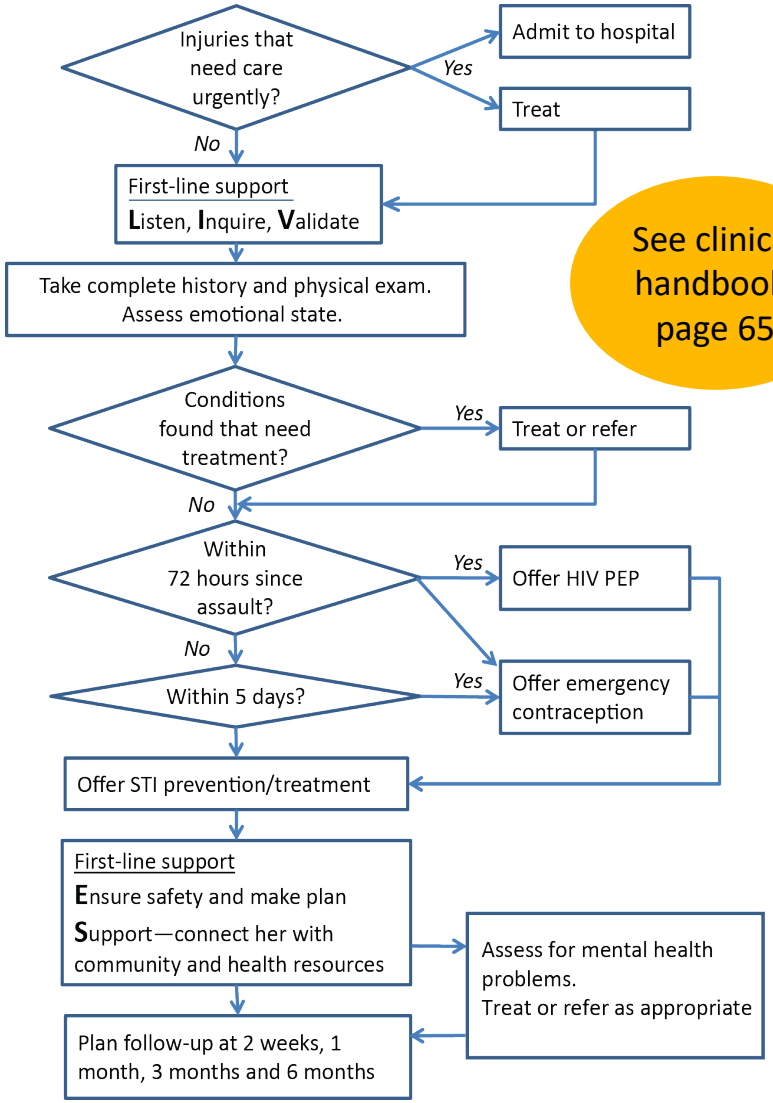
- Demonstrate skills to take history
- Know how to conduct physical examination
- Know when to collect forensic evidence and how to support or facilitate this

Summary protocol: Pathway for initial care after sexual assault

Immediately refer patient with injuries that need urgent care.

Otherwise:

1. First-line support: **L**isten, **I**nquire, **V**alidate
2. Take history, examine, assess emotional state, PLUS do forensic exam if needed
3. Treat any physical injuries
4. Offer PEP for HIV prevention (within 72 hours)
5. Offer emergency contraception (within 5 days)
6. Offer STI prophylaxis/presumptive treatment
7. First-line support part 2: **E**nhance safety, facilitate **S**upport
8. Assess mental health, discuss self-care & plan follow-up visits



See clinical handbook, page 65

Overview

1. Take the history
2. Prepare for physical examination
3. Conduct head-to-toe physical examination
4. Conduct forensic examination – when & what to tell her
5. Treat

General tips

- **Maintain respectful attitude**, calm voice, eye contact as culturally appropriate
- **Ask for consent separately** for history-taking, examination, forensic evidence collection and for reporting/sharing of evidence
- **Avoid distraction** and interruption
- **Take time** to collect all needed information

History-taking

Purposes

- To **guide exam** so injuries can be found and treated
- To **assess risk** of pregnancy, STIs, HIV
- To **guide specimen collection and documentation**

Four parts to history

- General medical information
- History of assault
- Gynaecological history
- Assessment of mental state

Taking history of assault

✓ **Review any papers**

✓ **Explain why asking**: to provide best care

✓ Ask **open-ended** questions

✓ **Listen empathically**

✓ Let her **speak in her own words** at her own pace

✓ Assure **confidentiality**

Avoid

✗ **asking** questions **already answered**

✗ **forcing her to talk** about the assault

Date of incident: _____/_____/____ DD MM YY	**Time of incident:**
Could you tell me what happened, please? Has something like this happened before? ☐ Yes ☐ No If "yes": When was that? _____/_____/____ DD MM YY Was the same person responsible this time? ☐ Yes ☐ No	

Physical violence	**Describe type and location on body**
Type (beating, biting, pulling hair, strangling, etc.)	
Use of restraints	
Use of weapon(s)	
Drugs/alcohol involved	

In cases of sexual assault	**Penetration**	**Yes**	**No**	**Not sure**	**Describe (oral, vaginal, anal)**
	Penis	☐	☐	☐	
	Finger	☐	☐		
	Other (describe)	☐	☐		
	Ejaculation	☐	☐	☐	
	Condom used	☐	☐	☐	

Form, handbook pages 89–98

Assess mental state

	Ask	Observe (but don't judge)
Appearance & behaviour		Clothing, hair Agitated, distracted, restless? Signs of substance abuse
Mood	How do you feel?	For example, calm, crying, angry, anxious, very sad, without expression
Speech		For example, silent, speaking clearly or with difficulty, confused, speaking very quickly or slowly
Thoughts	Have you thought about hurting yourself? Do bad thoughts or memories keep coming back? Do you see the event over and over in your mind?	

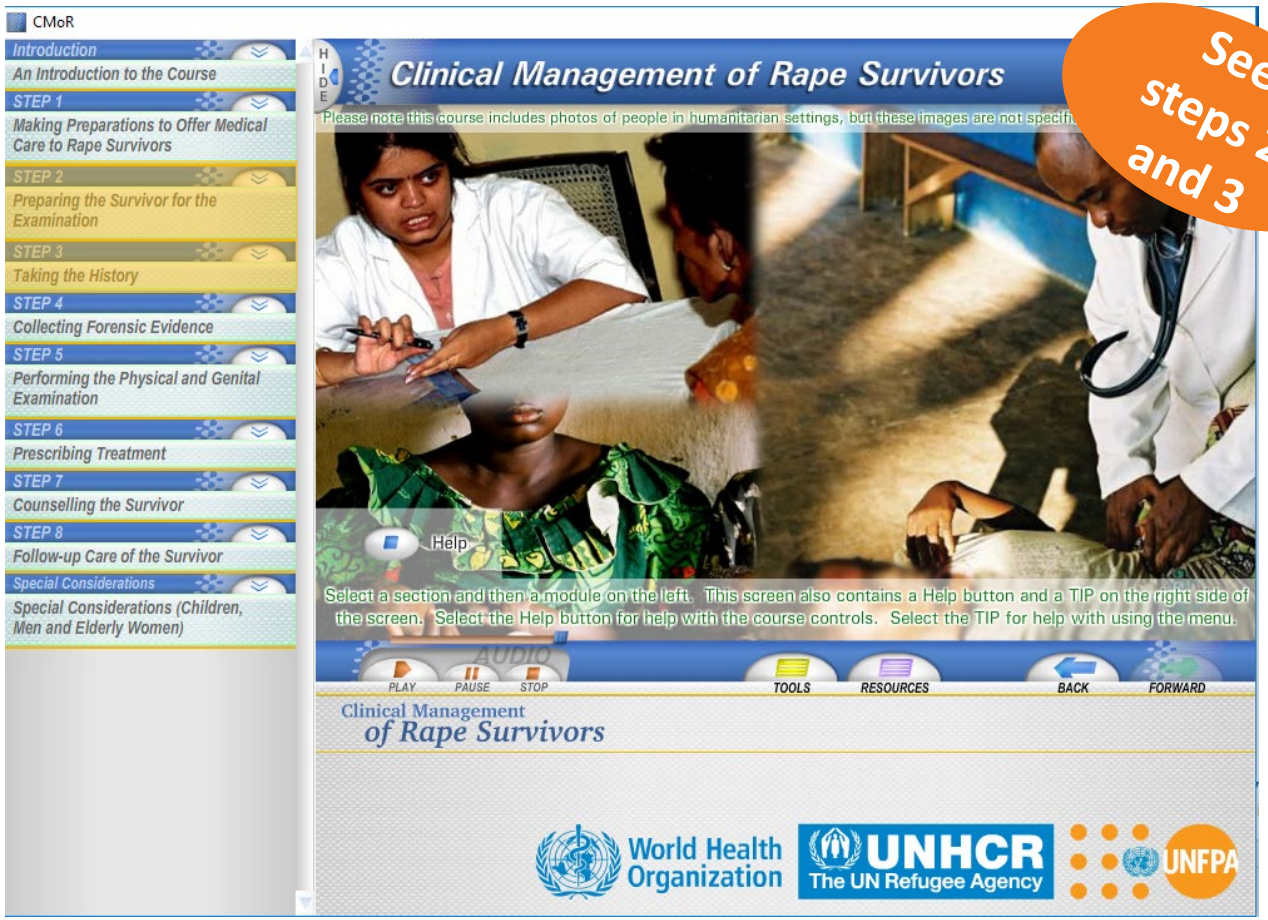
Discuss reporting to the police

If…	Then tell her…
…the law requires you to report to police	…you will be doing this, what you must report & to whom
…she wants to make a report to the police	…forensic evidence must be collected …what evidence collection involves
…she has not decided whether to go to the police	…evidence can be collected and held

For children & adolescents

- Assess implications of reporting for health & safety
- Explain obligation to report & limits of confidentiality
- Attention to confidentiality if care-giver is perpetrator

e-Learning on clinical management



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Prepare for the exam

1. Communicate

- ✓ Step-wise informed consent
- ✓ Specific support desired? (for example, friend, family member)
- ✓ Choice of sex of provider

2. Have an observer present

- ✓ Preferably a trained support person or female health worker
- ✓ Introduce and explain role of observer
- ✓ Besides the observer, keep the number of people to a minimum

Physical exam: Communicate

- Explain **purpose** of physical exam
- Women are likely to be **sensitive** to being examined/touched
- Assure her that **she is in control**
- **Look** at the woman before you touch her
- At each step, **tell her** what you are going to do, and **ask permission** first
- **Ask often** if she has any questions and if you can proceed

When should a forensic exam be done?

Only when:

- ✓ Forensic science **lab** is available
- ✓ Woman has come **within 7 days** after the rape
- ✓ Woman wants to report the case to the **police** or reporting is mandatory
- ✓ Trained health-care **provider** is available
- Only medico-legal evidence that can be collected, stored and analyzed should be gathered

End Virginity Testing

Health care professionals must never perform or recommend virginity testing.

The hymen is a poor marker of penetrative sexual activity or virginity in post-pubertal girls

Exercise 9.1: Role play on history-taking

Learning objective for this exercise: Develop skills for history-taking in a sexual assault incident

Instructions

- Divide into groups of 3. In each group choose roles: patient, patient's mother and health-care provider. Read your character description to yourself.
- *Health-care provider:* Listen to the patient's account and then ask about the history of the sexual assault, prepare the survivor for examination and record findings on the form
- Then, switch roles in your group and repeat the role play two more times

Time: 10 minutes for each role play

Key messages

- **History** determines the examination, forensic evidence collection and treatment
- Before taking the history, providers should explain any **obligations** to report and the **limitations** of confidentiality
- Obtain consent **separately** for each aspect of the exam
- Collect forensic evidence only when all **4 conditions** are met

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Session 9a

Forensic Examination (supplemental)

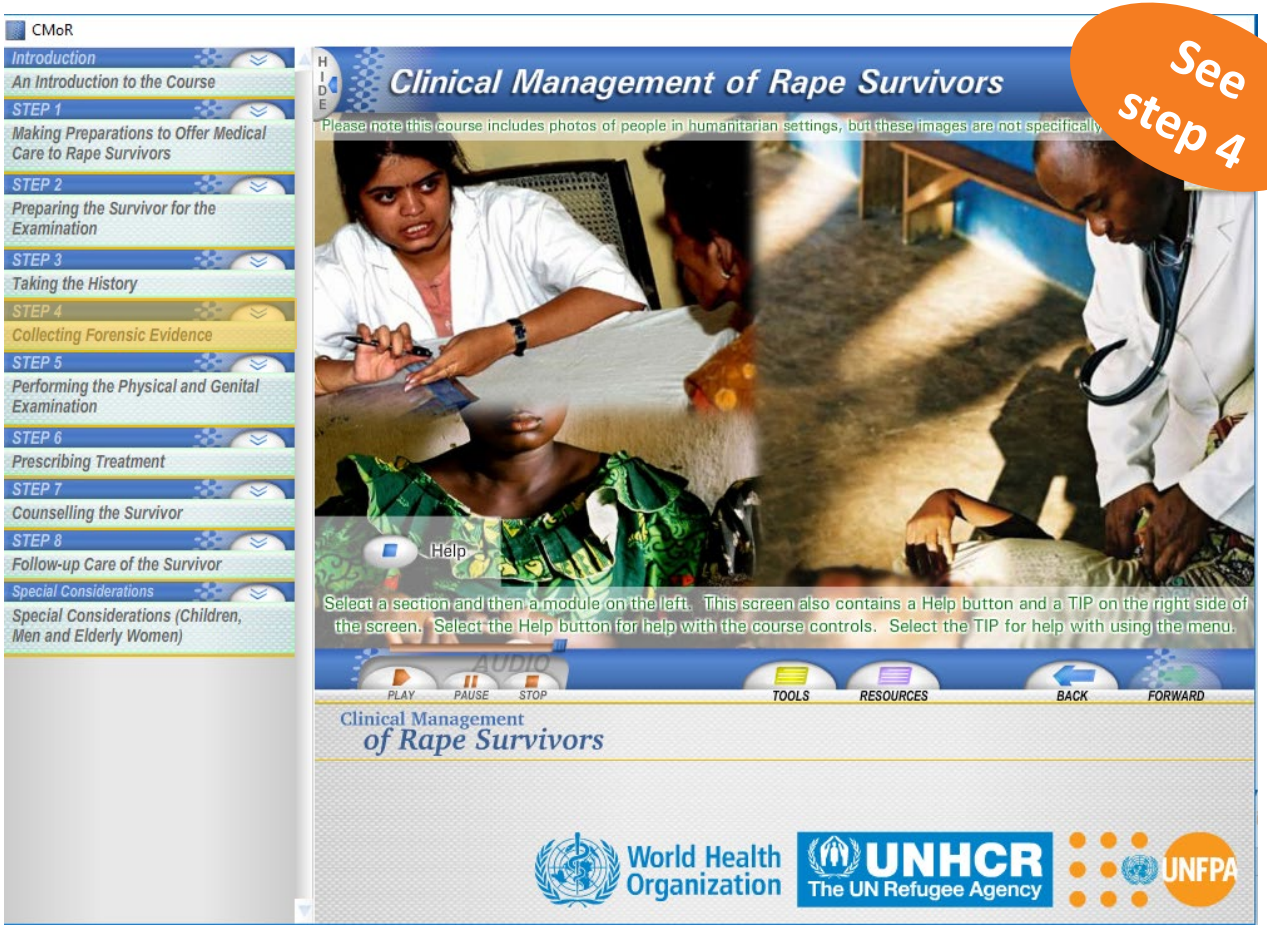
Learning objective

Demonstrate clinical skills appropriate to one's profession and specialty to respond to VAW

Competencies

- Know how to conduct a medico-legal (forensic) examination
- Know when and how to collect forensic evidence

Demonstration: Forensic examination



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Review the legal & policy context

- **Who** can examine?
  - What is the minimum training required?
  - Who can act as expert witness in court?
- **What forms** are required to document forensic evidence?
  - Who keeps these or where are they kept?
  - Who can issue/sign a medico-legal certificate?
  - Who gets a copy of the certificate and where are the copies kept?

— continued —

Review the legal & policy context

— continued —

- **Reporting**
  - What are requirements for reporting to authorities?
- **Storing and laboratory facilities**
  - What samples and evidence can be stored and analyzed & in what time frame?
  - What are the laws/policies regarding the chain of custody of the samples?

When should a forensic exam be done?

Four conditions must be met:

- ✓ Woman wants to go to the **police** or it is mandatory
- ✓ Woman has come **within 7 days** after sexual assault
- ✓ Health-care **provider** trained in forensic examination is available
- ✓ Forensic science **laboratory** is available

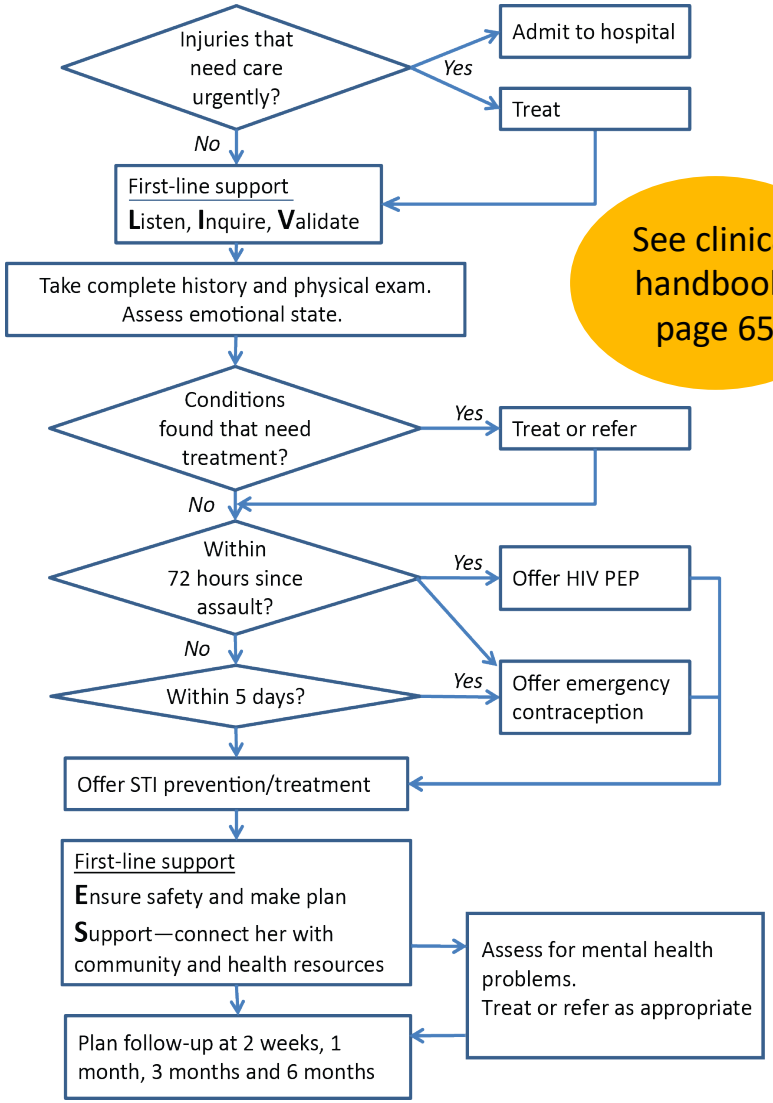
The physical health and emotional well-being and safety of the survivor should be the primary consideration.

Summary protocol: Pathway for initial care after sexual assault

Immediately refer patient with injuries that need urgent care.

Otherwise:

1. First-line support part one: Listen, Inquire, Validate
2. **Take history, assess emotional state, head-to-toe physical exam PLUS forensic examination**
3. Provide treatment (injuries, PEP, STI prophylaxis, EC)
4. First-line support part 2: Enhance safety, arrange Support
5. Assess mental health, discuss self-care & plan follow-up visits.



See clinical handbook, page 65

Overview: History-taking, conducting physical and forensic examination

1. History-taking (Session 9)
2. Prepare for physical examination (Session 9)
3. Conduct a head-to-toe physical examination (Session 9) PLUS
4. **Conduct full forensic exam/specimen collection when doing the physical examination** (this session – 9a)

General tips

- ✓ Only providers that are **specifically trained and have been supervised** doing itshould undertake full forensic examination
- ✓ Only medico-legal evidence that can be collected, stored and analyzed should be gathered
- ✓ Obtain **separate consent** for collecting forensic evidence including any photographs
- ✓ The head-to-toe physical exam is primarily for medical care, but it is also useful for documentation of forensic evidence
- ✓ **Documentation** of injuries can provide important evidence

Job aid for head-to-toe examination

Physical exam checklist *(job aid)*	
Look at all the following	**Look for and record**
• General appearance • Hands and wrists, forearms, inner surfaces of upper arms, armpits • Face, including inside of mouth • Ears, including inside and behind ears • Head • Neck • Chest, including breasts • Abdomen • Buttocks, thighs, including inner thighs, legs and feet	• Active bleeding • Bruising • Redness or swelling • Cuts or abrasions • Evidence that hair has been pulled out, and recent evidence of missing teeth • Injuries such as bite marks or gunshot wounds • Evidence of internal traumatic injuries in the abdomen • Ruptured ear drum

Job aid, handbook page 47

Physical examination form

Form, handbook pages 89–98

Weight	Height	Pubertal stage (pre-pubertal, pubertal, mature)	
Pulse rate	Blood pressure	Respiratory rate	Temperature

Physical findings

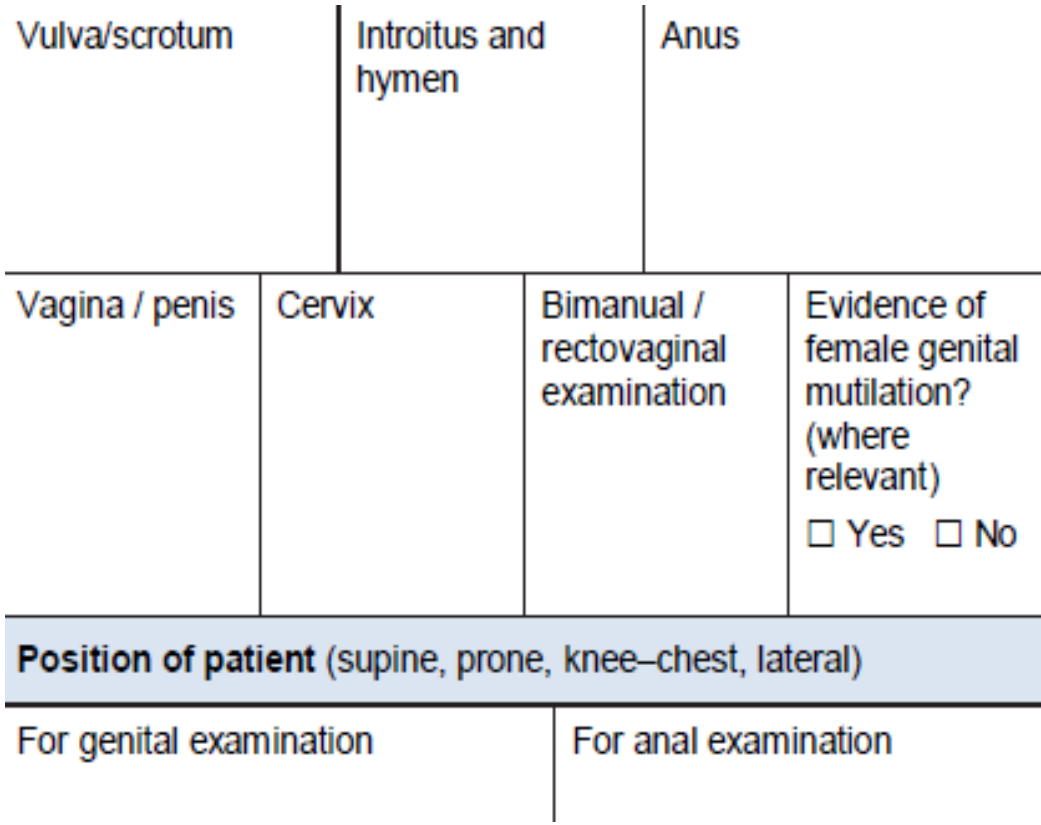
Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae (signs of bleeding under the skin), marks, etc. Document type, size, colour, form and other particulars. Describe as completely and accurately as possible. Do not interpret the findings.

Head and face	Mouth and nose
Eyes and ears	Neck
Chest	Back
Abdomen	Buttocks
Arms and hands	Legs and feet

Job-aid: genito-anal examination

Genito-anal examination checklist	
Look at all the following:	**Look for and record:**
• Genitals (external) • Genitals (internal examination, using a speculum) • Anal region (external)	• Active bleeding • Bruising • Redness or swelling • Cuts or abrasions • Foreign body presence

Job aid, handbook page 47



Form, handbook pages 89–98

End virginity testing

- Hymen is a poor marker of penetrative sexual activity or virginity in post-pubertal girls
- Digital examination of anus or vagina is rarely warranted and not an indication of likelihood or frequency of penetration

What specimens to collect?

- The **woman's account** of the assault guides what specimens to collect
- Health (pathology) versus legal (forensic) specimens
  - **Pathology specimens** – diagnose or monitor a condition
  - **Forensic specimens** – for legal purposes
  - Some pathology specimens may have forensic importance (for example, evidence of STI)

— continued —

What specimens to collect?

— continued —

- **Clothing** (especially underwear)
- **Blood and urine samples** (e.g. to assess covert or non-consenting drug administration)
- **Hair** if suspicion of drug administration
- Specimens where **biological material** may have been **deposited**: skin, hair, mouth, vagina and anus
- **Photographs** – to document injuries

Time frame for specimen collection

- After a certain time or activity following the rape, not all evidence can be collected
- **Maximum times** for collecting evidence after assault:
  - skin, including bite marks – 72 hours
  - mouth – 12 hours
  - vagina – up to 5 days
  - anus – 48 hours
  - foreign material on objects (condom/clothing) – no time limit
  - urine (toxicology) 50 mL – up to 5 days
  - blood (toxicology) 2 × 5 mL samples – up to 48 hours in tubes containing sodium fluoride and potassium oxalate

Storage

- Carefully **label, store and record** chain-of-custody
- **Document** information about specimen – time, date, patient name/ID number, nature and site of collection
- **Dry and package** samples

Documentation

- Note **general appearance** and functioning of the patient
- Note **limitations** to the examination (e.g., poor lighting)
- Describe in detail all recent and old **injuries**, recording any negative findings
- Survivor should be informed that some injuries may become evident only **after a few days**. In that case she should return for examination and documentation.
- **Note** the specimens collected, photographs taken, tests ordered and treatments given
- Give detailed **explanation** of findings and treatment

Understanding forensic evidence

- **Signs of injury** in penetrative sexual activity are rare
  - Absence of injury to hymen does not rule out penetration
  - Penetration of pre-pubertal genitalia does not necessarily result in physical injury
- The health-care practitioner **cannot make any comment** on whether the activity was consensual or not

Providing testimony

- Health-care providers **may be called** to answer questions and provide documentation
- **Information** that authorities may need:
  - **Types of injury** (cuts, bruises, abrasions, fractures)
  - **Where** injury is on body and description of injury (length, depth, other characteristics)
  - Possible **cause** of injury (for example, gunshot, bite, use of restraints)
  - Immediate and potential long-term **consequences** of injury
  - **Treatment** provided

Exercise 9a.1: Decision-making on forensic evidence collection

Learning objective for the exercise

- To understand how to establish whether and when forensic evidence should be collected and what evidence should be collected

Exercise 9a.1: Decision-making on forensic evidence collection

- In groups of 6–8 **read** the scenario
- Based on the scenario, **discuss**:
  - What questions would you ask or what information would you need to determine how to proceed with the examination? Explain why.
  - What forensic evidence would you collect? Explain why.
- **Document** responses, including the "why", in the table

Time: 15 minutes

Key messages

- Collect forensic evidence only when **all four conditions** are met
- **Separate consent** is needed for a forensic examination
- **Head-to-toe examination**, but NO vaginal/"two-finger test"
- The assault **history** guides forensic evidence collection
- **Time** elapsed and activities undertaken after the incident determines whether evidence can be found
- **Storage** that avoids contamination, **labelling** and detailed **documentation** are essential
- Health-care providers may need to provide testimony. They **cannot conclude** whether evidence points to rape. That is for the courts to establish.

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 10

Clinical care for survivors of sexual assault/rape, part 2: treatment and care

World Health Organization

Learning objective

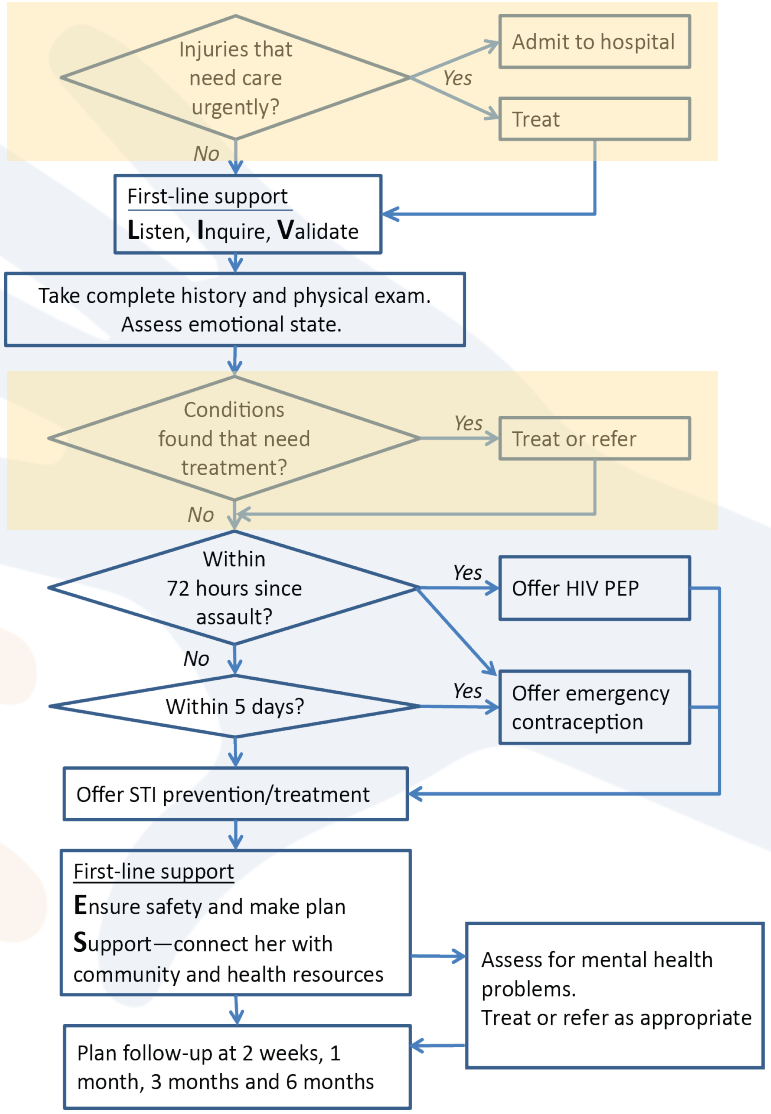
Demonstrate clinical skills appropriate to one's profession and specialty to respond to VAW

Competencies

- Know how to provide appropriate treatment/care to survivors of sexual assault, including rape and abuse

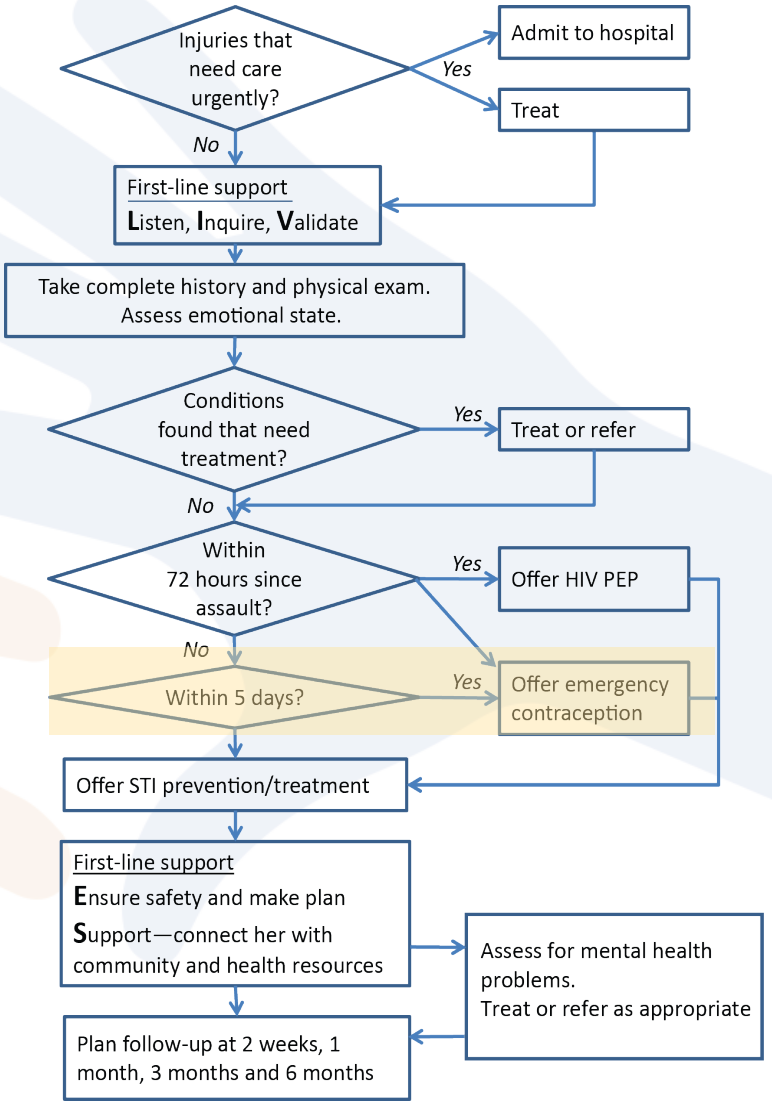
Treatment for injuries

- **Urgent hospitalization** if:
  - extensive injury
  - neurological deficits
  - respiratory distress
  - swelling of joints on one side of the body (septic arthritis)
- **Less severe injuries** can usually be treated on site.
- The following **medications** may be indicated:
  - antibiotics to prevent wound infection
  - tetanus booster or vaccination
  - medications for pain relief
  - medication for insomnia (for short-term use in exceptional cases)



Offer emergency contraception (EC)

- **Offer EC to all** women who have been raped
- **No need to screen for health conditions** or test for pregnancy
- **"Return if** your next menstrual period is **more than 1 week late"**



Instructions for taking EC

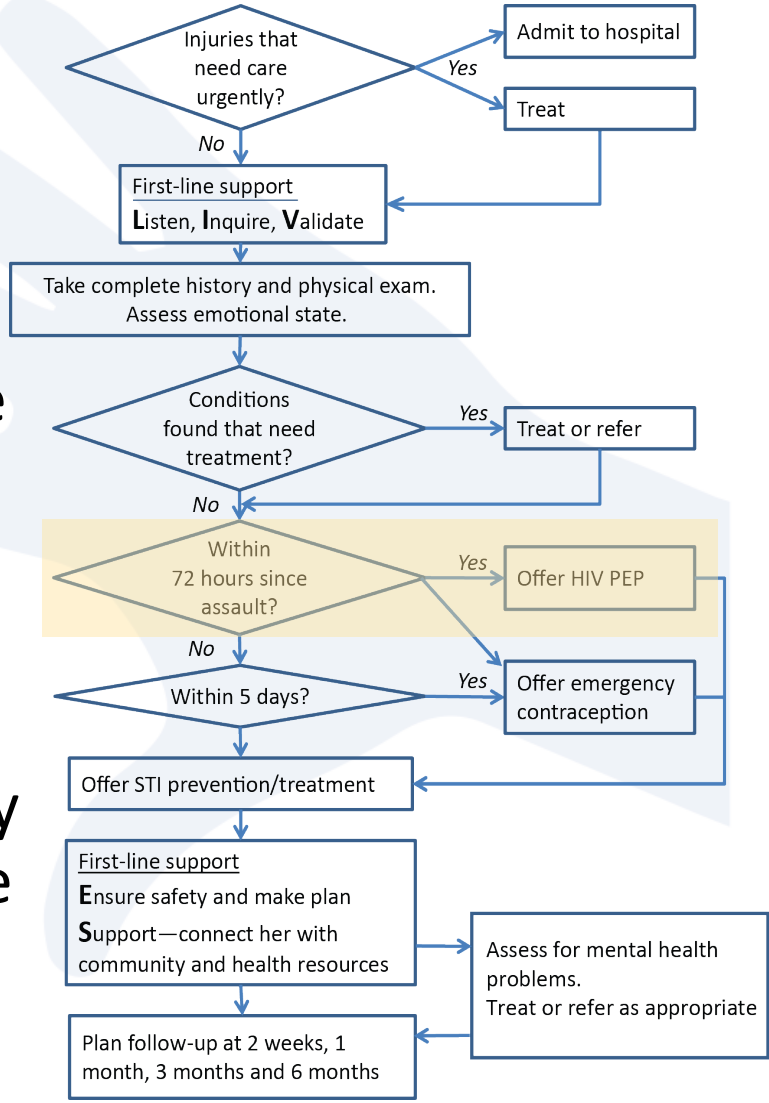
- Take EC pills **up to 5 days after** sexual assault
- May cause **nausea** and **vomiting**. If you vomit within 2 hours after taking EC pills, return for another dose as soon as possible.
- May have **spotting** or **bleeding** a few days after taking EC pills. This is normal.
- **EC pills**, **antibiotics** for STIs and **PEP** for HIV prevention can be taken at same time without harm (but may need to take an anti-vomiting medication)

Counselling on EC

- **Explain EC** and how it works – by stopping release of the egg.
- EC can help avoid pregnancy, but it is **NOT 100% effective.**
- EC will **NOT cause abortion**. If she is already pregnant, EC pills will not harm the pregnancy.
- EC pills will **NOT prevent pregnancy the next time** she has sex.
- EC pills are **NOT meant for regular use.** More effective continuing contraceptive methods are available.
- A **pregnancy test** may show if she was already pregnant. She can have a test if she wishes, but it is not necessary before taking EC.
    - For those who are already pregnant as a result of rape, discuss options including for accessing safe abortion to the full extent of the law

Offer PEP for HIV prevention

- **Test for HIV**. Do not give PEP (pre-exposure prophylaxis) to those who test positive for HIV.
- **PEP** should be started as soon as possible **up to 72 hours** after possible exposure to HIV
- Choose drugs based on **national guidelines/ current WHO ARV guidelines**
- In high HIV prevalence settings, it may be appropriate to offer PEP to all rape survivors coming within 72 hours
- A 28-day prescription of ARVs should be provided



PEP procedure depends on situation

Situation/risk factor	Suggested procedure
Perpetrator is HIV-infected or of unknown HIV status.	Give PEP
Her HIV status is unknown	Offer HIV testing and counselling
Her HIV status is unknown and she is NOT willing to test	Give PEP; plan follow-up
She is HIV-positive	Do NOT give PEP
She has been exposed to blood or semen (through vaginal, anal or oral intercourse or through wounds or other mucous membranes)	Give PEP
She was unconscious and cannot remember what happened	Give PEP
She was gang-raped	Give PEP

Handbook page 55

Deciding about PEP

Discuss these points to help her decide whether HIV PEP is appropriate:

- Whether **HIV is common** in that setting
- Whether she knows if **perpetrator is HIV-positive**
- Whether there was **more than one** perpetrator
- Whether the exam found **lacerations**
- PEP lowers chances of HIV infection but is **not 100% effective**
- Medicine must be **taken daily for 28 days**
- Half of people who take PEP have **side-effects** (nausea, tiredness, headaches). For most, these decrease after a few days.

PEP follow-up and adherence support

- Support adherence to PEP through, for example, calls or messages if safe and appropriate.

- **Retest** for HIV at 3 or 6 months or at both times.

- **If test result is positive:**
  - Refer for HIV treatment and care
  - Ensure follow-up at regular intervals

Offer STI prophylaxis/treatment

- **Test** if lab available, even if treating for STIs
- Give antibiotics to prevent or treat these STIs: **chlamydia**, **gonorrhoea**, **trichomonas** and, if common in the area, **syphilis**
- Also give preventive treatment for **other STIs common in the area** (such as chancroid)
- Give the **shortest courses available** in national protocol

STI treatments (fill in)

STI	Medication	Dosage and schedule
Chlamydia		
Gonorrhoea		
Trichomonas		
Syphilis (if common locally)		
Other locally common STIs (fill in)		

Job aid, handbook page 53

Prevent hepatitis B and, for adolescent girls, offer HPV vaccination

Has she been vaccinated for hepatitis B?	
NO OR **does NOT know** and **test not possible**	**1st dose**: at 1st visit **2nd dose**: 1–2 months after the 1st dose **3rd dose**: 4–6 months after the 1st dose
STARTED but has **not completed** series	Complete the series as scheduled
YES, completed series	No need to re-vaccinate

Has girl age 9–14 been vaccinated for HPV?	
NO OR **does NOT know**	**1st dose**: at 1st visit **2nd dose**: 6–12 months after 1st dose
STARTED but has **not completed** series	Complete the series as scheduled
YES, completed series	No need to re-vaccinate

Discuss self-care and plan follow-ups

Explain examination findings and treatment

- Invite her to voice questions and concerns

Care of injuries

- Show how to **care for any injuries**
- Describe signs & symptoms of **wound infection.** Ask her to return if these signs develop.
- Explain importance of **completing the course of medications**
- Discuss likely **side-effects** and what to do about them

Treatment of STIs

- Discuss signs & symptoms of STIs. Advise her to return if they occur.
- Avoid sexual intercourse until STI treatments finish

Exercise 10.1: Sexual assault treatment decisions

Learning objective of this exercise: To improve clinical decision-making on treatments for sexual assault survivors.

- Each group selects a rapporteur to present back to plenary
- Groups have 7 minutes per case study to discuss and fill out tables describing treatments to prescribe, tests to do and referrals to make and why
- After groups reconvene in plenary, rapporteurs will present one of their case studies (in 3–4 minutes) and explain their decisions

Key messages

- **Immediate treatment** includes first-line support and, as needed, treatment of injuries, EC, HIV PEP, STI prophylaxis and hepatitis B prevention
- Most survivors don't come in time for PEP (first 72 hours) or EC (first 120 hours)
- All survivors still need **first-line support (LIVES)**, and some may need additional **mental health care**
- Providers need to determine the **history** of the assault, and what has happened since, to decide on tests and treatments

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 11

Documenting intimate partner violence and sexual violence

Learning objectives

Demonstrate clinical skills appropriate to one's profession and specialty to respond to VAW

Competency

- Know how to document VAW in a safe and confidential manner

SOPs to assure confidentiality

SOPs should specify:

- where and how to **record** and **store** information
- what information will be **shared** with whom (including chain of custody for forensics)
- how **confidentiality** is kept, including who has access to records
- what information will be **compiled and reported up**, and how often

Confidentiality in documentation: Managers assure that…

- Staff are **sensitized to confidentiality** and secure record-keeping
- Identifying information will **not be visible** or accessible to those not directly caring for the survivor
- A **coded or anonymous system** (for example, codes or symbols) indicates patients who are survivors of violence
- Files are stored in a **secure place**
- Only **designated staff members** have access to records
- Staff with access are **trained** in record confidentiality and storage practices
- Destruction/erasure of sensitive information is done only by **authorized staff**

Confidentiality in documentation: As a provider…

- Recognize that **keeping documentation confidential** is an important part of sensitive care
- **Explain** to the patient what you need to write down and why
- **Follow her wishes** if she does not want something written down
- **Do not ask** about violence or document it in a public place
- If you must report to the authorities, **explain** to the patient the limitations on confidentiality

— continued —

Confidentiality in documentation: As a provider…

— continued —

- **Do not write** any indication of violence on…
  - — first page of patient record
  - — other records that might be seen by those who don't need to know (for example, bed charts, X-ray slips)
  - — any record that the woman might take home
- Make sure documents are **not left out** where others can see
- Ensure that documents are **locked up** when not in use
- Share documentation and information **only with those who need to know**

Tips for documentation of sexual assault

1. Use **structured history and exam forms** to record findings and treatment
2. Obtain **consent** for documentation, including any photos
3. Information that **authorities may need**:
   - types of injuries
   - description of injuries, including place on the body
   - possible cause of injury
   - immediate and potential long-term consequences of injury
   - treatment provided

Note: Absence of physical evidence does not mean that sexual assault did not occur

Date of incident: _____/_____/____ (DD / MM / YY) | **Time of incident:**

Could you tell me what happened, please?

Has something like this happened before? ☐ Yes ☐ No

If "yes": When was that? _____/_____/____ (DD / MM / YY)

Was the same person responsible this time? ☐ Yes ☐ No

Physical violence	**Describe type and location on body**
Type (beating, biting, pulling hair, strangling, etc.)	
Use of restraints	
Use of weapon(s)	
Drugs/alcohol involved	

In cases of sexual assault	**Penetration**	**Yes**	**No**	**Not sure**	**Describe (oral, vaginal, anal)**
	Penis	☐	☐		
	Finger	☐	☐		
	Other (describe)	☐	☐		
	Ejaculation	☐	☐		
	Condom used	☐	☐	☐	

Job aid, handbook pages 89–98

Sample intake/record form

Date (dd/mm/yr) _____/_____/_____			**Client number**	
Client's family name			**Client's given name**	
Client can be reached at _____				
Sex	☐ F	☐ M	**Date of birth (dd/mm/yr)** ____/____/____	☐ Married/cohabiting ☐ Not married/ not cohabiting
Reporting	☐ Provider asked about violence	☐ Client disclosed/ reported violence	☐ Provider suspects violence	
Referred by (if first visit)	☐ Self	☐ Other health facility/unit (specify)	☐ NGO	
	☐ Family/ acquaintance	☐ Police	☐ Other government unit	

Job aid, manager's manual pages 147–149

Sample facility register

Date of consultation (dd/mm/yy)	Client number	Reporting (see codes)[1]	If first visit, referred by (see codes)[2]	Presenting symptoms/ conditions (Y, N)				Type of violence (Y, N)					Perpetrator (see codes)[9]	Assessments & clinical care provided to all survivors (Y, N)					Additional care given to rape survivors seen within 72 or 120 hours (Y, N)								External referrals (Y, N)								Provider's initials
				Injuries	Sexual/reproductive health conditions[3]	Mental/emotional problems[4]	Other (specify)[5]	Physical violence[6]	Sexual violence[7]	Rape (if arrived within 72 hours, add code "72")	Psychological/emotional[8]	Other (specify)		First-line support[10]	Safety assessment	Injuries & wound care	Tetanus prophylaxis	Other (specify)	Head-to-toe & genital examination	Emergency contraception	Pregnancy test	PEP for HIV	HIV test	STI prevention/treatment	Forensic evidence selected	Other (specify)	Clinical care at higher-level facility[11]	Crisis intervention/ counselling	Police	Shelter or housing	Legal aid	Child protection	Livelihood support	Other (specify)	
Totals																																		

[1] Codes for **Reporting**: Provider asked about violence (A); Client disclosed/reported violence (D); Provider suspects violence (S).

[2] Codes for **Referred by**: Self (S); Family/acquaintance (F); Other health facility/unit (OH); Police (P); NGO (N); Other government unit (OG).

[3] **Sexual/reproductive health conditions** include sexually transmitted infection (STI), unwanted pregnancy, vaginal bleeding, pelvic pain, sexual dysfunction, pregnancy terminations, adverse birth outcomes.

[4] **Mental/emotional issues** include symptoms of stress, anxiety, depression, post-traumatic stress disorder (PTSD), sleep disorders, suicidality or self-harm (including thoughts, plans, acts), misuse of alcohol or drugs.

[5] **Other symptoms** can include chronic headaches, pain syndromes, gastrointestinal problems, kidney and bladder infections, cognitive problems, hearing loss.

[6] **Physical violence** includes hitting, slapping, beating, kicking, shoving/pushing, hurting with a weapon.

[7] **Sexual violence** includes using force, intimidation or coercion to have sex or to perform sexual acts that the woman does not want. It also includes harming a person during sex. It includes **rape**, and attempted rape, which involves use of force, intimidation, coercion or drugs/alcohol to obtain penetration of the vulva/vagina, anus or mouth by one or multiple perpetrators including by an intimate partner.

[8] **Psychological/emotional violence** includes criticizing repeatedly, calling names or insults, threats to hurt loved … hat the person cares about, belittling or humiliation in public.

[9] Codes for **Perpetrator**: Intimate partner (IP); Family member in household (FH); Family member/acquaintance …

[10] First-line support includes basic counselling or psychosocial support that can be implemented using the **LIVES** … ing, **I**nquiring about needs and concerns, offering a **V**alidating response to survivor's experience, assessing and helping her … onnection to information, services and social support.

[11] **Referral to higher-level facility** could include, for example, care for mental health, forensic evidence collection or … anaged within the primary health facility.

Job aid, manager's manual pages 152–154

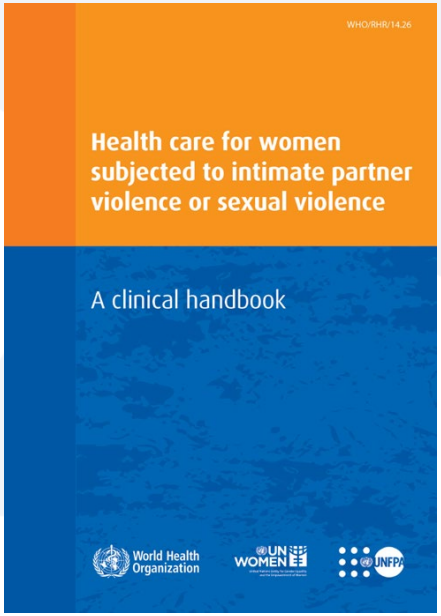
Key messages

- **Safety, confidentiality and privacy** are essential
- **Good documentation** is key to providing quality care & also for legal proceedings
- Health managers need to establish **SOPs** and facilitate providers' documentation
- Complete and easy-to-use **forms** improve documentation

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 12

Care for mental health and self-care for providers



Learning objectives

- Demonstrate clinical skills appropriate to one's profession and specialty to respond to VAW
- Demonstrate knowledge of how to access resources and support for patients and selves

Competencies

- Know how to provide basic mental health care
- Know how to access and practice self-care

True or false?

1. General health professionals should not ask about suicidal thoughts or attempts. It could encourage suicide attempts.
2. First-line support and teaching stress reduction exercises are part of basic psychosocial support for all survivors
3. Almost all women subjected to violence suffer from post-traumatic stress disorder (PTSD)
4. Difficulty functioning in daily life characterizes moderate to severe depression
5. Benzodiazepines and antidepressants should not be prescribed to treat acute distress

Offer basic psychosocial support

- Whether or not mental health care professionals are available, **front-line providers can provide basic psychosocial support**
- **You can:**
  - Offer first-line support (**LIVES**) at each meeting
  - Help strengthen her **positive coping methods**
  - Explore the availability of **social support**
  - Teach and demonstrate **stress reduction** exercises
  - Make regular **follow-up appointments** for further support

Strengthen positive coping

Encourage and help her to:

- Take **small, simple steps**
- Build on her **strengths and abilities**
- Continue **usual activities**
- Engage in **relaxing activities**, stress-reduction **exercises**
- Keep a **regular sleep** schedule
- Engage in regular **physical activity**
- AVOID self-prescribed medications, alcohol or drugs
- **Return** if you have thoughts of self-harm or suicide
- **Return** if these suggestions are not helping

What social support is available?

- **Connect with family and friends**
- Help her to identify **people that she trusts** and likes. Spending time with them can help her feel connected and supported.
- Help her to identify past **social activities or resources** that may help her get support/feel supported now
- Encourage her to **participate** in family gatherings, visit with neighbours, join in community and religious activities or other activities where she feels supported
- Collaborate with social workers, case managers or other trusted people in the community to **connect** her with resources for social support

Assess for more severe mental health conditions

- Risk of imminent suicide and self-harm
- Moderate-to-severe depressive disorder
- Post-traumatic stress disorder

Assess for risk of imminent suicide or self-harm?

- If she has:
  - **current thoughts** or **plan** to commit suicide or to harm herself **OR**
  - a **history of thoughts or plans** for self-harm in the past month or acts of self-harm in the past year, and she is now extremely agitated, violent, distressed or uncommunicative
- THEN:
  - **Refer her immediately** to a specialist or emergency health facility
  - **Do not leave her alone**

Assess for moderate-to-severe depressive disorder

Handbook pages 76–77

Has she had for at least 2 weeks?

- Persistent depressed mood **OR**
- Much diminished interest in or pleasure from activities previously enjoyed
- **AND**
- Difficulty functioning in daily life
- **AND** several of these symptoms:
- Sleep disturbances
- Change in appetite
- Beliefs of worthlessness or guilt
- Fatigue, loss of energy
- Reduced ability to concentrate or pay attention to tasks
- Indecisiveness
- Observable agitation or restlessness
- Talking, moving slower than usual
- Hopelessness about the future
- Suicidal thoughts or acts

Manage moderate–severe depressive disorder

1. Offer **psychoeducation**
   - Explain: “Depression is a very common. It can happen to anybody. You are not to blame.”
   - Suggest activities that improve mood
   - “If you notice thoughts of self-harm or suicide, do not act on them. Instead, tell a trusted person and come for help immediately.”
2. Strengthen her **social support** and teach **stress management**
3. Consider referral for **brief structured psychological treatments** if available
4. Prescribe antidepressants only if you are trained in their use
5. Offer **regular follow-up**

Assess for post-traumatic stress disorder

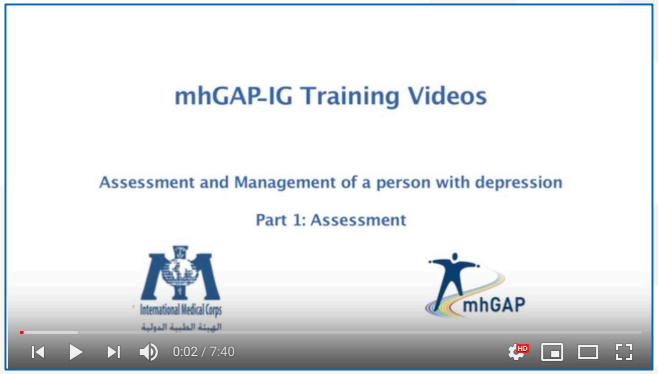
Handbook page 82

- A person with PTSD may have **non-specific symptoms** …
  - Sleep problems (for example, lack of sleep)
  - Irritability, persistent anxious or depressed mood
  - Multiple persistent physical symptoms with no clear physical cause (for example, headaches, pounding heart)
- … and, on further questioning, she may report **characteristic PTSD symptoms**:
  - **Re-experiencing**: repeated and unwanted recollection of the violence
  - **Avoidance**: deliberate avoidance of thoughts, memories, activities or situations that remind her of the violence
  - **Heightened sense of current threat**, such as excessive concern and alertness to danger or reacting strongly to unexpected sudden movements
  - **Difficulties in day-to-day functioning**
- If all 4 are present **approximately 1 month after the violence**, PTSD is likely

Manage PTSD

1. **Educate her about PTSD:** common feelings, fears, recollections, physical problems, the role of treatment, etc.
2. Strengthen **social support** and teach **stress management**
3. If trained **therapists** are available, consider referral for:
   cognitive behavioural therapy with a trauma focus (CBT-T)
   or
   eye movement desensitization and reprocessing (EMDR)
4. Prescribe **antidepressants** only if trained in their use
5. **Consult a specialist** if CBT-T or EMDR is not available OR when at risk of imminent suicide/self-harm
6. **Offer regular follow-up**: 2nd appointment at **2–4 weeks** and later appointments as needed

Links to WHO mhGAP training videos



Depression assessment

Depression management

Depression follow-up

Suicide

Take care of your own needs, too

- **Your emotional health** is important, too
- You may have strong **reactions or emotions** when listening to or talking with women about violence...
- …**especially** if you have experienced it yourself
- **Be aware** of your own emotions
- Get the **help and support** you need for yourself

Exercise 12.1, Options A & B
Stress reduction exercises

- **Learning objective of the exercise**
- To practice stress reduction exercises that providers can offer as part of basic psychosocial support and mental health care and also use themselves

Stress reduction: slow breathing

1. First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
2. Put your hands on your belly. Think about your breath.
3. Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
4. Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
5. Keep breathing like this for about 2 minutes. As you breathe, feel the tension leave your body.

Job aid, handbook page 70

Stress reduction: muscle relaxation

Curl your toes and hold the muscles tightly. This may hurt a little. **Breathe deeply and count to 3** while holding your toe muscles tight.

Then, **relax your toes** and **let out your breath**. Breathe normally and feel the relaxation in your toes.

Do the same for each of these parts of your body in turn:

- Hold your **leg and thigh muscles** tight and then relax
- Hold your **belly** tight and then relax
- Make fists with your **hands** and them relax
- Bend your arms at the elbows and hold your **arms** tight. Then relax.
- Squeeze your **shoulder blades** together and then relax
- Shrug your **shoulders** as high as you can and the relax
- Tighten all the muscles in your **face** and then relax

Job aid, handbook pages 70–71

– continued –

Stress reduction: muscle relaxation

– continued –

- Now, **drop your chin slowly** toward your chest. As you breathe in, slowly and carefully **move your head in a circle** to the right, and then breathe out as you bring your head around to the left and back toward your chest. Do this 3 times.
- Now, go the other way. Inhale to the left and back, exhale to the right and down. Do this 3 times.
- Now bring your head up to the centre. Notice how calm you feel.

Job aid, handbook pages 70–71

Exercise 12.2 Role play on problem-solving skills

- **Learning objective of the exercise:** To practice problem-solving skills as a method for offering basic psychosocial support to patients

Exercise 12.2 Role play on problem-solving skills

1. Form pairs – one is a person seeking help and one a health-care provider.
2. Person seeking help thinks of a problem (that you don't mind sharing), and shares it with health-care provider.
3. Health-care provider: Use the 5-step problem-solving approach. Ask the patient to:
   - name or identify the problem
   - describe the context of the problem
   - brainstorm solutions
   - prioritize solutions
   - make an action plan

Time: 10 minutes

Remember: Do not give advice

Key messages

- Even in low-resource settings, front-line providers can offer **basic psychosocial support**
- Basic psychosocial support includes **stress reduction exercises**
- **Assess** women with continuing mental health symptoms for moderate–severe depression and PTSD
- **Manage** moderate–severe conditions or refer to mental health care specialists

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 13

Addressing family planning and HIV disclosure for women subjected to violence (supplemental)

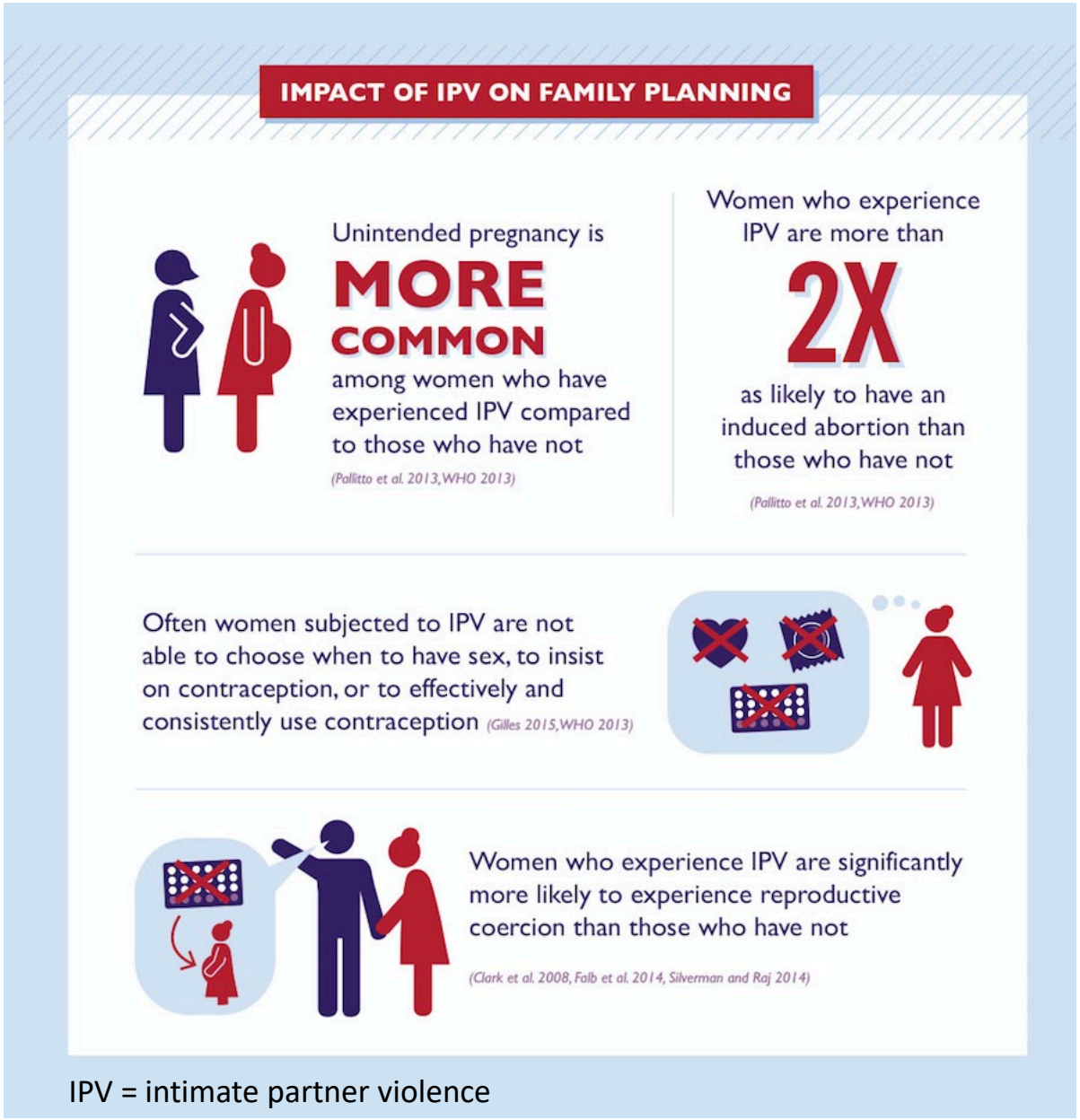
Learning objective

- Demonstrate clinical skills appropriate to one's profession and specialty to respond to VAW

Competency

- Demonstrate skills in identifying and caring for women experiencing violence who present to either family planning or HIV services

Why talk about IPV and family planning?



IPV = intimate partner violence

Family planning and IPV

- **What is reproductive coercion**?

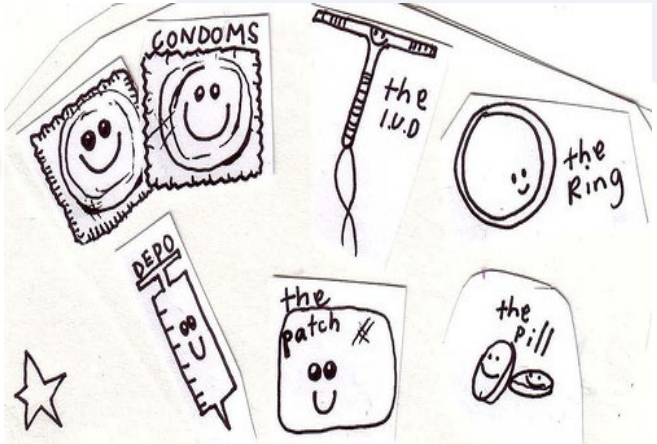
  Behaviours that interfere with contraceptive use and/or pregnancy

- **Family planning providers can help by**:
  - Knowing when to suspect and how to ask about IPV
  - Using "LIVES", especially enhancing safety and promoting autonomy regarding contraception and family planning

Asking about violence in the FP setting

In addition to questions about violence, ask:

- Has your partner ever **hidden** or taken away your contraceptive pills?
- Has your partner ever tried to **force you** or pressure you to become pregnant?
- Has your partner ever **refused** to use a condom?
- Has your partner ever **forced you** have sex without contraception to try to make you pregnant?

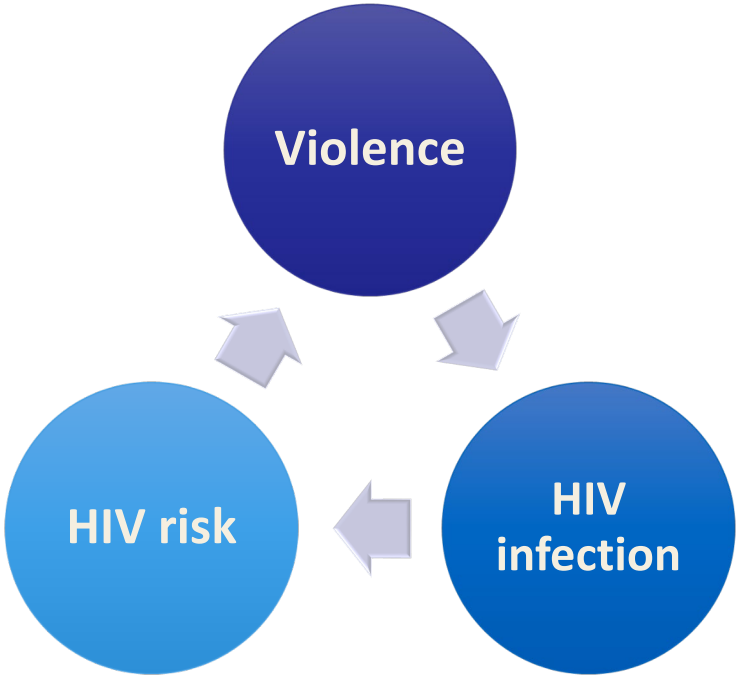


Consider and explain the pros and cons of contraceptive methods in the context of violence

Method	Pros	Cons	Discussion points
Injectable contraceptive, (depot shots)	- Does not leave any signs on the skin - No supplies to store	- With 2- and 3-month types, monthly bleeding often stops after a time - Another injection needed every 1, 2 or 3 months, depending on type	- Are you concerned that your partner may track your periods? - Do you think you could go for re-injection visits without fail?
Implant	- Works well for several years - Usually, no follow-up required - No supplies to store	- Sometimes can be felt and seen under the skin of the arm - May cause spotting or changes in menstrual bleeding (often improves after 3 months)	- Are you concerned that your partner may track your periods?
Copper or LNG IUD	- Remains out of sight in the uterus - Copper IUD works well for at least 12 years; LNG-IUD, for 3–5 years - Usually, no follow-up required - No supplies to store	- Copper IUDs often increase menstrual flow - Hormonal IUDs can make periods lighter or stop - Caution if woman has current STI or high STI risk - Partner may feel ends of strings in cervix	- Are you concerned that your partner may track your periods? - Do you think that you may have an STI or likely to get an STI?
The pill	- Does not leave any signs on the skin - Little effect on menstrual bleeding	- Must be taken every day - Pills/packaging must be kept in a safe place	- Do you have a safe place to keep the pills?

HIV testing in the context of violence against women

Links between IPV and HIV



Benefits

- Increased social support
- Increase access care and treatment
- also encourage partner-testing → safer sex and condom use, PreP
- Increase women to seek services for kids

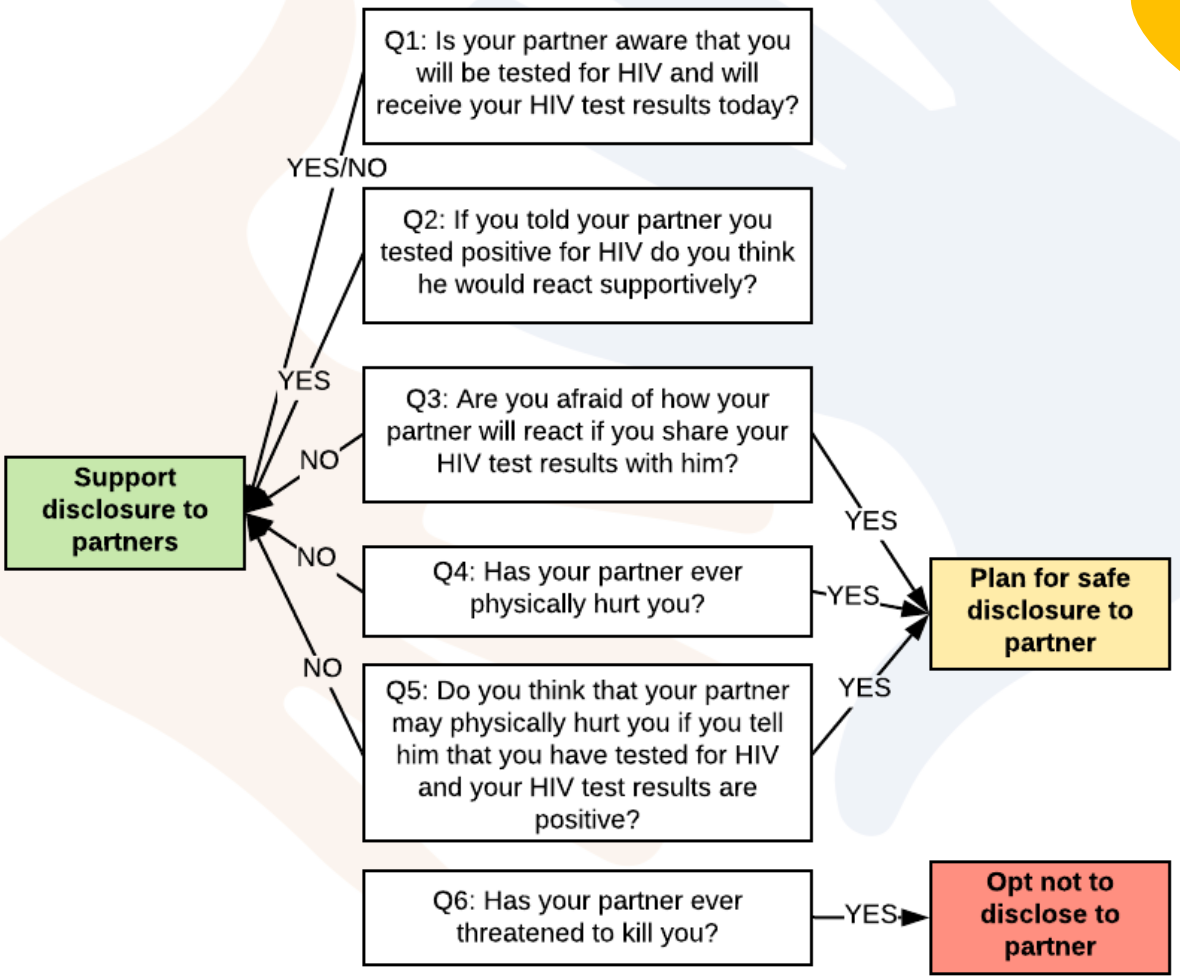
Risks

- For some women, risk of their lives
- Loss of trust
- Physical, emotional or sexual violence
- Thrown out of house, loss of kids, jobs
- Stigma

HIV disclosure: Is there potential for violence?

SOP for safe HIV disclosure counselling in the context of violence

Job aid



World Health Organization

Planning for safer HIV disclosure

- ***Timing:*** Discuss a suitable time – when partner is not tired, under the influence of alcohol or other substances or stressed for other reasons.
- ***Place:*** Discuss finding a place that gives privacy but where other adults are close by.
- ***Should others be present?***
- In some cases having another adult present can be crucial
- Should be someone the woman trusts and who knows her HIV status
- This person's role should be to support the woman, observing/ listening only. If tension builds, this person can try to calm the tension and, if necessary, to help the woman leave safely.
- Overhearing disclosure may be traumatic for the children. Finding a space to talk without the children present is important.

– continued –

Planning for safer HIV disclosure

– continued –

- ***Finding the words and role playing:*** Help the woman find and practice words that tell of her HIV-positive diagnosis directly and simply, without blaming. eg:

  "I have something important to tell you."

- ***Safe exit strategy :*** Help the woman develop an exit plan if tension escalates during disclosure (e.g., locating herself in a place where she can easily exit if she needs to leave quickly).

- ***Opting not to disclose:*** In some cases it may not be possible to enhance a woman's safety. If her partner has ever threatened to kill her, the safest plan would be to avoid disclosing her HIV-positive status to him.

Exercise 13.1: Case reviews for family planning and HIV settings

Learning objective of the exercise: To develop clinical decision-making/case management skills to respond to survivors of violence who present in family planning or HIV testing settings

1. Form 2 groups
2. Each group reads the scenario and discusses answers to the questions. Record answers on the flip chart.
3. Each group then reads the other scenario and answers the questions.

Time: 10 minutes for each group discussion
Then, 10 minutes for plenary discussion

Key messa

- Clinicians will need to develop
  provide care to survivors of vi
  presentations and her specifi
- Some aspects of care are st
  line support, **asking about vi** **nt of sexual assault** are relevant in any
- Family planning clients, however, may need specific **counselling on choice of a contraceptive method choice** that meets their need for safety
- Similarly, HIV-positive women will need specific **counselling on disclosure and safer sex negotiation**

Check your knowledge!

Yes or no: should you recommend that all women disclose their HIV status to their partners?"

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 14:

Assessing health facility readiness (module for health managers)

Learning objective

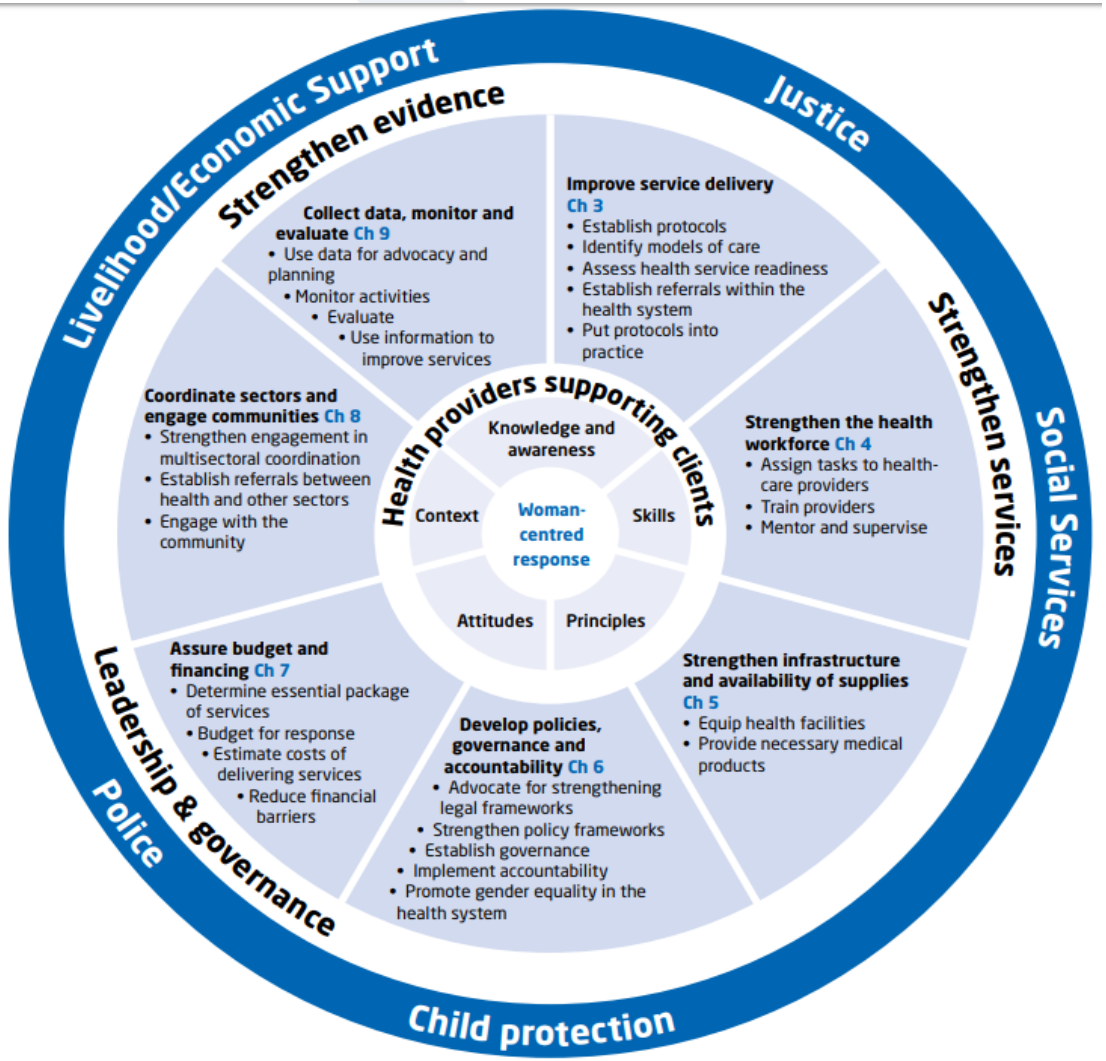
Demonstrate behaviours and understand values contributing to **safe** & **supportive** services

Competency

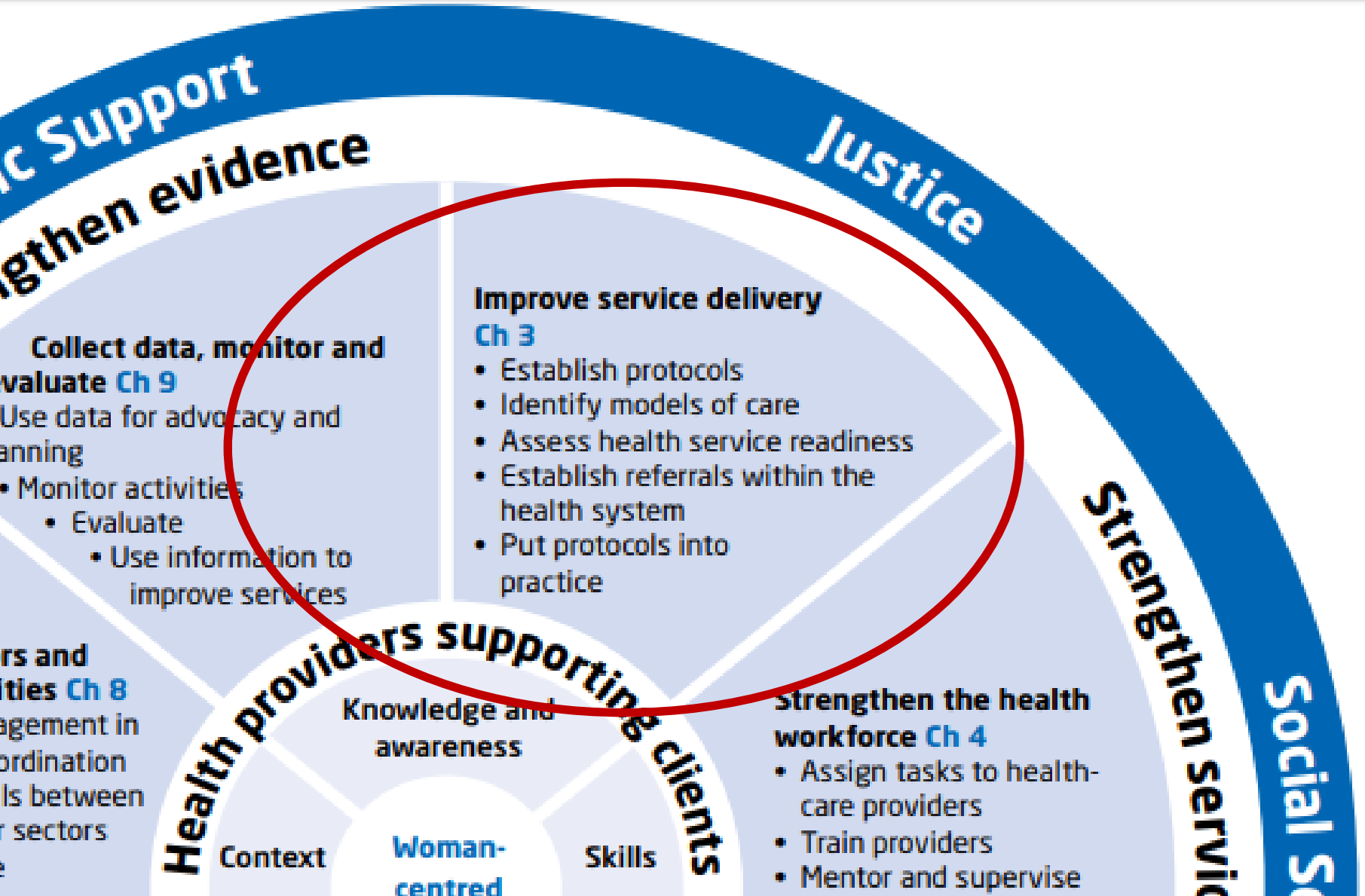
- Assess how to improve service quality and create an enabling environment for service delivery

Contents of manager's manual

- Part 1: Getting started
- **Part 2: Strengthening services**
- Part 3: Leadership and governance
- Part 4: Strengthening evidence & scaling up



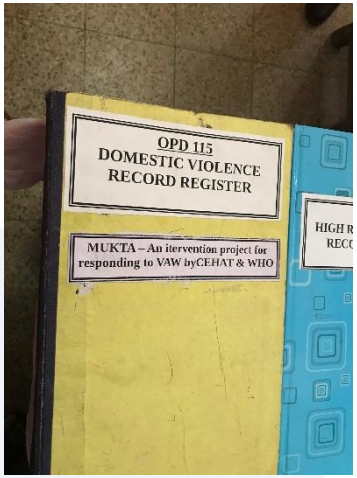
Contents of manager's manual

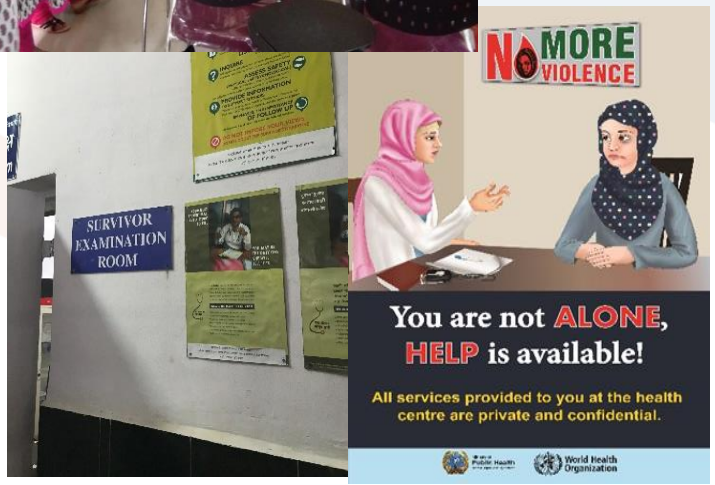


Training is not enough for sustained change

What else is needed?

- Improved infrastructure
- Communication, job aids, supplies
- Documentation, including procedures for confidentiality
- Supervision, mentoring and refresher training
- Supportive managers willing to champion
- Strengthened referral linkages with other services
- Community outreach to raise awareness





How can we assess service readiness?

- Service delivery (protocol)
- Health workforce (trained providers)
- Infrastructure and medical products (private
- Leadership, governance and accountability (manager's support)
- Budget & financing (budget allocation)
- Coordination (referrals)
- M&E (confidentiality in intake forms)

Job aid 3.2 Manager's manual, pages 31–32

Minimum requirements for health facility readiness

1. A written protocol/SOP
2. Training on how to ask & minimum response
3. Private setting + Confidentiality policy
4. Documentation system
5. System for referral in place

Requirement 1: A written protocol

- Regulations and key principles of care
- Service provision
  - Roles
  - Self-care
  - Essential services
  - Patient flow
  - Coordination
- Documentation and data collection and management

Job aid 3.1: Manager's manual, pages 26–27

Requirement 2: Trained providers

- Train health-care providers on *how to ask about IPV, how to respond to disclosures of SV & IPV; provide acute post-rape care + reflect on their own attitudes*
- Assign the necessary health-care providers to care for women subjected to violence
- Offer mentoring and supervision to support providers' performance

Minimum requirement 3: Privacy & confidentiality: space

- Private consultation space
- Strengthen privacy
- Reduce stigma
- Privacy & confidentiality policy
- Access to washroom

Job aid 5.1: Manager's guide, pages 53–54

Minimum requirement 3: Confidentiality policy

- Privacy and confidentiality in data collection, sharing and reporting
  - Establish a policy
    - Ensure staff understand privacy and confidentiality
    - Identifying information not visible
    - Do not leave documents unattended
    - Do not document violence in public spaces
    - Develop code/symbol to indicate violence
    - Advise about keeping records home safely

Manager's guide, pages 155–156

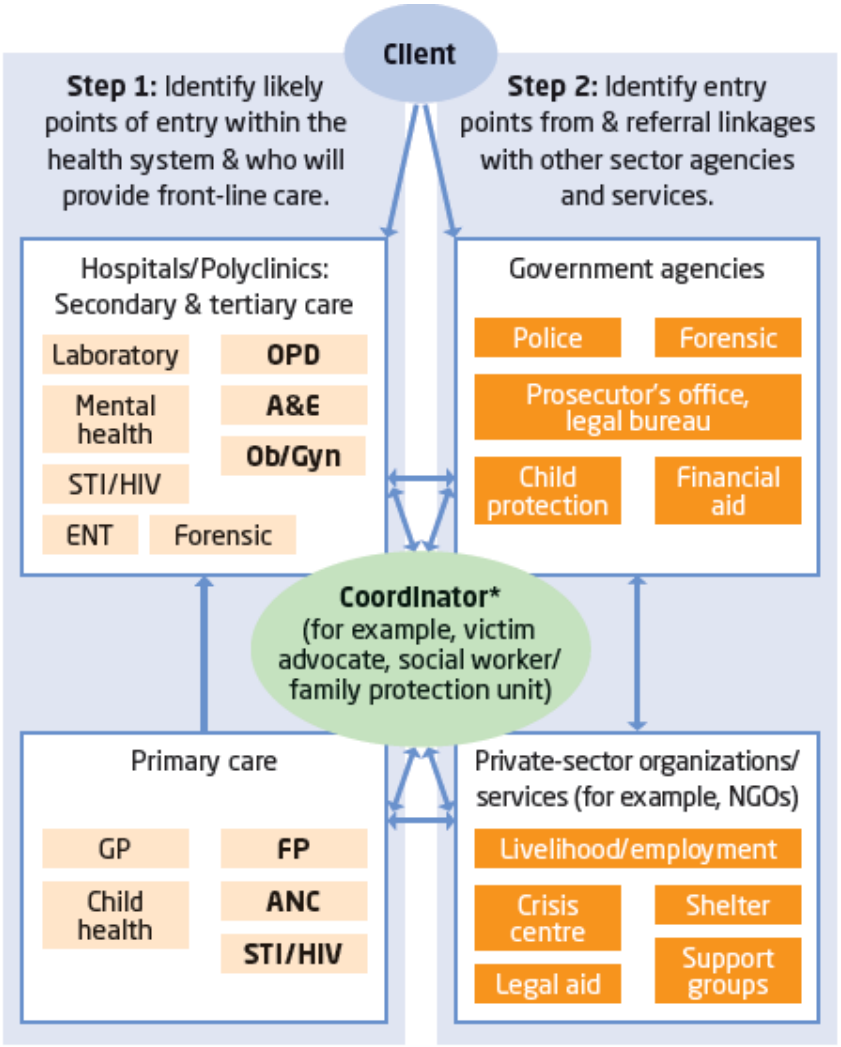
Minimum requirement 4: Documentation

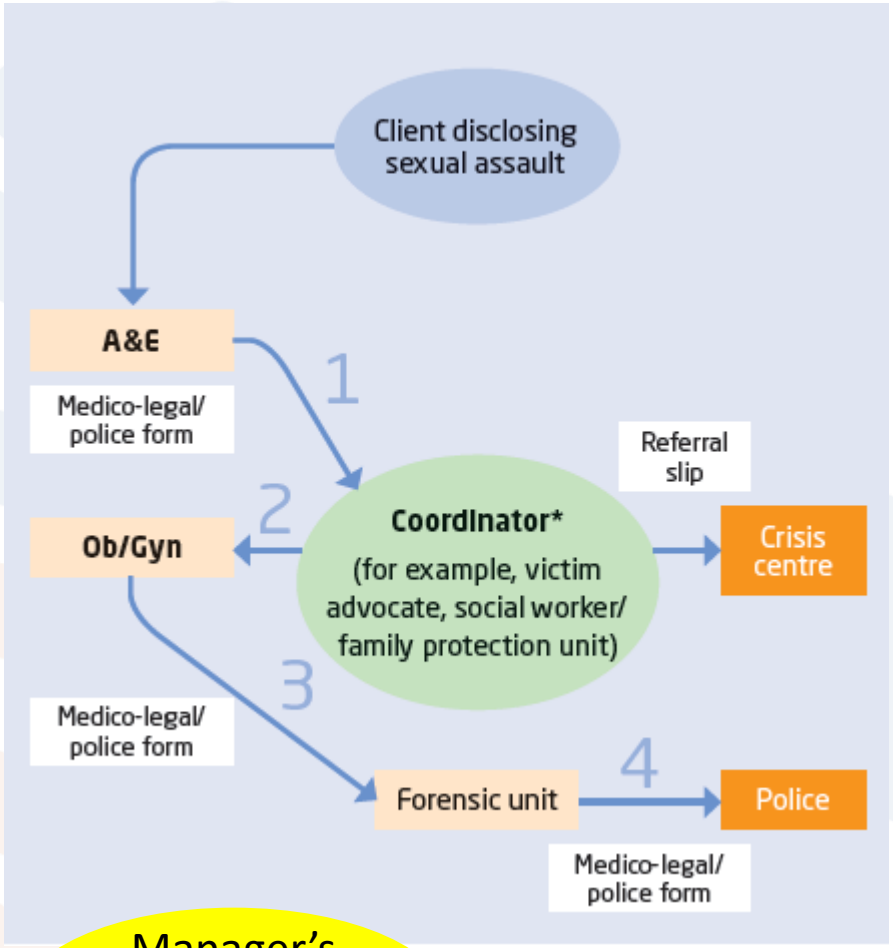
Manager's guide, pages 147–151

Annex 9. Sample intake/record form for clients subjected to intimate partner violence or sexual assault

Date (dd/mm/yr) _____/_____/_____			**Client number**	
Client's family name			**Client's given name**	
Client can be reached at _____				
Sex	☐ F ☐ M	**Date of birth (dd/mm/yr)** ____/____/____	☐ Married/cohabiting	☐ Not married/ not cohabiting
Reporting	☐ Provider asked about violence	☐ Client disclosed/ reported violence	☐ Provider suspects violence	
Referred by (if first visit)	☐ Self	☐ Other health facility/unit (specify)	☐ NGO	
	☐ Family/ acquaintance	☐ Police	☐ Other government unit	
Presenting symptoms/ conditions	☐ Injuries	☐ Sexual/reproductive health conditions	☐ Mental/emotional problems	☐ Other (specify)
Type of violence	☐ Physical violence	☐ Sexual violence ☐ Rape ☐ Rape – arrived within 72 hours	☐ Psychological/ emotional	☐ Other (specify)
Perpetrator	☐ Intimate partner	☐ Family member in household	☐ Family member/ acquaintance living elsewhere	☐ Stranger
Assessments and clinical care for all survivors	☐ First-line support[1]	☐ Safety assessment	☐ Injuries & wound care	☐ Tetanus prophylaxis
	☐ Other (specify)			
Additional care for rape survivors seen within 72 or 120 hours	☐ Head-to-toe & genital examination	☐ Emergency contraception (within 120 hours)	☐ Pregnancy test	☐ STI prevention/ treatment
	☐ PEP for HIV (within 72 hours)	☐ HIV test	☐ Forensic evidence collected	☐ Other (specify)

Minimum requirement 5: System for referral





Manager's guide, pages 91–93

Assessing policy readiness

Job aid 2.2

Is there policy-level readiness? Conduct a situation analysis

☐ **Is there political will to address violence against women among different stakeholders (see Job aid 2.1)?**

- ✔ Determine whether violence against women is considered or perceived to be a priority by policy-makers, in public opinion, by the media.

☐ **Are there data available on violence against women?**

- ✔ Identify what quantitative and qualitative data on violence against women are available in your setting – for example from demographic health surveys or other special surveys or studies, or administrative statistics collected by police, hospitals, judicial and social service agencies.
- ✔ Describe what these data tell you about the burden of violence against women in your setting – for example which groups of women and what types of violence are they most affected by; what are the risk factors and consequences on their health and well-being; and what are their help-seeking patterns.
- ✔ Gather any information on barriers women face in accessing services (for example, geographic, financial, lack of time, limited mobility, stigma from family and communities, and health service delivery factors).

☐ **Are there laws supportive of the health system response?**

- ✔ Find out what forms of violence against women are criminalized in the legal frameworks.
- ✔ Understand the obligations of the health system in addressing violence against women and legal barriers.

☐ **Are there policies or plans specifying the health system response to violence against women?**

- ✔ Identify existing national or subnational policies and plans for a multisectoral or a health system specific response to violence against women.
- ✔ Assess whether provision of services addressing violence against women is specified in the essential package of health services?

☐ **Are there existing health services and other sector programmes addressing violence against women?**

- ✔ Map/list what services and programmes are in place to address violence against women including for medico-legal, psychological support, and social services.
- ✔ Collect evaluation results and lessons learned from previous or other initiatives that provide services to survivors of violence.

☐ **Are human, financial and technical resources available?**

- ✔ Identify any experts and staff who have been trained on violence against women.
- ✔ Determine whether there are dedicated budgets allocated to addressing violence against women or th… to provide services.
- ✔ Assemble any guidelines, protocol… have been developed on the issue…

☐ **Is there a governance structure to g… response to violence against women?**

- ✔ Ascertain if there is a focal point or unit/mi… or working group designated/mandated to coordi… response to violence against women.
- ✔ Identify any mechanisms for coordination and referral between the health and other sectors on violence against women.

☐ **Are there institutions/organizations, partnerships, networks, addressing violence against women?**

- ✔ List which organization or institution is already working on this issue, what they are doing and who can be potential partners.
- ✔ Identify any networks, partnerships or alliances addressing this issue.

Manager's manual, pages 15–17

Strengthening political will

- ✓ Build alliances
  - Champions in government, health facilities, civil society
- ✓ Define the issue
  - Gather statistics and human interest stories
- ✓ Create a persuasive argument
  - Align your argument with strategic targets (for example, national priorities or SDGs)
- ✓ Use the mass media to speak out against acceptability of VAW
- ✓ Identify windows of opportunity and use them for advocacy

Key messages for policy makers

Violence against women:

- is a **critical** and **preventable** public health problem
- seriously **affects** women's and children's **health**
- **has** great social and economic **costs**

The **health system** needs:

- to play a major role in a **coordinated**, **multisectoral** response
- **sustainable systems** to support health-care providers' response

- Policymakers, managers, providers and advocates must **challenge beliefs and norms** that condone gender inequality and VAW

Exercise 14.1: Barriers to providing care and facility readiness assessment

Learning objective for the exercise:

- To assess how ready the facility is to address barriers to providing services
- To understand barriers at the facility and community levels to provision of services for women subjected to violence
- To identify and prioritize solutions

Exercise 14.1: Barriers to providing care and facility readiness assessment

Instructions:

- **Fill out the worksheet:**
  - Has your facility met the standard in column 1? (yes/partially/no/don't know)
  - If partially met, explain what is missing
  - List 2 barriers to meeting that standard.
  - List 1 solution for each barrier.
  - Solution implementable in next 12 months Y/N/DK.
  - Star the solution that can be implemented with existing resources and put a square next to one that requires additional resources

Exercise 14.1: Barriers to providing care and facility readiness assessment

Plenary discussion

1. Each group to present self-assessment for no more than 2 items.

2. Complete the rest of the readiness assessment with own facility/institution after the training.

Key messages

- **Training alone** is **not sufficient** to improve service quality
- **Addressing barriers** & improving service readiness are important to improve quality of care
- **Minimum requirements** for facility readiness include having:
  - a written protocol
  - trained providers
  - a private space
  - a documentation system
  - confidentiality mechanisms
  - a referrals system

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 15:

Improving health workforce capacity (module for health managers)

Learning objective

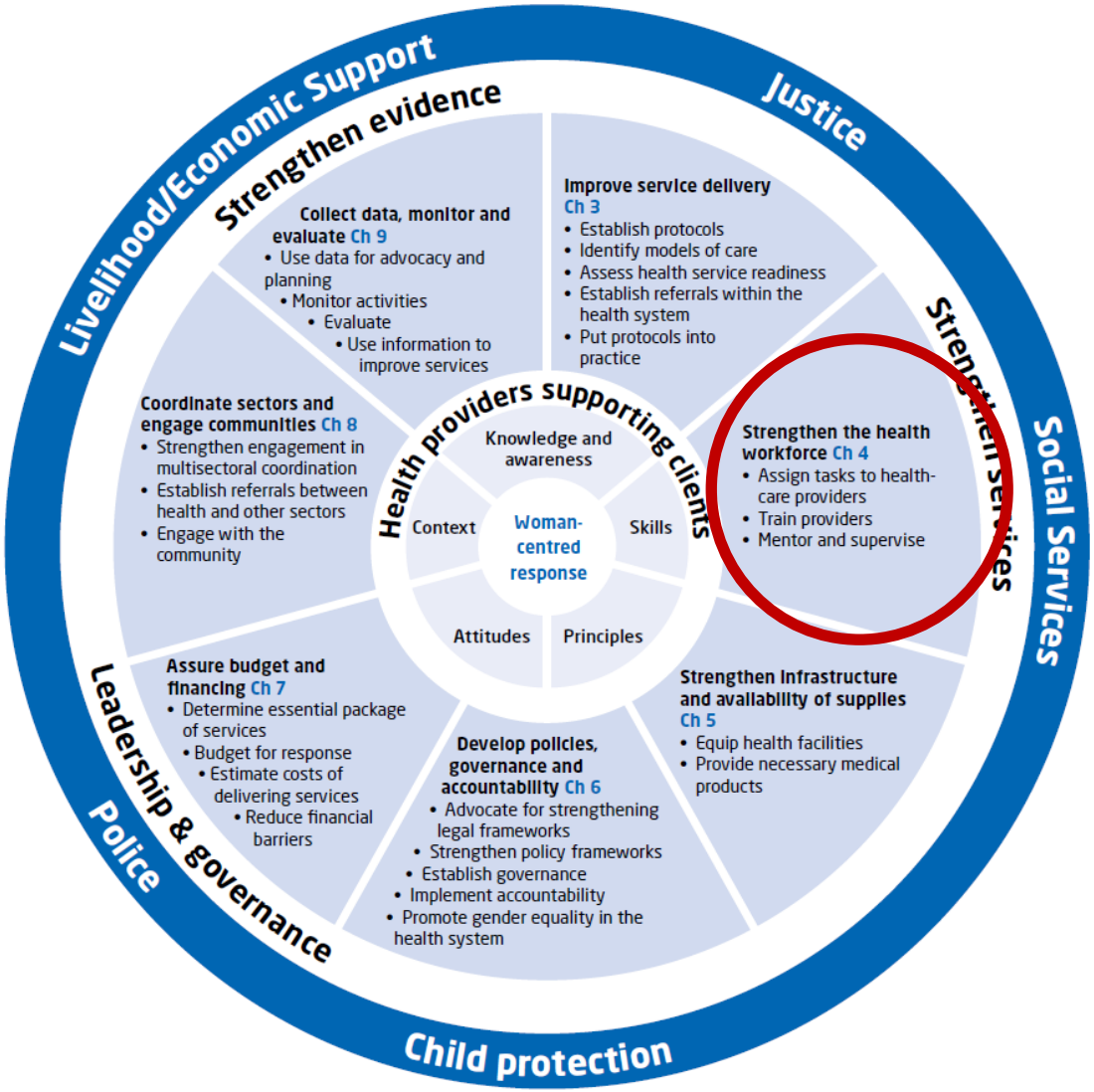
Demonstrate behaviours and understand values contributing to **safe** & **supportive** services

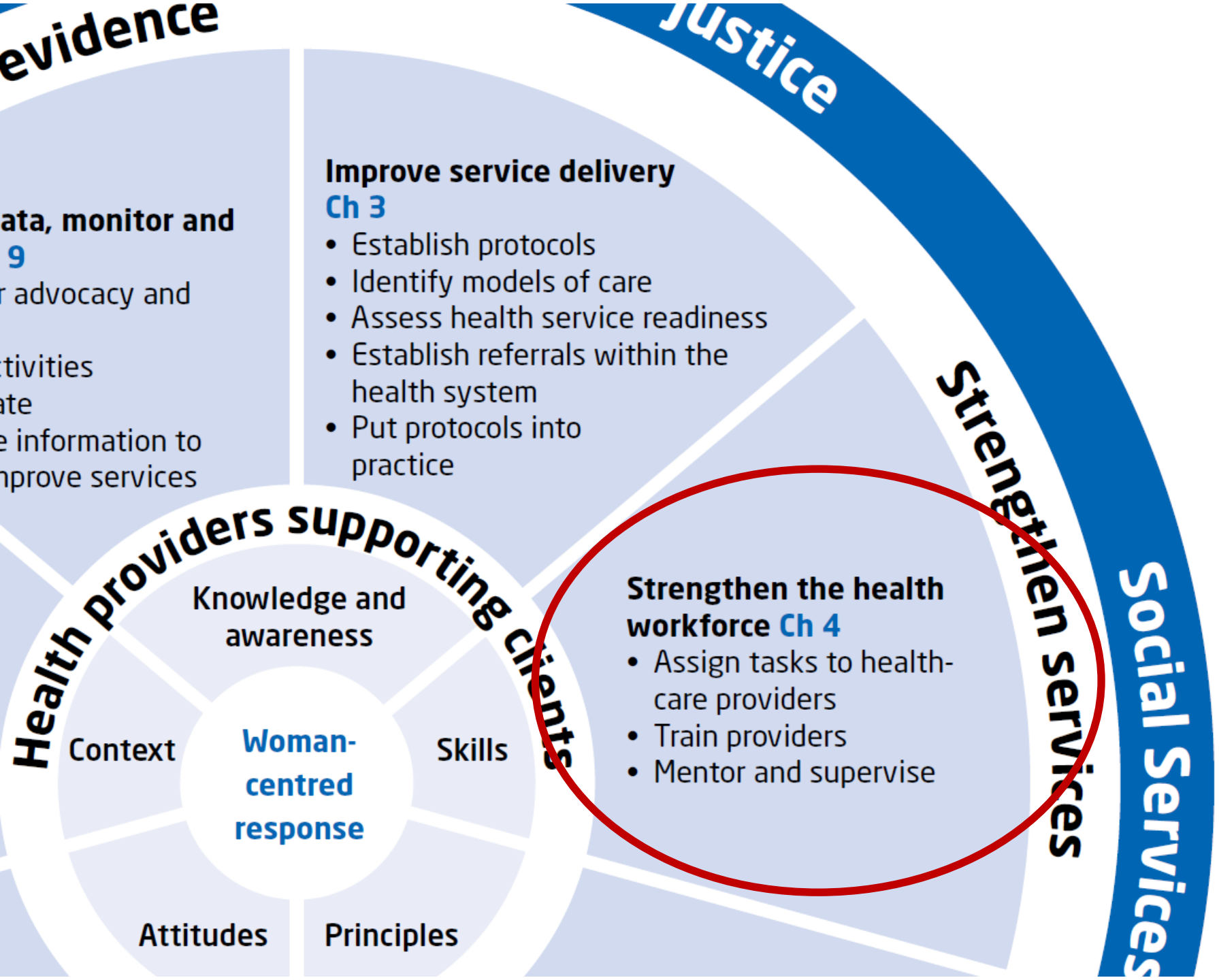
Competency

- Facilitate training, supervision and mentoring of health-care providers

Contents of manager's manual

- Part 1: Getting started
- **Part 2: Strengthening services**
- Part 3: Leadership and governance
- Part 4: Strengthening evidence & scaling up




evidence
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nprove services
Improve service delivery
Ch 3
• Establish protocols
• Identify models of care
• Assess health service readiness
• Establish referrals within the health system
• Put protocols into practice
Justice
Strengthen services
Social Services
Health providers supporting clients
Knowledge and awareness
Context
Woman-centred response
Skills
Attitudes
Principles
Strengthen the health workforce Ch 4
• Assign tasks to health-care providers
• Train providers
• Mentor and supervise

Assign roles & responsibilities

- Create a **multi-disciplinary** team
- A trained provider needs to be available at **all times of day**
- In some settings **female providers** may be preferred, but important to train male health-care providers also

Guiding principles for training

Training should:

- ✓ be **ongoing** to change provider practices
- ✓ cover **basic knowledge**
- ✓ be **competency- and skills-based**
- ✓ **align** with national policies, guidelines and protocols
- ✓ include **multisectoral training facilitators** (ideally)
- ✓ be **interdisciplinary**
- ✓ provide **support** during and after training for providers who have experienced violence

Tips for supporting training

- ✓ Publicly acknowledge and **speak out** about addressing VAW
- ✓ Lead by example: **participate** in trainings and give staff time to participate
- ✓ Make **protocols/SOPs and job aids** available
- ✓ Allocate **resources**
- ✓ Make an institutional policy about **protecting staff** from violence and harassment at work
- ✓ Facilitate **on-site trainings** to promote attendance
- ✓ Publicly **recognize staff members** who complete training and use their skills
- ✓ Advocate that trainings to be part of **Continuing Medical Education**

Develop the training plan

- ✓ Determine **objectives and outcomes**
- ✓ Determine **content**
- ✓ Who will be **trained** on what
- ✓ Who will **conduct** the training
- ✓ **How** will the training be conducted
- ✓ What is needed to **support and facilitate** the training
- ✓ **Where** will the training take place
- ✓ **Evaluate** achievement of objectives & necessity of improving training
- ✓ **Sustain quality performance** after training

Mentoring and supervision

Mentoring…

…by **experienced health-care providers** who develop supportive relationships, respond to questions, review clinical cases, provide constructive feedback

- helps providers **reflect** on attitudes, behaviours, beliefs
- supports providers who have **experienced VAW** and/or are **experiencing trauma/burnout**
- **models skills**, including communication, in the health-care setting

Mentoring and supervision

Supportive supervision…

…by health services managers to ensure that new skills are applied correctly

- supports health-care providers in setting realistic **expectations and goals**
- assesses **performance**, reviews practice against goals
- identifies and helps **solve problems** in quality of care
- facilitates on-the-job **learning**

Job aid 4.4
Manager's manual, pages 48-50

Supportive supervision

- Assess training needs
- Assess preparedness to provide care
- Review cases to assess the management
- Review and discuss challenging cases in past 3 months
- Identify barriers/challenges and areas for improvement

Job aid 4.4: Manager's manual, pages 48–50

Support providers to practice self-care/address vicarious trauma

- **Provider's emotional health** is important, too
- They may have strong **reactions or emotions** when listening to or talking with women about violence...
- …**especially** if they have experienced it yourself
- **Remind them to be aware** of their own emotions
- Facilitate providers to get **help and support** they need for them selves
- Help them practice stress reduction

Exercise 15.1: Selecting staff members for training and assigning roles and responsibilities

Learning objectives for the exercise:

- To understand **the background, motivations and challenges** of health-care providers in order to select those to be trained
- To understand the **roles and responsibilities** of providers to be able to assign tasks for care of survivors accordingly

Exercise 15.1: template & instructions

Nurse	Roles and responsibilities
Social worker or counsellor or other (name)	Roles and Responsibilities
Junior or Senior Doctor	Roles and responsibilities
Other cadres (lab technician, receptionist, assistants etc)	Roles and responsibilities

Instructions – Part 1

On a flip chart, list different cadres of health-care providers who interact with patients. For each, write :

- their roles and responsibilities

Note: in your health facility, discuss the training opportunity with each staff member, ask them about their motivations to care for survivors, the challenges they may face and finalize the list of health workers who will be prioritized for training based on roles & responsibilities and motivations.

Exercise 15.1

Instructions – Part 2

- Fill out the template for Job aid 4.1, assigning the staff members best suited to carry out each task listed
- Once completed and confirmed, the job aid can be posted so that staff members know who is to do what

Job aid 4

Assigning roles and responsibilities to different cadres of health-care providers

Activity/function[1]	Physician at primary health facilities	Physician at district/ tertiary hospital/ facilities	Nurse	Social worker or counsellor	Other (specify
Identification, first-line support, history taking and examination					
Identifying survivor of intimate partner violence					
Offering first-line support (psychological first aid)					
Taking/documenting history including emotional state					
Preparing survivor of sexual assault for exam					
Performing head-to-toe exam for sexual assault					
Collecting forensic evidence for sexual assault					
Conducting relevant lab tests for sexual assault					
Prescribing treatment					
Caring for injuries needing urgent or immediate attention					
HIV post-exposure prophylaxis if sexual assault survivor presents within 72 hours					
Emergency contraception if sexual assault survivor presents within 5 days					
STI treatment/prophylaxis for sexual assault survivor					
Vaccinations for hepatitis B and tetanus for sexual assault survivor					
Planning follow-up visits					
Offering basic psychosocial support					
Helping with more severe mental health problems					
Preparing and signing the medico-legal certificate for cases of sexual assault					
Reporting to legal authorities					
Providing/facilitating referrals to other services					

Manager's manual, pages 38–39

Exercise 15.1A: Prioritizing who to train in what

Learning objective for the exercise:

- To prioritize which cadres of health providers will receive training based on their roles and responsibilities

Instructions:

- Participants from same facility/department or district or region to be in same group
- Document on a flip chart your group's responses to the following scenario and questions
- Report back in plenary

Scenario: You have been asked to develop a training plan to strengthen response to violence against women with a focus on integrating VAW response into SRH and HIV services.

1. Identify which cadres of service providers you will prioritize for training?
2. What content will you cover in the training: list at least 3-4 priority topics?
3. How will you assess whether the training has led to improvement in skills and actual practice of providers?

Exercise 15.2: Develop a training plan

Learning objective for the exercise:

To understand how to develop a training plan for responding to violence against women.

Instructions

- Fill in the right column of the Job aid 4.2 worksheet, responding to each question and item.
- Use the job aid worksheet to respond to the questions on training considerations.

Exercise 15.2: Job Aid 4.2- developing a training plan

The job aid and exercise covers the following items with guiding questions:

- Purpose and outcome
- Content
- Target group
- Facilitators
- Training format
- Length
- Modality
- Necessities for the training
- Location
- Evaluation methods
- Sustainability

Manager's manual, pages 41–43

Optional Exercise 15.3: Providing mentoring support

Learning objective for the exercise:
To learn how to provide mentoring support to health providers who have been trained and are caring for women subjected to violence.

Instructions:

- Work in the same small groups as before
- Discuss and respond to each question on a flip chart
- Report back in plenary

Optional Exercise 15.3: Providing mentoring support

Scenario. You have overseen a training of 50 health care providers in your district/province who have now been practicing what they learned for 6 months. You conduct a follow up assessment and find that while knowledge and attitudes toward survivors has improved and most providers are identifying cases of IPV, they are still not offering all aspects of first-line support – particularly safety planning with survivors. You also find that some of the younger providers are feeling stressed by listening to stories about survivor abuse when they identify cases.

Questions to discuss:

- As a manager, what will you do to identify why providers cannot offer all aspects of first-line support and safety-planning in particular to survivors?
- What will you do to improve this aspect of clinical practice? (list 2 ideas for supportive supervision and 2 ideas for mentoring).
- How will you support the younger providers who are feeling stressed or experiencing vicarious trauma?

Key messages

- **Training needs to…**
- be **ongoing** and **bolstered by supervision and mentoring**
- work with **multidisciplinary teams** based on the roles, responsibilities and motivations of different health workers
- be **competency-based**
- be **interdisciplinary -** train different cadres and sectors together and hold separate sessions tailored/relevant to each

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 16:

Improving infrastructure and ensuring supplies (module for health managers)

Learning objective

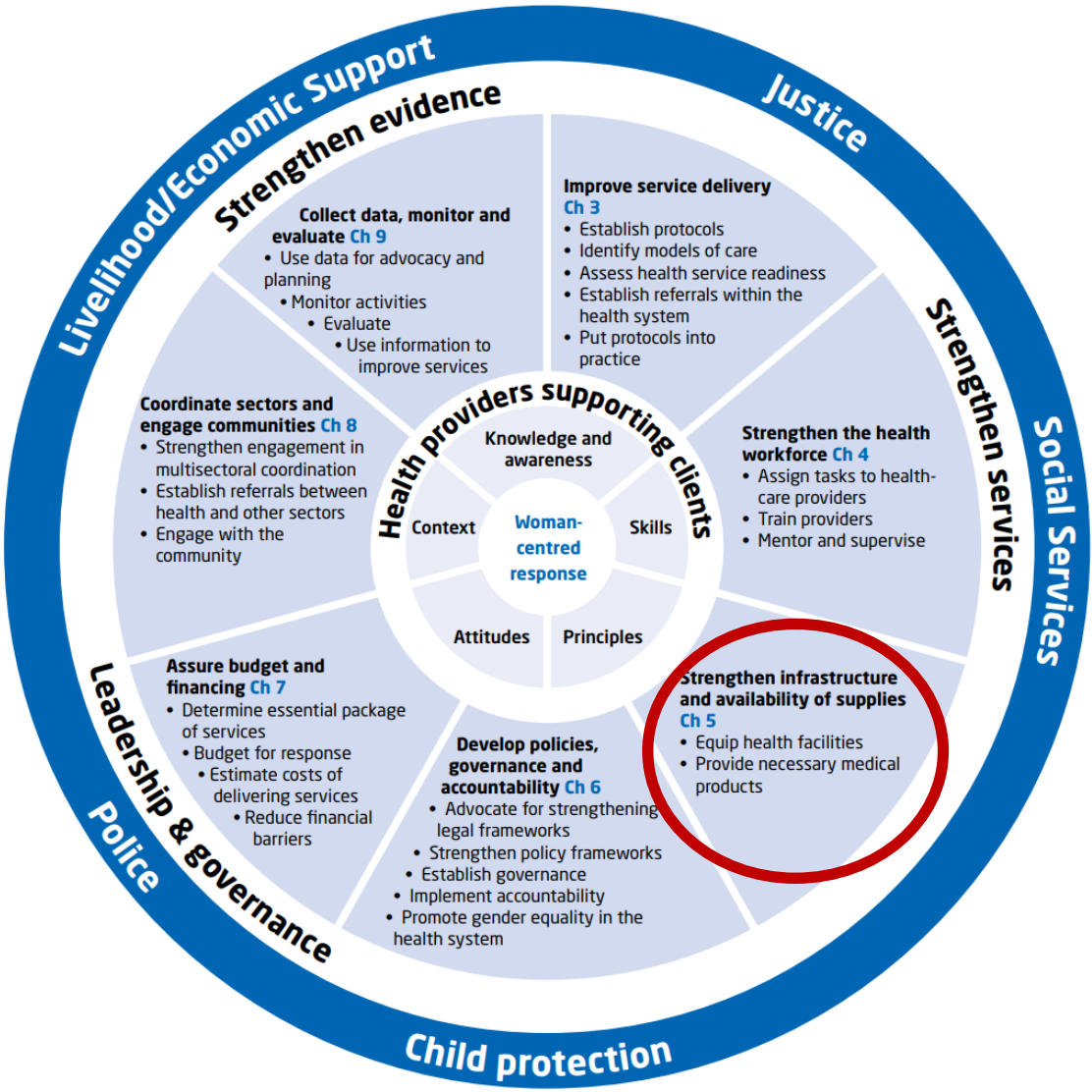
Demonstrate behaviours and understand values contributing to **safe** & **supportive** services

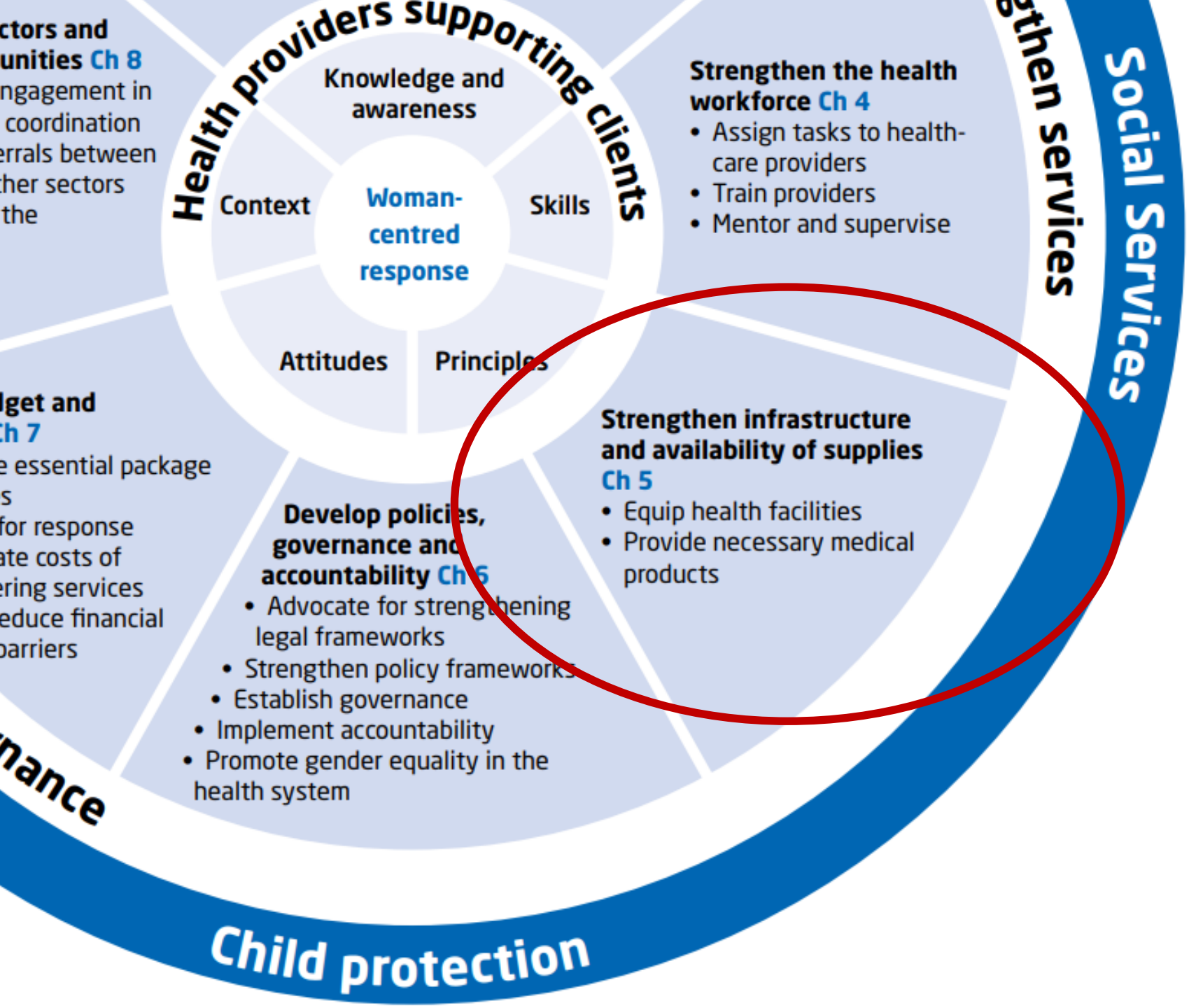
Competency

- Planning to improve infrastructure and procurement of equipment and supplies

Contents of managers' manual

- Part 1: Getting started
- **Part 2: Strengthening services**
- Part 3: Leadership and governance
- Part 4: Strengthening evidence & scaling up

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Health providers supporting clients
Knowledge and awareness
Context
Woman-centred response
Skills
Attitudes
Principles
Strengthen the health workforce Ch 4
• Assign tasks to health-care providers
• Train providers
• Mentor and supervise
Strengthen infrastructure and availability of supplies Ch 5
• Equip health facilities
• Provide necessary medical products
Develop policies, governance and accountability Ch 6
• Advocate for strengthening legal frameworks
• Strengthen policy frameworks
• Establish governance
• Implement accountability
• Promote gender equality in the health system
gthen services
Social Services
Child protection

Equipping facilities for privacy

- Minimum requirement 3: **private setting**
- Facility managers' roles:
  - Designate a quiet, private space
  - Instruct staff to prioritize use of private space

Job aid 5.1
Manager's manual, pages 53-54

Equipping facilities for privacy

Roles of district, regional or national policy-makers:

- Map facilities with adequate infrastructure & which require improvements. (Which facilities can provide 24-hour/day services?)
- Allocate budgets for improving infrastructure

Job aid 5.1 Manager's manual, pages 53-54

Job aid 5.1: infrastructure considerations (Handout)

Job aid 5.1

Infrastructure considerations, barriers and suggestions to overcome them[1]

☐ **Requirement: Allocate a private consultation space** – a separate room with 4 walls and a door, where the woman cannot be seen and her conversation cannot be overheard from outside the consultation room. If resources permit, consider having a private, separate or outside entrance to the examination and consultation room and creating a space where children accompanying their mothers can play, watched by other health facility staff.

Barriers: Lack of private consultation rooms that protect confidentiality and privacy.

Overcoming barriers: Many facilities have an unused or little-used room that could be repurposed.

If the room must also be used for other purposes, assure priority for women who have been subjected to violence so they do not have to wait for care.

Instruct staff not to ask about violence in front of anyone, including children. Arrange for staff who are not attending to patients to watch children during the mother's consultation.

☐ **Requirement: Strengthen privacy** by adding doors to existing consultation space to improve privacy. If possible, also insulate walls. If doors are not possible, at least have curtains.

Barriers: In resource-poor settings many consultations can be seen or heard from adjoining areas because doors or walls are thin, or there are only curtains to separate consultation areas.

Overcoming barriers: If the walls are thin or only curtains are available, instruct staff to speak softly so that they cannot be overheard. Ask others to leave the area, if that is feasible.

☐ **Requirement: Reduce stigma** by avoiding explicit names and signs that indicate that those who enter the exam room have been subjected to violence.

Barriers: Health-care providers or receptionists may use stigmatizing language, su… …the "room for abused women".

Overcoming barri… stigmatizing langua… consultation area. Use… simply a room number.

☐ **Requirement: Establish a priv…** limiting what women are asked or requ… areas of the health facility.

Barriers: Receptionists or health-care providers may ask women to state the reason for their visit or provide intake information (such as name, address, medical history) in front of others or in waiting rooms.

Some women may be accompanied by the police, which may indicate to others that they have been subjected to violence.

Waiting in a public area for treatment can be difficult for women who have just been subjected to violence.

Overcoming barriers: Consider changing patient flow so that women can bypass public waiting areas. If this is not possible, instruct staff to ask intake information only in a private space or in writing.

Brainstorm with staff how to get the woman alone for a few minutes if family members or the abusive partner accompany the woman.

Instruct staff not to interrupt a consultation between the woman and the health-care provider.

☐ **Requirement: Easy access to a toilet.** Also, for women who have been subjected to sexual assault, access to a bath or shower would be desirable once forensic evidence has been collected if appropriate.

Barriers: In many resource-poor settings, toilets may be outside the health facility premises, or there may not be clean toilets.

Overcoming barriers: Explore how to install toilet(s) accessible to women subjected to violence on the premises of the hospital or health facility.

Job aid 5.1
Manager's manual,
pages 53-54

Exercise 16.1: Using patient flow mapping to assess infrastructure needs for privacy

Learning objectives for the exercise:

To map patient flow so as to identify:

- The points where clients interact with health providers with the potential to breach privacy and confidentiality
- Options for rerouting patient flow to improve privacy and confidentiality

Exercise 16.1: Using patient flow mapping to assess infrastructure needs for privacy

Instructions:

Half of groups will work on the sexual violence case & half on the IPV case.

Following the template on the next slide, draw a patient flow chart on the flip chart as follows:

- Indicate with circles the patient's points of entry and exit.
- Note interactions with each provider/staff member, including examination, consultation, information/counselling.
- Show sequence, including branches, with arrows.
- Indicate with "P" if private consultation is possible or "NP" if not possible.
- Indicate with "E" where the provider could ask about or discuss violence.
- Indicate with "CB" where there could be a confidentiality breach.

Exercise 16.1 Template for patient flow chart

Leela (Patient) + older sister	Enters Casualty/ Emergency						
Registration							
Nurse							
Junior Doctor							
Senior Doctor							
Counsellor or Social Worker							
Other (Add as needed)							
							Leaves hospital
Footnotes							

Exercise 16.1. Discussion

- Where in the patient flow can the woman be asked – and by whom – about possible experience of violence?
- For points in the patient flow marked “NP” or “CB”, how can privacy and confidentiality can be enhanced?

Exercise 16.1A (Alternative if time short) : Improving privacy in a facility (15 mins)

For each of the pictures numbered 1 to 6 (on the next slide):

1. Identify how the setting does or does not promote privacy and confidentiality in the health facility for the survivor.
2. Provide one suggestion to improve or to have a private and confidential discussion with the survivor in each image/settings.

Record the responses to the two questions on a flip chart (on one left side record responses to Q1 and on the right side responses to Q 2 for each picture.

Exercise 16.1A (Alternative if time short): Improving privacy in a facility (15 mins)

Scenario: These are images from actual health facilities in different settings.

1

2

3

4

5

6

Provide necessary equipment, medicines and supplies

Deciding what is necessary

- Adapt Job aid 5.2 to national guidance on what should be available at different levels of health facilities
- Equipment and supplies for forensic specimen collection and analysis depend on the legal or policy context
- Availability of forensics laboratory determines specimens collected and supplies needed

Job aid 5.2
Manager's manual, pages 56

Job aid 5.2. Checklist of supplies

Job aid 5.2
Manager's manual, pages 56

Job aid 5.2

Checklist of equipment, medicines and other supplies for examination and care of women subjected to violence

Examination equipment and laboratory products

- ☐ examination couch (with curtains or screen if needed for privacy)
- ☐ secure record storage cabinets
- ☐ light source (lamp or torch)
- ☐ speculum
- ☐ pregnancy testing kits
- ☐ rapid tests for HIV, syphilis
- ☐ urinanalysis kits
- ☐ test strips for vaginal infections
- ☐ forensic evidence collection kits (depending on forensic laboratory capability), including:
  - swabs & container for transporting swabs
  - microscope slides
  - blood tubes
  - urine specimen containers
  - sheets of paper(drop sheet)
  - paper bag
  - plastic bags for specimens
  - tweezers
  - scissors
  - comb
- ☐ digital camera to document injuries

Medicines

- ☐ supplies for wound care
- ☐ analgesics
- ☐ anti-emetics
- ☐ emergency contraception
- ☐ antiretroviral drugs for post-exposure prophylaxis for HIV prevention
- ☐ drugs for treatment or prophylaxis for sexually transmitted infection
- ☐ hepatitis B vaccination
- ☐ tetanus toxoid

Administrative supplies

- ☐ a protocol/SOP for care
- ☐ job aids (for example, flow charts, algorithms, pictograms)
- ☐ consent forms
- ☐ documentation forms (for example, medical intake forms, police forms for forensic evidence, medico-legal certificates)
- ☐ referral directory
- ☐ communication materials

Disposables

- ☐ sheets, blankets and towels
- ☐ in case the woman's clothes are soiled or torn or taken for evidence collection
- ☐ sanitary pads

World Health Organization

Providing necessary medical supplies

Facility manager's roles:

- Prepare and distribute list of equipment, medicines and supplies
- Prevent stock-outs by ensuring adequate, continuous stocks

Ensure adequate, continuous stocks

Manager's manual, pages 57–58

- Periodically estimate supplies
- Plan ahead to avoid stock-outs (EC especially)
- Determine supplies needed to collect and store forensic specimens
- Determine what supplies are available and in what formulations
- Provide checklist of supplies to relevant departments, facilities
- Assign staff member to gather supplies in one place and monitor
- Keep up to date all relevant documentation

Providing necessary medical supplies

Roles of district, regional or national policymakers:

- Procure equipment, supplies & medicines
- Include needed medicines on essential medicines list
- Arrange with pharmacies and laboratories to procure/distribute equipment, supplies list

Exercise 16.2. Review list of supplies, equipment & medicines

Learning objectives for the exercise

- To determine what equipment, medicines and other supplies are missing
- To determine how they can be obtained

Instructions

- Using the worksheet based on Job aid 5.2, mark whether each item is available in the facility
- Indicate which items need to be ordered
- Indicate items that should be kept where consultation takes place, to minimize need for the woman to move from place to place
- Record in the notes section any challenges related to availability of specific supplies, medicines or equipment

Exercise 16.2. Discussion

- Which equipment, supplies & medicines are typically lacking?
- Why are they lacking? Are there common barriers or diverse barriers?
- How can the barriers be overcome?

Key messages

- Patient flow, SOPs, consultation space and record-keeping should **ensure** visual and auditory **privacy and confidentiality**.
- Managers should make sure that **all needed** equipment, medicines and other **supplies** and are in continuous supply and **stocked** where consultations take place. Job aid 5.2 can help.

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Session 17:

Preventing violence against women

(Supplemental module)

Learning objective

Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women

Competencies

- Understand how to enhance protective factors, minimize risk and mitigate harmful consequences of VAW
- Know about multisectoral prevention strategies that the health sector can promote or advocate with other sectors
- Identify prevention strategies that can be implemented by health-care providers/settings

Violence against women is preventable

Risk and protective factors

- Definition: Aspects of a person (or group), experience or environment that make it more likely **(risk factors)** or less likely **(protective factors)** that women will experience violence or that men will perpetrate violence
- Not all risk factors are causal
- The **more risk factors**, the greater the likelihood of violence
- There are risk and protective factors both for experiencing violence and for perpetrating violence
- Many risk factors are related to **multiple outcomes** – for example, IPV, sexual violence, child maltreatment
- The most effective prevention programmes work on **both reducing risks and enhancing protective factors**

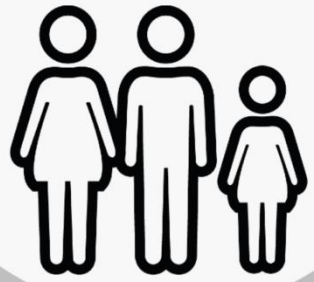
Risk and protective factors can occur at multiple levels

Individual

Biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence

Relationship

Close relationships that may increase the risk of experiencing violence as a victim or perpetrator



Community

Characteristics of settings, such as neighborhoods, in which social relationships occur that are associated with becoming victims or perpetrators of violence

Societal

Broad societal factors that help create a climate in which violence is encouraged or inhibited

Assess **the risk & protective factors**

SOCIETAL	COMMUNITY	INTERPERSONAL	INDIVIDUAL

Individual

Risk factor	Intervention
Experiencing or witnessing violence in childhood	Address childhood abuse
Low education	Improve access to education & social skills
Harmful use of alcohol	Reduce harmful drinking
Personality disorders	Early identification & treatment of conduct disorders

Relationship

Risk factor		Intervention
Men's control over women	→	Working with men & boys to promote respectful and consensual relationships and gender-equitable attitudes & behaviours
Marital dissatisfaction	→	
Multiple partners	→	Promoting gender-equitable attitudes & behaviours / healthy relationship skills / conflict resolution skills among men, women & couples

Community level

Risk factor

Unequal gender norms that condone violence against women;
weak community sanctions against violence against women

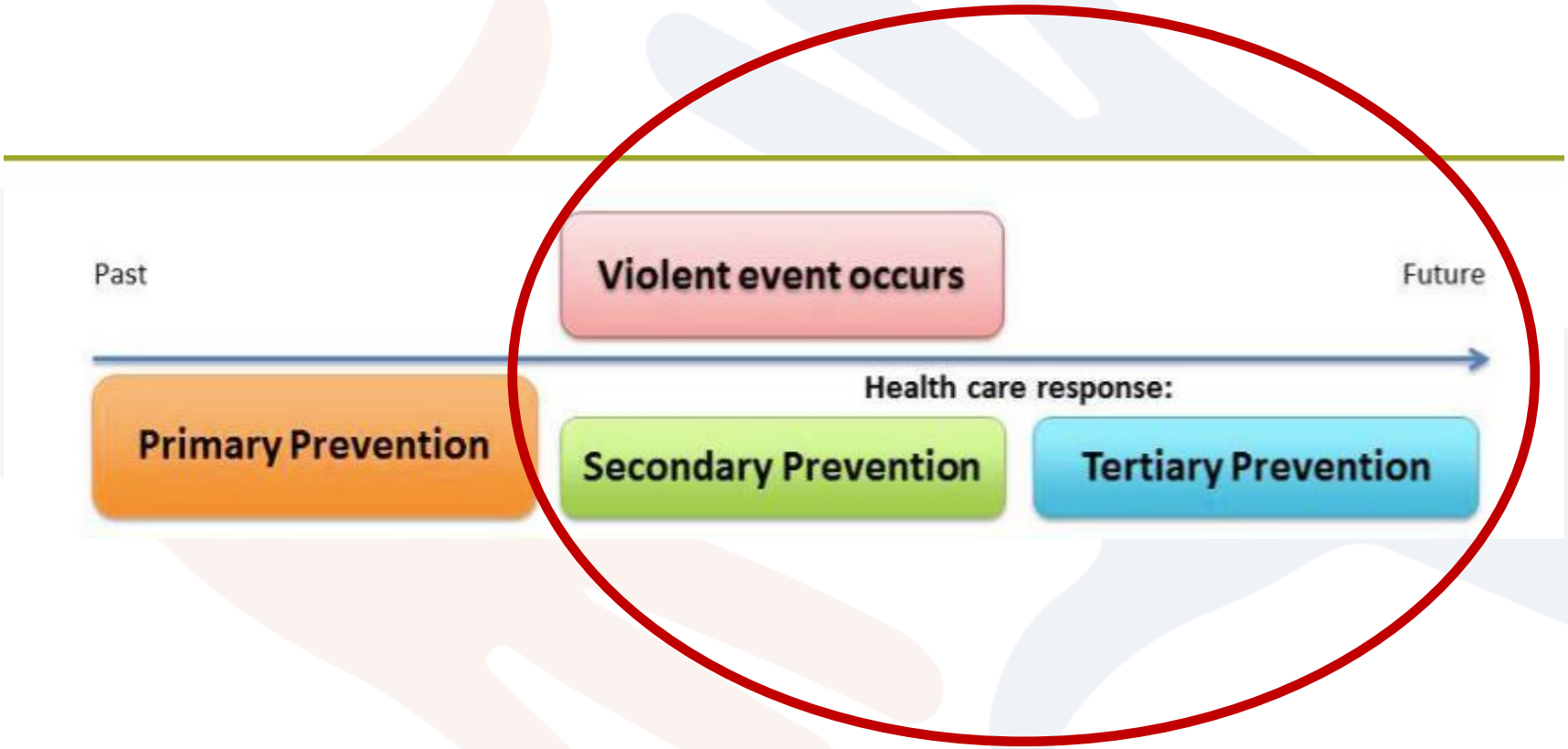
Intervention

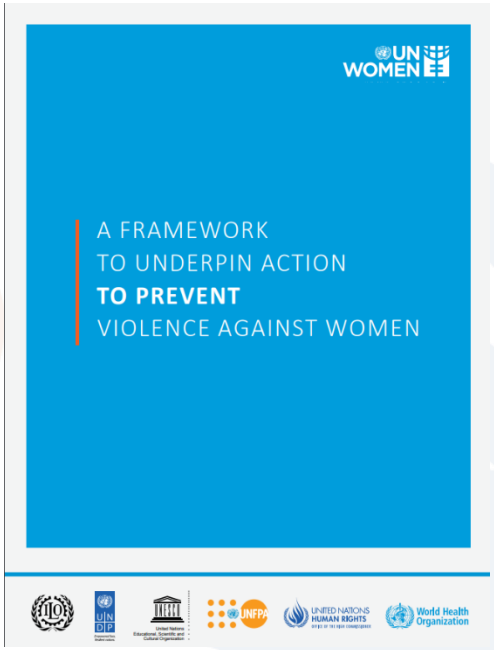
Promoting equitable gender norms through community mobilization, schools and religious institutions, edutainment, mass media

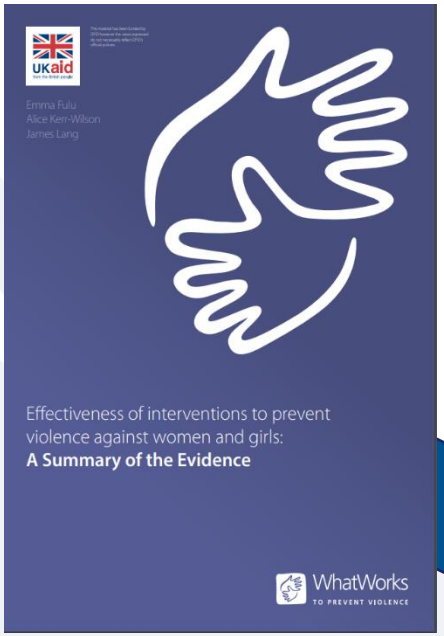
Societal level

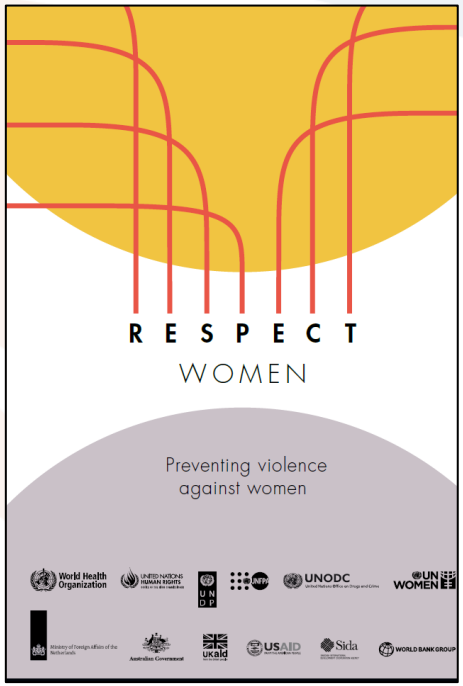
Risk factor	Intervention
Harmful use of alcohol	Policies & programmes to reduce harmful use of alcohol
Women's lack of access to education & employment	Laws, policies & programmes that promote women's access to employment, microcredit or cash transfers and girls' access to education
Gender & social norms accepting violence/ ideologies of male entitlement	Interventions addressing social & gender norms; laws that prohibit violence against women
Lack of or poor enforcement of laws against VAW	Strengthen & enforce legislation prohibiting VAW, promoting equality in marriage & divorce, property & inheritance

Violence against women is preventable









World Health Organization


R E S P E C T
Relationship skills strengthened
Empowerment of women
Services ensured
Poverty reduced
Environments made safe
Child and adolescent abuse prevented
Transformed attitudes, beliefs, and norms
Implement
7 strategies to
prevent violence
against women

https://www.youtube.com/watch?v=kYu3mFjuhTM&ab_channel=MediaHRP

Assess the **evidence** on **interventions**[3]

Relationships skills strengthened

Group-based workshops with women and men to promote egalitarian attitudes and relationships

H L

Couples counselling and therapy

H L

EXAMPLE

Group-based Workshops

In the two-year period following the implementation of *Stepping Stones* in South Africa with female and male participants aged 15–26 years, men were less likely to perpetrate intimate partner violence, rape and transactional sex in the intervention group compared to the baseline.[x]

Empowerment of women

Empowerment training for women and girls including life skills, safe spaces, mentoring

H L

Inheritance and asset ownership policies and interventions

H L

Micro-finance or savings and loans plus gender and empowerment training components

H L

EXAMPLE

Microfinance plus gender and empowerment

The *iMAGE project* (intervention with Microfinance for Aids and Gender Equity) in South Africa empowers women through microfinance together with training on gender and power and community mobilization activities. Studies show it reduced domestic violence by 50% in the intervention group over a period of two years. At US$244 per incident case of partner violence averted during a 2-year scale up phase, the intervention is highly cost-effective.[w]

Services ensured

Empowerment counselling interventions or psychological support to support access to services (i.e. advocacy)

H L

Alcohol misuse prevention interventions

H L

Shelters

H L

Hotlines

H L

One-stop crisis centres

H L

Perpetrator interventions

H L

Women's police stations/units

H L

Screening in health services

H L

Sensitization and training of institutional personnel without changing the institutional environment

H L

EXAMPLE

Advocacy for survivors

The *Community Advocacy Project* in Michigan and Illinois, United States, is an evidence-based program designed to help women survivors of intimate partner abuse re-gain control of their lives. Trained advocates provide advocacy and individually tailored assistance to survivors so that they can access community resources and social support. The intervention was found to lower recurrance of violence and depression and improve quality of life and social support. Two years after the intervention ended, the positive change continued.[y]

Poverty reduced

Economic transfers, including conditional/ unconditional cash transfers plus vouchers, and in-kind transfers

H L

Labour force interventions including employment policies, livelihood and employment training

H L

Microfinance or savings interventions without any additional components

H L

EXAMPLE

Economic transfers

In Northern Ecuador, a cash, vouchers and food transfer programme implemented by the World Food Programme (WFP) was targeted to women in poor urban areas, intending to reduce poverty. Participating households received monthly transfers equivalent to $40 per month for a period of 6 months. The transfer was conditional on attendance of monthly nutrition trainings. The evaluation showed reductions in women's experience of controlling behaviours, physical and/or sexual violence by intimate partners by 19 to 30%. A plausible mechanism for this was reduced conflict within couples related to poverty-related stresses.[p]

Environments made safe

Infrastructure and transport

H L

Bystander interventions

H L

Whole School interventions

H L

EXAMPLE

Right to play - preventing violence among and against children in schools

In Hyderabad (Sindh Province), Pakistan, a right to play intervention reached children in 40 public schools. Boys and girls were engaged in play-based learning providing them opportunity to develop life skills such as confidence, communication, empathy, coping with negative emotions, resilience, cooperation, leadership, critical thinking and conflict resolution that help combat conflict, intolerance, gender discrimination and peer violence. An evaluation showed decreases in peer victimization by 33% among boys and 59% among girls at 24 months post intervention; in corporal punishment by 45% in boys and 66% in girls; and in witnessing of domestic violence by 65% among boys and by 70% in girls.[o]

Child and adolescent abuse prevented

Home visitation and health worker outreach

H L

Parenting interventions

H L

Psychological support interventions for children who experience violence and who witness intimate partner violence

H L

Life skills / school-based curriculum, rape and dating violence prevention training

H L

Transformed attitud beliefs, and norms

Community mobilization

H L

Group-based workshops wi women and men to promote changes in attitudes and no

H L

Social marketing or edutain and group education

H L

Group education with men boys to change attitudes an norms

H L

Stand-alone awareness campaigns/single compone communications campaigns

H L

EXAMPLE

Community Mobilizations S is a community intervention in Uga that prevents violence against wom by shifting the power balance beN men and women in relationships. S show that in SASAI communities 7 of women and men believe physic violence against a partner is not acceptable while only 26% of wor and men in control communities be the same. At the cost of US$ 460 incident case of partner violence a in trial phase, intervention is cost-el and further economies of scale car achieved during scale-up.[y]

LEGEND[4]

- **promising**, >1 evaluations show significant red violence outcomes
- **more evidence needed**, > 1 evaluations sho improvements in intermediate outcomes related to
- **conflicting**, evaluations show conflicting results violence[z]
- **no evidence**, intervention not yet rigorously eva
- **ineffective**, >1 evaluations show no reductions outcomes
- **H** World Bank High Income Countries (HIC)
- **L** World Bank Low and Middle Income Countries (L

Apply the **guiding principles** for effective programming

CORE VALUES

- Put women's safety first and do no harm
- Promote gender equality and women's human rights
- Leave no one behind

GENERATE AND DISSEMINATE KNOWLEDGE

- Develop a theory of change
- Promote evidence informed programming

PROGRAMME DESIGN

- Use participatory approaches
- Promote coordination
- Implement combined interventions
- Address the prevention continuum
- Take a life-course approach

Exercise 17.1. Assessing risk and protective factors

Lifeline	Problem tree
Case study 1: Adolescent girl – 16 years	Case study 2: Young man – 25 years

Note: Different emphasis in the 2 exercises

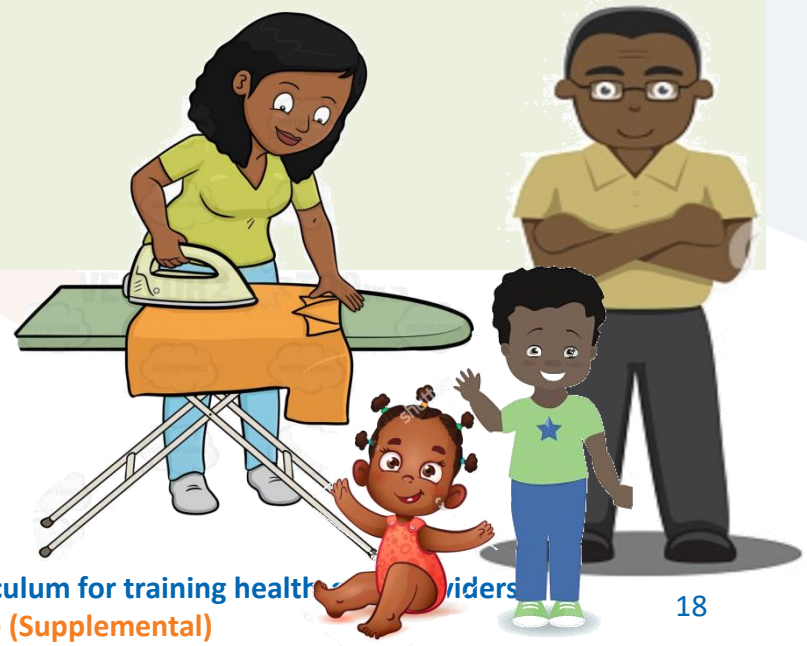
Time to work : 45 minutes

Time for plenary: 30 minutes

Exercise 17.1. Case studies

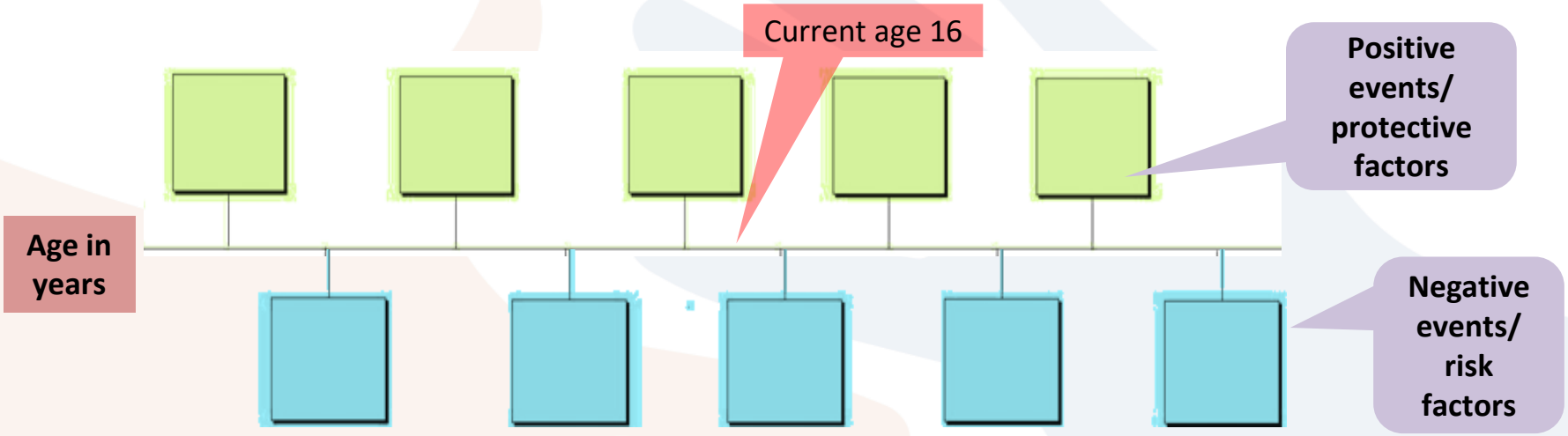
Adolescent girl: 16-year-old girl from family of 6, has experienced sexual abuse since childhood.

Young man: 25-year-old married man. Has sexually transmitted infections (STIs). Abuses his wife and their 2 children.



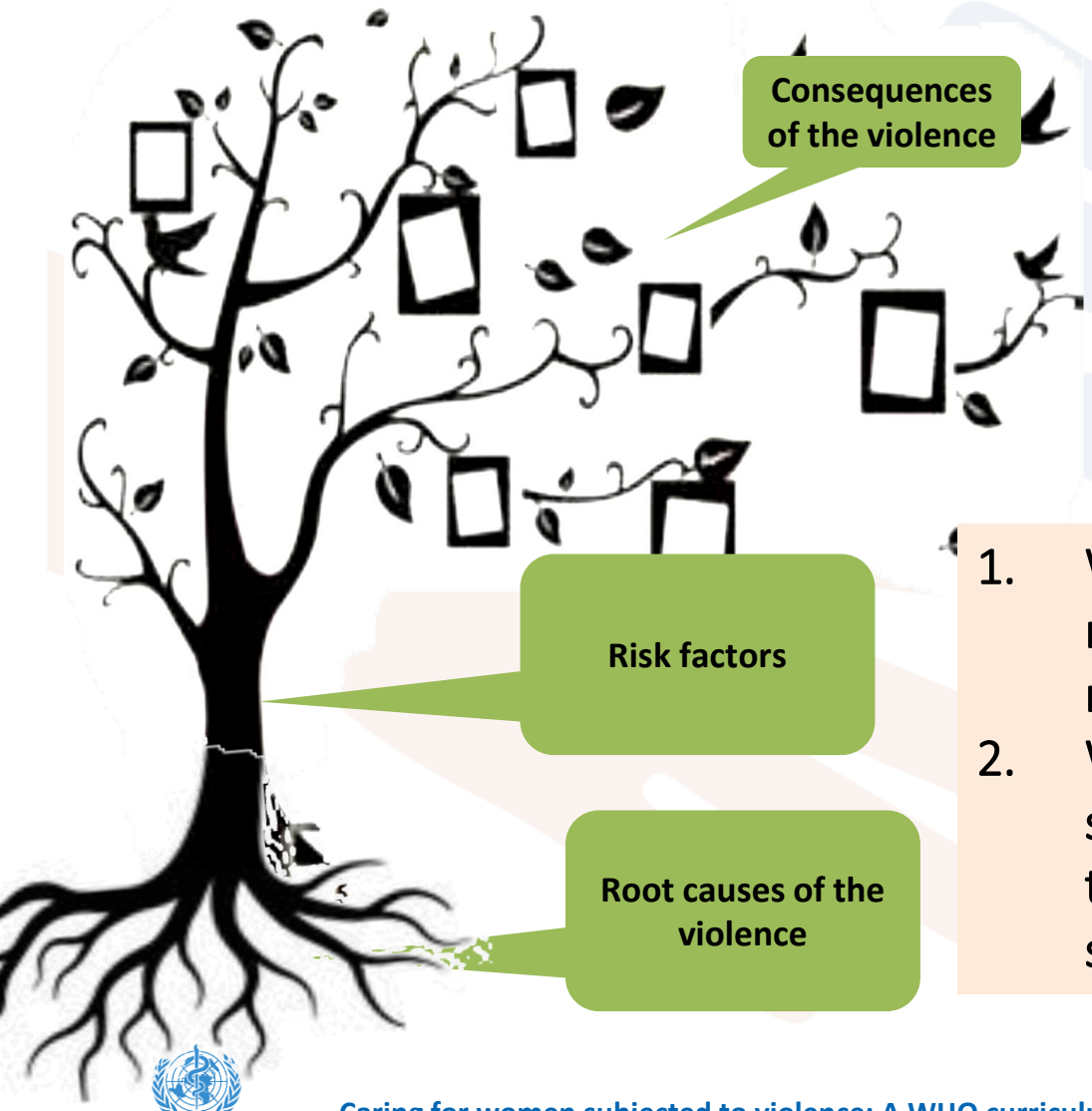
Exercise 17.1. Lifeline

Draw/map life stories of 16-year-old girl on a flip chart page.



1. What interventions can re-enforce and amplify the positive events/protective factors? What interventions can mitigate or reduce the negative events or risk factors?
2. Which interventions can the health sector implement directly and which through advocacy with other sectors? Mark these with a star.

Exercise 17.1. Problem tree



Imagining the life of the 25-year-old man abusing his wife, draw the tree. Place causes of the problems in the roots, the risk factors in the tree trunk and the consequences on the branches.

1. What interventions can address risk factors and root causes and mitigate consequences?
2. Which interventions can the health sector implement directly or through advocacy with other sectors? Mark these with a star.

Exercise 17.2. Solutions Tree

Each group/table brainstorms for 10 minutes.

On three Post-its write:

1. One **prevention message** to communicate to patients, communities
2. One **facility activity** where prevention messages can be incorporated
3. One activity **outside the facility** where you can promote prevention messages

Stick post-its on the solutions tree where shown.

Key messages

- Violence against women is **preventable**
- The **health sector** has a **role** to play **in prevention**
- Identify interventions to **enhance protective factors**, **reduce risks** and harmful consequences
- The **RESPECT framework** identifies promising prevention strategies and guiding principles for implementation
- As health-care managers, you can:
  - incorporate messages about prevention into **health promotion** activities
  - implement **interventions through services**, including for mental health, alcohol and drug use problems/conditions
  - **advocate** for preventionwith peers, communities and leaders