Provision of coordinated sectoral services for sexual and gender-based violence victims/survivors by the health sector

A RESOURCE FOR CAPACITY DEVELOPMENT for Central Asia

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East European Institute for Reproductive Health

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Provision of coordinated sectoral services for SGBV victims/survivors by the health sector – A resource for capacity development for Central Asia, 2022

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The Spotlight Initiative is a global initiative of the United Nations which has received generous support from the European Union. Its aim is to eliminate all forms of violence against women and girls.

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Introduction

Context

The training curriculum is elaborated in the framework of the Regional Spotlight Initiative Program for Central Asia (Regional SI Program), a regional project that aims to address Sexual and Gender-Based Violence (SGBV) and accelerate achieving the SDGs through fostering a transformational approach across the region, while bolstering the work of the SI Country Programmes. The project is implemented by UNFPA with financial support of European Union. The Regional SI covers the five Central Asian countries of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan.

The Regional SI Program ensures that the models, tools, and transformational approaches adopted at the regional level reinforce and support the implementation of the international norms and standards guiding work on SGBV, including the CEDAW, the CRC and the Council of Europe (CoE)'s Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention).

In the context of this project, the term Sexual and Gender-Based Violence (SGBV) is understood to comprise the following forms:

- Domestic violence (family violence and abuse, intimate partner violence)
- Sexual violence: limited to rape and sexual assault
- Harmful practices: limited to early marriage, bride kidnapping

Gender-based violence is violence directed against a person because of their gender. Both women and men experience gender-based violence but the majority of victims are women and girls[1]. To this respect, CEDAW defined gender-based violence as "violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty[2]. Furthermore, in 1993 UN DEVAW defined violence against women as "any act of gender-

[1] EIGE website. https://eige.europa.eu/gender-based-violence/what-is-gender-based-violence.
[2] Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), General recommendation No. 19: Violence against women, 1992.

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, whether occurring in public or in private life"[3]. Considering all these, within the Regional Spotlight Initiative, by gender-based violence we shall refer to violence against women and girls because they are at greater risk of experiencing certain types of violence.

Victim/survivor refers to any person who have experienced or is experiencing SGBV to reflect both the terminology used in the legal process and the agency of these women and girls in seeking essential services[4]. Different terms can be used when referring to a person who have had experienced SGBV at least once in the lifetime. The term "victim" should be avoided to be used alone because it implies passivity, weakness, and inherent vulnerability, contributes to a feeling of powerlessness for those who have suffered some form of SGBV and fails to recognize the reality of person's resilience and agency. The term "survivor" defines the persons who suffered from SGBV and seek help, cope with trauma, and take back their lives, but the term is problematic because it denies the sense of victimization experienced by persons who have been the target of violent crime. Sometimes, but rarely, the term client is used to register a person by the psycho-social service providers. Therefore, this document uses the term "victim/survivor".

The aim of the training curriculum is to offer a quality response of health care services to sexual and gender-based violence (SGBV), by focusing on the health care service providers offering coordinated sectoral and/or one stop shop services for SGBV victims/survivors.

The training curriculum will employ multiple training methods including presentations, case-studies and practical tools and exercises (group work and role-play) to increase participants' knowledge, skills and attitudes needed to respond to women's diverse needs and experiences.

The content of the training curriculum is anchored in the following best-practices guides:

1. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva, Switzerland: World Health Organization; 2013.
2. WHO, UNW, UNFPA. Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook. Geneva: WHO, 2014. (WHO/RHR/14.26)
3. Bewley, Susan, and Jan Welch, eds. ABC of domestic and sexual violence. John Wiley & Sons, 2014.
4. Johnson Medina, Dulf Diana, Sidor Alexandra. RESPONSE Training Manual for Reporting of Gender-Based Violence in Women's Health Services. Project RESPONSE, 2017. http://gbv-response.eu/wp-content/uploads/2017/03/00_manual_response-english_web.pdf
5. UNFPA-WAVE Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia. 2014
6. UN Women, UNFPA, WHO, UNDP, UNODC (2015), Essential social services for women and girls who experience violence, Modules 1 and 2. https://www.unfpa.org/sites/default/files/pub-pdf/Essential-Services-Package-en.pdf.
7. UNFPA (2018) Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights for Women and Young Persons with Disabilities. https://www.unfpa.org/featured-publication/women-and-young-persons-disabilities.
8. UNFPA, EEIRH (2015), Multi-sectoral response to GBV. An effective and coordinated way to protect and empower GBV victims/survivors.
9. UNFPA, EEIRH (2020), Multi-sectoral response to Gender-based Violence, A resource package.

[3] UN Declaration on the Elimination of Violence against Women (DEVAW), 1993.
[4] UN Women, UNFPA, WHO, UNDP, UNODC (2015), Essential social services for women and girls who experience violence.

Learning outcomes

After completing this training workshop, learners will have acquired the following knowledge, skills and attitudes.

Increase their knowledge by being able to:

- Define SGBV
- List forms of SGBV
- List causes and impact of SGBV
- Recognize different healthcare services that can identify SGVB
- List the steps of the case-management process
- Explain how to conduct injury examination and following care
- Explain how to conduct sexual assault examination and following care
- Discuss communication strategies used with SGBV victims/survivors when offering treatment and care for sexual assault
- List the impact of SGBV on the mental health of victims/survivors
- Discuss communication strategies used with SGBV victims/survivors when communicating mental health
- Recognize and implement the correct steps of SGBV medico-legal documentation and recording
- Understand the steps and role of a risk-assessment plan
- Understand the steps and role of a safety plan
- Identify pathways for reporting and referral taking into consideration best practices and national recommendations and laws.

Improve their skills by being able to:

- Illustrate the link of healthcare facilities with the other services provided to SGBV victims/survivors
- Demonstrate the ability to recognize different categories of SGBV victims/survivors
- Demonstrate the ability to document and record injuries after a SGBV event
- Demonstrate communication skills with victims/survivors of SGBV
- Demonstrate referral skills for victims/survivors of SGBV.

Change their attitudes to:

- Show sensitivity towards SGBV victims/survivors
- Accept responsibility of the role of healthcare personnel in the treatment and care of SGBV victims/survivors
- Explain the differences in offering support for vulnerable victims/survivors of SGBV
- Demonstrate openness to offer support for vulnerable victims/survivors of SGBV.

Target learner groups

Women who experience SGBV and go to health care services require a supportive and positive treatment, including a potential screening and onward referral to other professionals who provide care and support like social worker and police officer, depending on the need of the victim/survivor.

The training is designed for health care staff who are in direct contact with SGBV/DV victims/survivors and can facilitate disclosure, provide appropriate medical care, and offer support and referral.

The manual aims to support the training of health care professionals which are more likely to identify and refer women who experience SGBV and how to work side-by-side with social workers and police officers, offering coordinated sectoral and/or one stop shop services for SGBV victims/survivors.

The major health care sectors which can participate to the increase of identification and reporting of SGBV cases are emergency health care providers, gynecology, obstetrics and women's health clinics professionals, and family practice.

The manual includes guiding information to improve the skills of health care workers to provide a comprehensive, patient-centered response. By health care workers we refer to doctors, nurses, midwives, health visitors; particularly those working in emergency department, primary/family care physician, neurology, psychiatry, orthopedics, gynecology, obstetrics and sexual health at clinical or hospital level, as well as any support workers and psychologists who work in clinics or hospitals, with the role of SGBV prevention advocate.

Duration of the training

The training consists in three main modules on the topic of health sector's response to SGBV, completed with the introduction and closure of the training. The total duration of learning activities is 18 hours, to which time for summing up each day, reflecting the day before and breaks will be added.

Proposed structure of the training and time allocation

The training has 3 major modules. Each module has 2 to 5 topics included. The package offers to trainers the model of a 3-day workshop to facilitate the training activities:

	Time allocation (min)
Introduction to the workshop	**60**
Module 1. SGBV core concepts and health care practices	**290**
Topic 1.1. Sexual and gender-based violence core concepts	130
Topic 1.2. Guiding principles for providing women-centered care	40
Topic 1.3. Identifying SGBV survivors/patients addressing different health care services	120
Module 2. Essential health services addressing SGBV	**490**
Topic 2.1. Essential health services	120
Topic 2.2. Documenting SGBV	90
Topic 2.3. Management of risk	90
Topic 2.4. Providing health support to vulnerable group experiencing SGBV	90
Topic 2.5. Communication skills for health care providers	90
Module 3: Multi-sectoral coordinated response to SGBV	**190**
Topic 3.1. Referral system	90
Topic 3.2. Multi-sectoral response to SGBV	100
Closure	**45**

Each module outlines a set of topics, the theoretical knowledge related to these topics as well as practical activities aimed to help participants explore in more depth and consolidate these notions, as well as experience how to use them in their work with SGBV victims/survivors. Each module contains:

- Structured information on topics and subtopics organized to cover the proposed learning outcomes in terms of knowledge, skills, and attitudes.
- The learning outcomes are detailed in the learning outcomes section and in the proposed training outline in a comprehensive manner and attributed to each topic.

Each topic is organized as a session which is supported by:

- Extensive description in the Part. 1 Resource package
- PPT presentation
- Handouts representing practical activities or worksheets that can be used during training
- Additional supporting materials for readings or videos that can be used by the trainer taking into consideration any time limitations or constraints
- Instructions by trainers in terms of timeline and when/how to use handouts and additional supporting materials; as well the needed materials and equipment to be used during the training roll-out.

Evaluation

Participants will have a knowledge evaluation through a multiple-choice test before and after the workshop and ideally at a three and six-month period after that. There will be also a reflection time after each module and after the workshop, and a feedback questionnaire to assess the level of satisfaction with the training.

Part 1.
Resource package

Module 1.
SGBV core concepts and health care practices

Topic 1.1. Sexual and Gender-based Violence core concepts

Definitions and terms[5]

The Council of Europe Convention on preventing and combating violence against women and domestic violence, also known as the Istanbul Convention, is a ground-breaking European convention that is based on the understanding that violence against women is a form of GBV that is committed against women because they are women (RESPONSE). Violence against women means "any 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, whether occurring in public or in private life"[6].

SGBV violates a number of women's rights, including the right to life, the right to not be subject to torture or to cruel, inhuman or degrading treatment or punishment, the right to equal protection under the law, the right to equality in the family, or the right to the highest standard attainable of physical and mental health[7,8,9].

SGBV against women and girls is one of the most widespread violations of human rights, with a significant impact on physical, psychological, sexual and reproductive health. SGBV is a structural problem that is deeply embedded in unequal power relationships between men and women and includes all forms of sexual harassment and harmful practices against women and girls[10].

Gender-based violence (GBV) and violence against women (VAW) are often used together or interchangeably, since most violence against women is gender-based, and most gender-based violence is perpetrated by men against women and girls. Below you can find some definitions and terminology that we use in this manual and training when working with patients and victims/survivors of sexual and gender-based violence.

"Gender-based violence is violence that is directed against a woman because she is a woman, or that affects women disproportionately" - Committee on the Elimination of Discrimination Against Women, General Recommendation No. 19, Violence Against Women (1992).

Violence against Women (VAW) is "(...) a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of women's full advancement. [...]Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men" - Declaration on the Elimination of Violence Against Women (1993), Preamble

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[5] Adapted from RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services."

[6] Council of Europe, "Convention for the Prevention of Violence Against Women and Domestic Violence", the Istanbul Convention, (2011), and ratified in 2014, http://www.coe.int/en/web/istanbul-convention.

[7] Idem.

[8] Convention on the Elimination of all Forms of Discrimination Against Women. (1992).

[9] RESPONSE Training Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services."

[10] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia". (2014), p. 18.

"Sexual and Gender-Based Violence (SGBV) is any harmful act of sexual, physical, psychological, mental, and emotional abuse that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females."

Forms of SGBV

Domestic violence (family violence and abuse, intimate partner violence)

Intimate partner violence refers to behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors.

Physical harm	Refers to any action that results in bodily injury, pain, or impairment. The severity of the injury might range from minimal tissue damage which might not require medical treatment, to injuries to the tissues and bones that might require immediate medical treatment or hospitalization, or injuries that might lead to permanent disabilities and/or death. Acts of physical harm include, but are not limited to: • Slapping, shoving, pushing, punching, beating, scratching, choking, biting, grabbing, shaking, spitting, burning, twisting of a body part, forcing the ingestion of an unwanted substance • Using household objects to hit or stab a woman, using weapons (knives, guns).
Sexual harm	Is defined separately below.
Phycological harm	Refers to any action that results in the impairment of the woman's psychological integrity. Acts of psychological harm include, but are not limited to: • Threats of violence and harm against the woman or somebody close to her, e.g., stalking, displaying weapons • Harassment and mobbing at the workplace • Humiliating and insulting comments • Isolation and restrictions on communication • Use of children by a violent intimate partner to control or hurt the woman. These acts constitute both, violence against children, as well as violence against women.
Controlling behaviors	refers to any action that results in a woman's dependence and subordination that leads to the impairment of woman's rights and free-will. Acts of controlling behaviors include, but are not limited to: • Assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim/survivor • Isolating women from sources of support: colleagues, family, friends • Exploiting woman's resources and capacities for personal gain, e.g. not letting a woman have a job, or have an education • Depriving them of the means needed for independence, resistance and escape and regulating their everyday behavior • Removing girls from school, prohibiting or obstructing access of girls and women to basic, technical, professional or scientific knowledge.

Figure 1. Types of domestic violence.

Sexual violence (limited to rape and sexual assault)

Sexual violence refers to any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality, using coercion, by any person, regardless of their relationship to the victim/survivor, in any setting, including, but not limited to home and work[11]. Sexual violence includes sexual exploitation and sexual abuse. It refers to any act, attempt, or threat of a sexual nature that result, or is likely to result in, physical, psychological and emotional harm. Sexual violence is a form of gender-based violence.

Acts of sexual violence can include:

- Rape, or other forms of sexual assault
- Unwanted sexual advances or sexual harassment (including demands for sex in exchange for job promotion or advancement or higher school marks or grades)
- Trafficking for the purpose of sexual exploitation
- Forced exposure to pornography
- Forced pregnancy, forced sterilization, forced abortion.

Harmful practices: limited to early marriage, bride kidnapping

Early marriage/ Child marriage	Is defined as arranged marriage under the age of legal consent (sexual intercourse in such relationships constitutes statutory rape, as the girls are not legally competent to agree to such unions). Depending on the specific legislation of the countries, the age for legal consent varies. In EECA countries, the age is 16.
Forced marriage	Is defined as arranged marriage against the victim/survivor's wishes, which is exposed to violent and/or abusive consequences if he/she refuses to comply.
Honor killing and maiming	Is defined as maiming or murdering a woman or a girl as a punishment for acts considered inappropriate with regards to her gender, and which are believed to bring shame on the family or community (e.g. pouring acid on a young woman's face as punishment for bringing shame to the family for attempting to marry someone not chosen by the family), or to preserve the honor of the family (i.e. as a redemption for an offence committed by a male member of the family).

Figure 2. Definitions of harmful practices.

Prevalence of SGBV

The 2018 World Health Organization (WHO) Report[12] on violence against women prevalence estimates acknowledge that 27% off ever-married/partnered women aged 15–49 years have been subjected to physical and/or sexual intimate partner violence at least once in their lifetime; compared to 2013 WHO Report where 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence, we could see a small improvement in the rates of abuse, but we can honestly admit that still, 1 in 3 women have suffered some type of gender-based violence.

While there are many other forms of violence that women may be exposed to, this already represents a large proportion of the world's women. In the last 12 months, the prevalence was 13% globally, of ever-married/partnered women aged 15–49 years being subjected to physical and/or sexual intimate partner violence. Available national data was used to calculate the estimates, which includes the

[11] World Health Organization (WHO), "World Report on Violence and Health". (2002). p. 149

[12] Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva: World Health Organization; 2021.

2000-2018 Global Violence Against Women Database, national representative studies and subnational studies as well.

For the partner countries included in the project, the table below reflects the calculated prevalence estimates[13]; unfortunately Turkmenistan and Uzbekistan did not have available data.

Country	Intimate Partner Violence	
	Past year	Lifetime
Kazakhstan	6%	16%
Kyrgyzstan	13%	23%
Tajikistan	14%	24%
Turkmenistan	NA	NA
Uzbekistan	NA	NA
Afghanistan.	35%	46%

Figure 3. 2018 Global and European region intimate partner violence prevalence estimates.

Dynamic of violence

The Power and Control Wheel offers a framework for understanding the dynamic of violence in an intimate relationship[14]. This model was developed by the Domestic Abuse Intervention Programs in Minnesota, US, weaving in the experiences of women victims/survivors of intimate partner violence who had participated in focus groups. The wheel consists of eight spokes that summarize the patterns of behaviour used by an individual to intentionally control or dominate the intimate partner, actions that serve to exercise 'power and control' – which is written in the middle of the wheel. The rim of the wheel is made of physical and sexual violence – this violence holds it all together[15].

Why SGBV is a problem

Sexual and gender-based violence is widely recognized as a worldwide violation of human rights with significant consequences on girls and women's well-being. SGBV widely affects victim/survivor's physical, mental, sexual and reproductive health. Although, one in three women worldwide suffer from at least a type of SGBV in their lifetime, SGBV goes underreported most of the times.

Violence against women is costly in terms of economic cost and health[16, 17]. Emergency departments are often the first point of access to health services for women experiencing gender violence and the healthcare professional plays a key role in the diagnosis and treatment of a situation of violence that are not declared.

[13] WHO European Region Factsheet. Violence against Women Prevalence Estimates, 2018: https://apps.who.int/iris/bitstream/handle/10665/341602/WHO-SRH-21.9-eng.pdf

[14] UNFPA-WAVE, "Strengthening Health System responses to gender-based Violence in Eastern Europe and Central asia" (2014), p. 32. also cited in WHO, "Integrating Poverty and Gender into Health Programmes, a Sourcebook for Health Professionals module on gender-based Violence", (2005).

[15] UNFPA-WAVE, "Strengthening Health System responses to gender-based Violence in Eastern Europe and Central asia" (2014), p. 32. also cited in WHO, "Integrating Poverty and Gender into Health Programmes, a Sourcebook for Health Professionals module on gender-based Violence", (2005).

[16] Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. *Lancet*2002;360:1083-8.

[17] Reynaldos, B., Sánchez-Rodríguez, F., Legaz, I., & Osuna, E. (2018). Analysis of the information in mandatory reporting in victims of gender violence. *Journal of public health research*, *7*(3), 1443. https://doi.org/10.4081/jphr.2018.1443

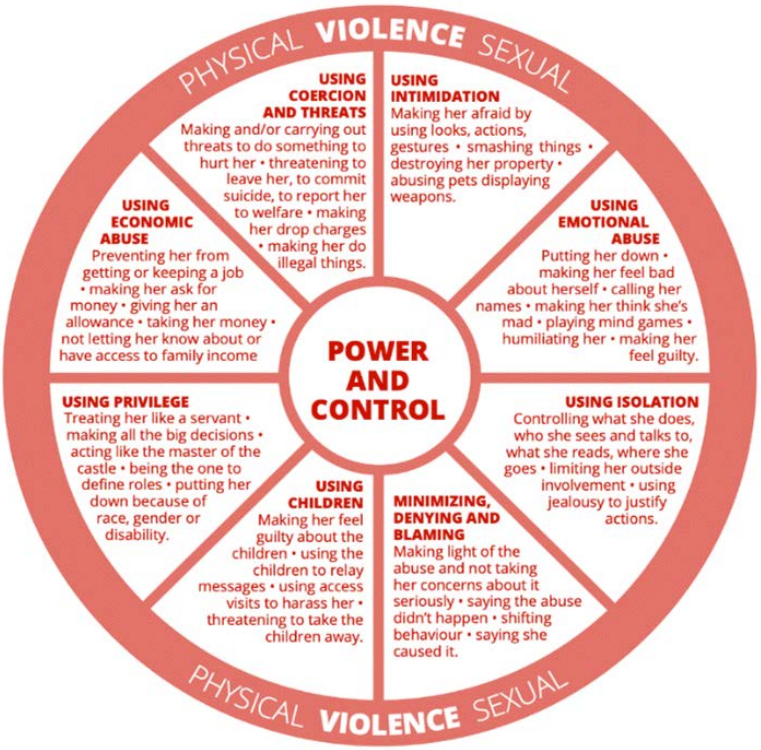

Figure 4. Power and control wheel.

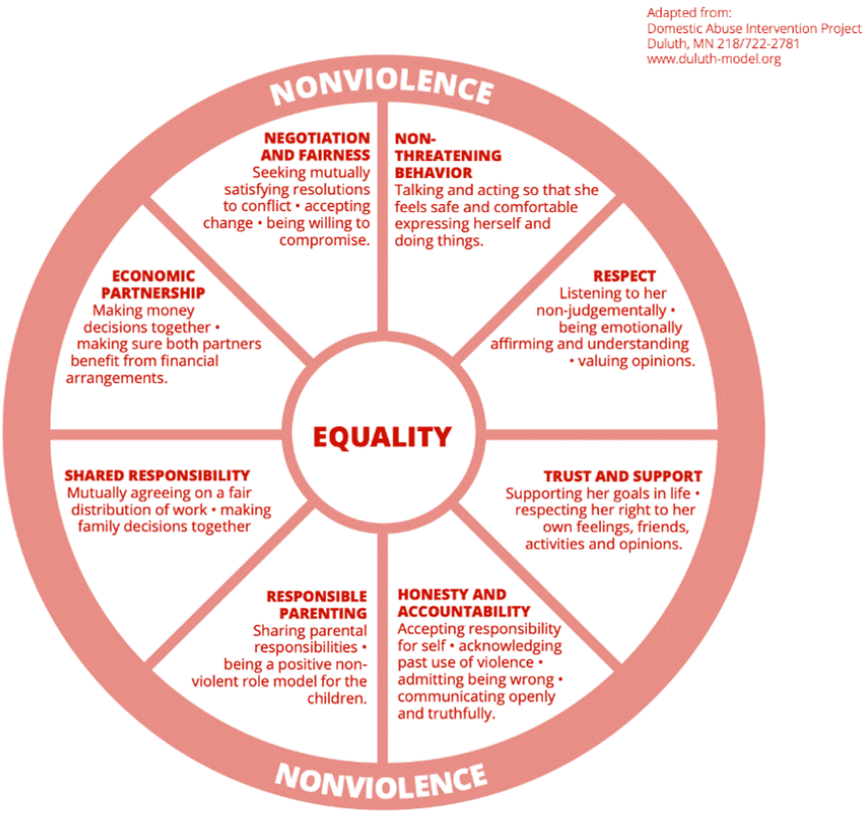

Figure 5. Non-violence power and control wheel.

As SGBV is still an underreported health problem, it is crucial for health care professionals to have the necessary knowledge and skills to identify cases of SGBV and to properly document the event. Collecting data and information it is important for the health system as well as for the SGBV

victims/survivors, as the medical chart which correctly describes the violent injury event can be used for any legal actions, as long as the samples and information is collected respecting the legal requirements specific to EECA countries. Efforts are needed to raise awareness among health professionals about the importance of providing the correct information[18], and their role in documenting and reporting cases of SGBV, which will lead to better knowledge and information on this topic, as well as more prevention efforts and control of SGBV.

Causes and impact of SGBV on health

SGBV is considered a major health and public health problem with devastating health consequences and enormous costs and challenges for the health care system and the services it provides[19]. GBV is linked to a different health outcome and is a risk factor for a wide range of both immediate and long-term health conditions. The health impacts may show as physical symptoms, injuries, chronic pain, neurological symptoms, gastrointestinal disorders, gynecological problems and increased cardiovascular risk. GBV may lead to unintended pregnancies, gynecological problems, induced abortions and sexually transmitted infections, including HIV[20]. Miscarriage, stillbirth, pre-term delivery and low birth weight are other possible effects of GBV during pregnancy[21]. The patient may be depressed, self-harm, have post-traumatic stress disorder (PTSD), anxiety, insomnia, increased substance use and have thoughts about suicide. Cessation of abuse does not necessarily mean that mental health problems cease as well. The influence of abuse can persist long after the abuse itself has stopped and the more severe the abuse, the greater its impact on physical and mental health, as victimization is associated with an increased risk of mental disorder[22], mental health professionals being identified as a group of professionals with an important role in the identification and referral of SGBV. Less well recognized are dental problems and dental neglect (due to dental phobia).

GBV can also start or escalate in pregnancy with the most serious outcome being the death of the mother or the fetus. Less recognized are the impacts of unintended pregnancies. Health care services spend more time dealing with the impact of violence against women and children than almost any other agency and they are often the first point of contact for women who have experienced GBV.

The health service can play an essential role in responding to and helping prevent further GBV by intervening early, providing treatment and information and referring patients to specialist services. Thus, health care professionals are in a unique position to help those who experience GBV to get the support they need.

[18] Reynaldos, B., Sánchez-Rodríguez, F., Legaz, I., & Osuna, E. (2018). Analysis of the information in mandatory reporting in victims of gender violence. *Journal of public health research*, *7*(3), 1443. https://doi.org/10.4081/jphr.2018.1443

[19] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”

[20] Haddad L, Shotar A, Younger J, Alzyoud S, Bouhaidar CM, “Screening for domestic violence in Jordan: validation of an Arabic version of a domestic violence against women questionnaire.” International Journal of Women’s Health. (2011), p. 79-86

[21] Halpern CT, Spriggs AL, Martin SL, Kupper LL, “Patterns of Intimate Partner Violence Victimization from Adolescence to Young Adulthood in a Nationally Representative Sample”. Journal of Adolescent Health. (2009), p. 508-516.

[22] Oram, S., Khalifeh, H. and Howard, L.M., 2017. Violence against women and mental health. The Lancet Psychiatry, 4(2), pp.159-170.

SGBV can impact all aspects of women's health. Health consequences of GBV can be both immediate and acute, as well as long-lasting and chronic. Negative health consequences may persist long after the violence has stopped[23].

SGBV can result in [24,25]:

- **Death** – fatal outcomes as immediate result of a woman being killed by the perpetrator, or as a long-term consequence of other adverse health outcomes, (for example, mental health problems resulting from trauma can lead to suicide, alcohol abuse, HIV infection or cardiovascular diseases)
- **Reduced life expectancy** – the World Bank estimates that rape and domestic violence account for 5% of the healthy life years of life lost to women aged 15 to 44 in developing countries
- **Physical harm** – Injuries, functional impairments, permanent disabilities
- **Risky health behaviors** – Alcohol and drug use, smoking, sexual risk-taking, self-injuring behaviour
- **(Psycho)-somatic consequences** – Chronic pain syndrome, irritable bowel syndrome, gastrointestinal disorders, urinary tract infections, respiratory disorders
- **Reproductive health consequences** – Pelvic inflammatory disease, sexually transmitted diseases, unwanted pregnancy, pregnancy complications, miscarriage/low birth weight
- **Psychological consequences** – Post Traumatic Stress Disorder, depression, fears, sleeping disorders, eating disorders, suicidal thoughts, and low self-esteem.

The 2013 World Health Organization (WHO) report[26] on violence against women and the health effects of intimate partner violence and non-partner sexual violence recognizes the consequences of the violence on women's emotional, physical and reproductive health. Women who have been physically or sexually abused by their partners report higher rates of a number of important health problems. They are:

- 16% more likely to have a low-birth-weight baby
- More than twice as likely to have an abortion
- Almost twice as likely to experience depression
- In some regions, 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence.

The diagram below highlights the impact on health of intimate partner violence as evidenced in the WHO report[27] and included in the RESPONSE Manual:

[23] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 39.
[24] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 40.
[25] IMPLEMENT Manual. Blank K, Rösslhumer M. 2015. IMPLEMENT Training Manual on Gender-Based Violence for Health Professionals.
[26] WHO, Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. (2013), p. 2.
[27] Idem, p. 8.

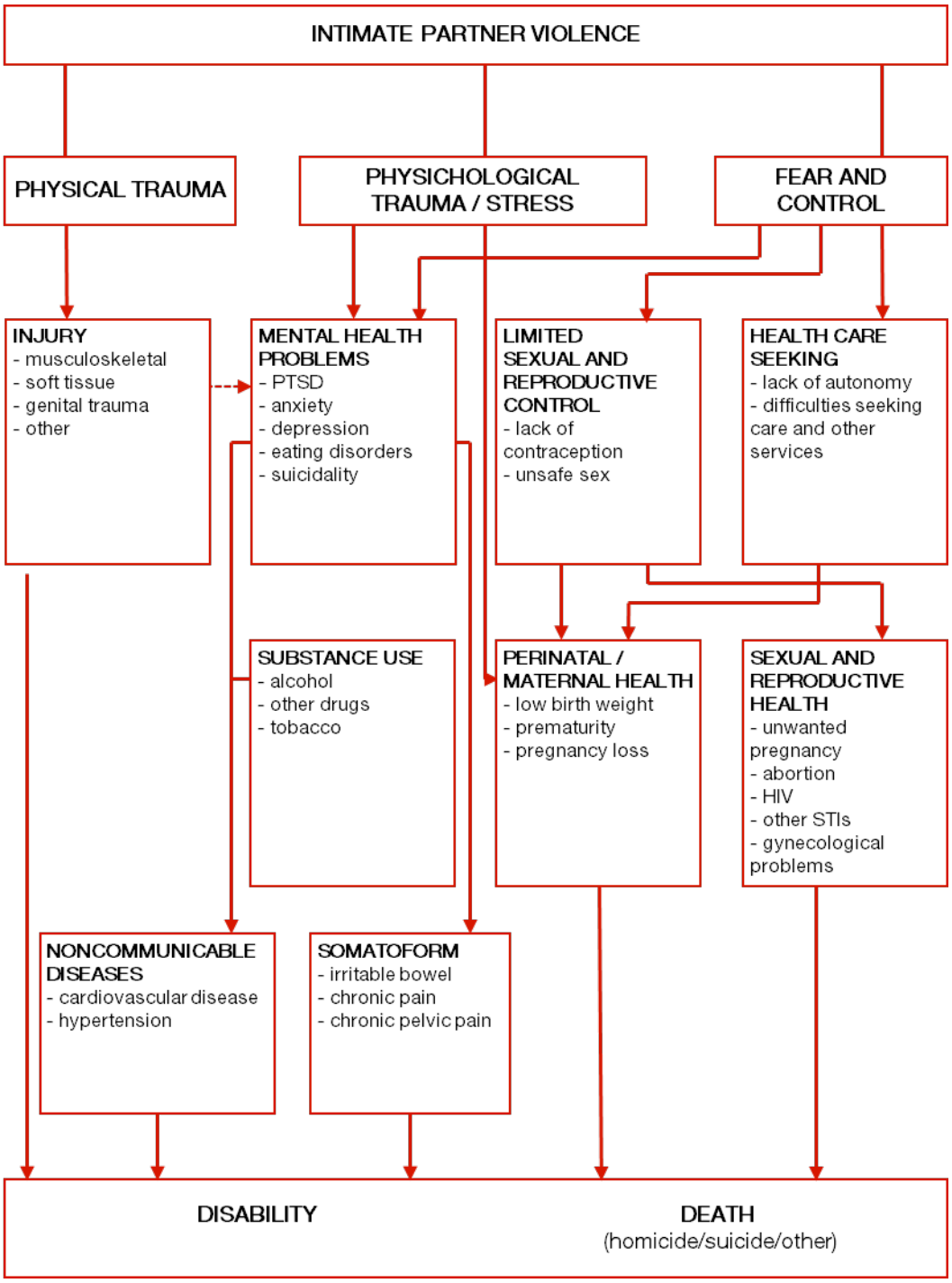

Figure 6. Impact on health of intimate partner violence.

Additionally, Valpied and Hegarty[28] have identified a list of indicators that health care practitioners can be considered warning signs for SGBV. By being able to identify risk factors, symptoms, and/or conditions that can be underlying for SGBV, health care practitioners could inquire for SGBV in some scenarios that usually they do not lead to the identification or referral of SGBV.

[28] Valpied J, Hegarty K. Intimate partner abuse: identifying, caring for and helping women in healthcare settings. Womens Health (Lond). 2015 Jan;11(1):51-63.

Although health care professionals have patients who are victims/survivors of SGBV, a lot of signs and symptoms are linked to tertiary prevention and treatment of direct injuries and conditions, not to primary prevention and identified as red flags for possible case of SGBV. The table below includes four categories of indicators that could help health care practitioners in identifying SGBV, the table is adapted from the RESPONSE Manual[29]:

Physical health	Gynecological/Reproductive health	Psychosocial health
• Chronic gastrointestinal symptom • Chronic diarrhoea • Chronic abdominal pain • Chronic headaches • Other chronic pain (unexplained) • Unexplained hearing loss • Injuries, especially to head/neck or multiple regions • Bruises in various stages of healing • Lethargy	• Chronic pelvic pain • Sexual dysfunction • Vaginal bleeding (especially repeated cases) • Frequent bladder or kidney infections • Sexually transmitted infections • Multiple unintended pregnancies/ terminations • Miscarriages • Delayed prenatal care • Low infant birth weight	• Anxiety • Depression • Eating disorders • Panic disorders • Post-traumatic stress disorder • Sleep disorders • Somatoform disorders • Alcohol or other substance misuse • Suicide ideation or attempts • Any type of self-harm
Environmental settings/Access to medical care and treatment		
• Frequent health care service use and/or hospital admissions • Frequent/high-level medication use • Abuse of a child in the family • Delays in seeking treatment • Not following through with treatment and/or appointments • Inconsistent, implausible, or vague explanation of injuries • Partner who is intrusive or over-attentive in medical consultations • Social isolation • Recent separation or divorce from (ex) partner		

Figure 7. Possible health indicators of intimate partner abuse.

Vulnerable groups

Persons with disabilities

Women and young persons with disabilities may experience the same forms of SGBV as individuals without disabilities. However, they also encounter unique forms of SGBV due to their disability, and service providers must commit to understanding them[30].

Some of those unique forms of SGBV are the following[31]:

- Sexual abuse by a caregiver
- Purposefully substandard care
- Withholding of medication or an assistive device
- Financial control
- Early or forced marriage
- Forced or coerced medical procedures, such as forced sterilization, contraception, or abortion
- Restriction of communication devices
- Denial of necessities like food, toileting, or grooming

[29] Idem, p. 51-63.
[30] Idem.
[31] Idem.

- Control of sensory devices
- “Virgin rape”
- Enforced isolation.

This understanding is a critical first step to adapting and developing programmes that effectively serve women and young persons with disabilities. Healthcare professionals are essential for secondary prevention aimed to stop or minimize SGBV by screening for SGBV and provide the needed support and referrals to prevent additional occurrences. Moreover, tertiary prevention can also be offered through treatment and harm reduction for persons with severe injuries and health consequences[32].

Essential health services for SGBV victims/survivors include[33]:

- identification procedures for victims/survivors
- First-line support to respond to the immediate emotional and physical needs of victims/survivors
- Necessary medical care
- Exams of sexual assault and further consideration for victims/survivors of sexual violence (including access to emergency contraception to prevent unintended pregnancies, abortion services where is needed and legal, and actions taken to avoid HIV and other sexually transmitted infections)
- Mental health evaluations and follow-up psychosocial care
- Documentation of violence for medico-legal evidence

Physical, social, economic, and cultural accessibility is crucial to guaranteeing that essential services are disability-inclusive both in theory and practice. Providers should identify and eliminate barriers to services that women and young persons face. The preferred form of access should be directed and chosen by the woman or young person with the disability[34].

Elderly

Elder abuse is any action or lack of action that affect physical, psychological, sexual, economical or well-being integrity of an older person. Usually, the perpetrators are persons in a position of trust, like family members, caregivers, etc. Elder abuse can happen at home, in the community, and in care facilities, including the long-term ones.

Elder abuse includes:

- Physical abuse such as slapping, punching, pushing, beating or forced isolation
- Sexual abuse
- Neglect or mistreatment, as failing to facilitate access of an older person to food, medical care, or abandoning an older person
- Mental abuse as humiliating, insulting, frightening, threatening, or ignoring an older person
- Financial abuse such as stealing, fraud or extortion.

Other terms that refer to elder abuse are “elder mistreatment”, “abuse in later life”, “senior abuse”, “abuse of older adults”.

[32] Idem.
[33] Idem.
[34] UNFPA. 2018. “WOMEN AND YOUNG PERSONS WITH DISABILITIES Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights.”

Young persons

Young persons are another category prone to SGBV as most of the times they not only know the abuser, but they are also dependent on them. Adolescent girls also face consequences of SGBV due to their young age, less awareness of existing services, lack financial resources to access services and hesitancy to seek services due to lack of confidentiality. Adolescents are also less likely to report violence because they might not recognize the behaviour of perpetrators as violence or are afraid of not being believed or taken seriously. Sexual violence might affect young girls more due to the possible consequences such as: higher pre-natal, neonatal, and infant mortality and morbidity, pregnancy-related complications leading to death, early marriage, and reproductive health issues such as fistula [35].

Training of health-care professionals

The Istanbul Convention has a specific section in which they mention and encourage countries to focus on the training of professionals. In Article 15, the Convention specifically states that: [36]

1. Parties shall provide or strengthen appropriate training for the relevant professionals dealing with victims/survivors or perpetrators of all acts of violence covered by the scope of this Convention, on the prevention and detection of such violence, equality between women and men, the needs and rights of victims/survivors, as well as on how to prevent secondary victimization.
2. Parties shall encourage that the training referred to in paragraph 1 includes training on coordinated multi-agency co-operation to allow for a comprehensive and appropriate handling of referrals in cases of violence covered by the scope of this Convention.

It is often the health care professionals who have the most contact with victims/survivors, therefore health care workers could become the main identifier of victims/survivors of SGBV.

To increase the likelihood of health care professionals to identify, refer and report cases of SGBV and in order to increase the likelihood of women to disclose cases of SGBV the following recommendations can be implemented (adapted from RESPONSE Manual):

- Include initial and continuing education for health care professionals who encounter potential SGBV victims/survivors
- On-going training on identification and support of SGBV victims/survivors in the health care setting: clinics and/or hospitals
- Training on identification, referral and reporting of SGBV cases should be included in the existing national frameworks for educating and preparing future health care professionals
  - Introduction of mandatory training modules in the medical/nursing/midwives school curriculum and questions related to GBV in the medical exams
  - Propose specific training modules in the continuous education courses that are mandatory for doctors/nurses/midwives to follow
  - Propose a training plan for health professionals, including pedagogical tools
  - Approve continuing education credits for health professionals' trainings including SGBV identification and referral.

[35] Idem.

[36] Council of Europe, “Convention for the Prevention of Violence Against Women and Domestic Violence”, the Istanbul Convention, (2011) and ratified in 2014 http://www.coe.int/en/web/istanbul-convention

Topic 1.2. Guiding principles for providing women-centered care

According to the Istanbul Convention, standards for SGBV support services should be based on:

- Human rights and the safety of the victims/survivors.
- Integrated approach taking into consideration the relationship between all parties involved: victims/survivors, perpetrators, their children and their wider social environment.
- Avoiding secondary victimization when accessing services and support.

Facilitating disclosure of SGBV is an essential starting point in reducing the burden of SGBV. When asked about SGBV, if done in a professional and supportive manner, it counters feelings of isolation, shame and guilt that victims/survivors of violence may experience[37]. It also helps communicate the message that help is available and that the victim/survivor may use it if she feels ready.

The health care professional, in whatever health care environment, has to know how to[38]:

- Ask about SGBV
- Carry out a security check
- Give a validating and understanding response
- Give a referral to a local specialist for support
- Record the discussion in the patient's medical record, information that can be used by other stakeholders like the police or social workers, taking into consideration the national regulations and legislation.

[37] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”
[38] Idem.

Topic 1.3. Identifying SGBV survivors/patients addressing different health care services

The number of women spontaneously disclosing their experience of violence is low as their safety is often at stake and, generally, health care professionals are not trained in how to ask about violence. Active asking about GBV by health care professionals, through clinical enquiry/screening, is needed to help victims/survivors of GBV to disclose. In turn, once the health care professional has asked about GBV and received a disclosure, a safety plan for referring the victim/survivor into specialist support needs to be in place.

It is often the health care professionals who have the most contact with victims/survivors, therefore health care workers could become the main identifier of victims/survivors of SGBV. There are two ways of discussing with patients about SGBV in health care settings, mentioned by WHO [39] and detailed below, but WHO clinician guidelines recommend against screening, particularly in low to middle income health settings mainly because of the lack of other support services where cases can be reported to and women experiences SGBV can further receive support.

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- Give a validating and understanding response
- Give a referral to a local specialist for support
- Record the discussion in the patient's medical record [41], information that can be used by other stakeholders like the police or social workers, taking into consideration the national regulations and legislation.

Identification of SGBV victims/survivors

“Screening” in public health refers to the use of a test, examination, or other procedure rapidly applied in an asymptomatic population to identify individuals with early disease. Although the intention is to identify “asymptomatic” and “early” SGBV to prevent morbidity and mortality, SGBV can be a stigmatized social problem that many victims/survivors may not be truly “asymptomatic” when screened, simply hidden. In fact, the health impact may be quite advanced. Thus, “screening”

[39] WHO, “Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines” (2013)
[40] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”
[41] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”

in the traditional sense is not consistent with what happens in the clinical encounter; the screening procedure refers more to empathic inquiry and may or may not include a standardized question[42].

Therefore, for the purpose of this manual screening in health care settings is used as the action to identify women with current or past experience of violence from an intimate partner or ex-partner so they can be referred to, or be offered, other (therapeutic) interventions leading to beneficial outcomes[43]. There are many barriers that influence woman's disclosure of a violent event, and this impacts the effectiveness of screening. Traditional medical screening might not work when it comes to identifying cases of SGBV as violence it is not a disease, rather its consequences can lead to serious injuries and long-term diseases that will need medical attention.

There are, however, many barriers that influence the capacity of women to disclose such events and that impact on the effectiveness of screening[44]. Intimate partner violence is therefore problematic when traditional screening criteria are applied[45] because it is a complex social phenomenon rather than a disease.

The main medical specialties that can make a difference in the identification, referral and reporting of SGBV patients are: emergency settings, women's health clinics and family practice. In a systematic literature review and meta-analysis conducted by O'Doherty et al[46]. screening pregnant women had a 300% greater likelihood of clinicians' identification (the studies did have a wide confidence interval) and 161% greater likelihood of clinicians' identification if a screening was performed in the medical setting, compared with no screening. These three specialties should take the lead in the identification and referral of SGBV and contribute to women's health and wellbeing.

There are two main ways in which SGBV victims/survivors can be identifying in clinical settings:

Universal screening – also identified as routine examination, is routinely asking all women from health care settings about exposure to SGBV[47]. If universal screening is used, health care professionals should receive specialized training on doctor-patient communication specific to identification of SGBV as they are encouraged to use adequate language using a victim-centered approach and taking into consideration the situation of providing care and support: e.g. if the woman is accompanied by a family member or children, asking about SGBV is recommended to be done in a separate and intimate space, to protect the women's confidentiality and decision of disclosure.

Case-finding – also known as clinical examination, is asking women from health care settings based on clinical conditions, the history and (if suitable) examination of the patient[48]. Case-finding is usually recommended after specialized training on identification, reporting and referral of SGBV, as there are specific clinical considerations that the health care professional should use.

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[42] Elizabeth Miller, Brigid McCaw, Betsy L. Humphreys, and Connie Mitchell. Integrating Intimate Partner Violence Assessment and Intervention into Health care in the United States: A Systems Approach. Journal of Women's Health. .Jan 2015.92-99.http://doi.org/10.1089/jwh.2014.4870

[43] O'Doherty LJ, Taft A, Hegarty K, Ramsay J, Davidson LL, Feder G (2014). Screening women for intimate partner violence in health care settings: abridged Cochrane systematic review and meta-analysis. BMJ. 348-2913.

[44] Hegarty KL, Taft AJ. Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. Aust N Z J Public Health 2001;25:433-7

[45] Hegarty K, Feder G, Ramsay J. Identification of partner abuse in health care settings: should health professionals be screening? In: Roberts G, Hegarty, K, Feder, G, ed. Intimate partner abuse and health professionals. Elsevier, 2006.

[46] O'Doherty LJ, Taft A, Hegarty K, Ramsay J, Davidson LL, Feder G (2014). Screening women for intimate partner violence in health care settings: abridged Cochrane systematic review and meta-analysis. BMJ. 348-2913.

[47] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services."

[48] Idem.

Health care professionals face difficulties in asking and supporting women effectively around the issue of SGBV, and some of them are summarized below[49]:

- Insufficient knowledge about causes, consequences and dynamics of SGBV
- Own attitudes and misconceptions
- Lack of clinical skills in responding to SGBV and so hesitation to ask as doubtful of what to do next
- Own experiences of SGBV
- Lack of time for medical care for presenting problem let alone dealing with subsequent GBV disclosure
- Concern over what happens once a disclosure has been made and not knowing who the health care professional might speak with or who else might become involved, e.g., police.
- Lack of information about existing support services
- Lack of internal protocols around SGBV, including asking, responding and documenting
- Absence of standard procedures, policies and protocols to ensure that health professionals' response to all victims/survivors of SGBV follow standards of good clinical care.
- Existing laws around confidentiality and statutory reporting duty. This is specifically important in countries where mandatory reporting by health care staff exists, such as the Eastern Europe and Central Asia (EECA) countries.

The role of health care professionals is to identify and refer victims/survivors of SGBV. Medical doctors, nurses and/or midwives, should be able to:

- Recognize when SGBV might be an issue for a patient
- Ask about SGBV in a sensitive way when there are clinical reasons to do so
- Ask routinely about SGBV when women are attending numerous appointments
- Validate what the patient is telling them
- Know their responsibility about referring their patients and provide their patients with prior information about consent to report and confidentiality of the shared information
- Refer patients to whom to talk to for more support e.g., available support and specialized services available in their area
- Record and document disclosures.
- Support staff working in clinics and hospitals (secretaries, cleaning staff, etc.) should be able to recognize and understand SGBV in order to support health care professionals in their role to identify and refer victims/survivors of SGBV.

In order to perform their role, the following information should help health care professionals in identifying SGBV victims/survivors and providing them with the care they need. The examples below are specific to medical signs and symptoms that a patient with SGBV might have when addressing health services.

[49] Idem.

Signs and symptoms specific to emergency settings

- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Bilateral injuries, especially to extremities
- Injuries to the face and neck
- Injuries at multiple sites, pattern injuries, injuries suggesting a defensive posture
- Central distribution of injury (chest, breast, abdomen, face, neck, throat, and genitals)
- Fingernail scratches, cigarette burns, rope burns
- Bite marks, strangulation
- Subconjunctival hemorrhage which shows struggle of the victim/survivor
- Suicidal thoughts/attempts or self-harm
- Alcohol and other substance abuse
- Unexplained chronic gastrointestinal symptoms
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Unexplained genito-urinary symptoms, including frequent bladder or kidney infections

Signs and symptoms specific to obstetrics

GBV is a major cause of maternal and fetal death. A number of factors should raise concerns about experience of GBV in pregnant women[50]:

- Patient books late or does not attend clinics
- Patient repeatedly attends with minor problems or has repeat admissions
- Patient does not complete treatment or self-discharges
- Patient is depressed, anxious or self-harms (high levels of symptoms of perinatal depression, anxiety, and
- PTSD are significantly associated with having experienced domestic violence[51]
- Patient presents with injuries, in particular to abdomen, breasts, inner thighs, head and neck. She may try to persuade the health care professional that these are not very serious.
- Patient experiences frequent vaginal discharge, post-coital bleeding, urine infections or pelvic pain
- Patient experiences recurrent miscarriages, unexplained stillbirths or pre-term labor
- There is intrauterine growth restriction or low birth weight
- The pregnancy is unplanned or unwanted
- Patient makes a termination request or has undergone multiple terminations
- Patient may have problematic substance use or be unable to stop smoking

[50] Lewis et al., “Why Mothers Die 2000-2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom”. (2004), available at: http://www.hqip.org.uk/assets/NCAPOP-Library/CMACE-Reports/33,2004-Why-Mothers-Die-2000-2002-The-Sixth- Report-of-the-Con dential-Enquiries-into-Maternal-Deaths-in-the-UK.pdf.

[51] Howard L M, Oram S, Galley H, Trevillion K, Feder G, “Domestic violence and perinatal mental disorders: a systematic review and meta-analysis”. PLoS Med. (2013), 10: e1001452.

In addition, women who experience GBV are more likely to have obstetric complications including: [52]

- Premature labor
- Unwanted teen pregnancy[53]
- Stillbirth
- Low birth weight baby
- Antepartum hemorrhage
- Chorioamnionitis

Violence occurring during pregnancy poses a danger to both the woman and her unborn child. Among the respondents to the European Agency for Fundamental Rights (FRA) 2014, Violence Against Women study, who were pregnant during the relationship with their partner and who experienced violence in the relationship, 20% of the victims/survivors of current partner violence and 42% of victims/survivors of previous partner violence say that physical or sexual violence also took place during pregnancy[54].

Signs and symptoms specific to general health and wellbeing

When family care practitioners are screening for general health and wellbeing, they care identify a series of risk factors that are associated with SGBV. Therefore, they could further open a discussion with their patients to identify cases of SGBV. Some of the associated risk factors are:

- Alcohol consumption. Women experiencing abuse tend to consumer more alcohol and women who misuse alcohol are more likely to report experiences of violence
- Smoking[55]
- Risky sexual behaviour which can lead to women' health problems.

Signs and symptoms specific to mental health[56]

- Symptoms of depression, anxiety, PTSD
- Suicidal thoughts/attempts or self-harm
- Alcohol and other substance abuse
- Sleep disorders
- Withdrawal from touch

[52] Bewley S, Welch, J, eds. "ABC of domestic and sexual violence". John Wiley & Sons. (2014), p. 69-72.
[53] World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non- partner sexual violence. 2013.
[54] FRA, "Violence against Women: An EU-wide survey". Brussels, FRA. (2014), p. 46.
[55] World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non- partner sexual violence. 2013.
[56] What health workers need to know about gender-based violence: an overview: http://www.healthscotland.scot/media/2096/gbv-an-overview.pdf

Gender-based violence adversely affects mental health and there is an association with greater access of health care services by victims/survivors of abuse[57, 58]:

- Women subjected to domestic abuse are at almost twice the risk of experiencing depressive symptoms than women not exposed to domestic abuse.
- The prevalence of domestic abuse among women with post-traumatic stress disorder has been found to be 61%.
- Childhood sexual assault is associated with increased subsequent risk of physical and sexual victimization and poor mental health including depression, anxiety, eating disorders, posttraumatic stress disorder, self-harm, psychosis, and suicidal ideation[59].
- The mental health impacts of rape and sexual assault include posttraumatic stress disorder, anxiety, panic attacks, somatic symptoms, depression, and suicide[60].

Identifying SGBV against people with disabilities

People with disabilities may show all the signs and symptoms from above. Sometime, depending of the degree of disability, SGBV against people with disabilities might be difficult to identify. Some examples of identification questions that medical providers ca use with people with disabilities, include[61]:

- “Is there anything I need to know [about you] to be able to provide the best services possible?”
- “Does anyone control your communication with others or change what you are trying to say?”
- “Has anyone taken or broken something that you need to be independent? For example, your cane, walker, wheelchair, respirator, or any other device?”
- “Does anyone have legal control over your money or your decisions? What happens if you disagree with them about their decisions?”
- “Does anyone prevent you from using resources and support your need to be independent? (For example, resources such as vocational services, personal care attendants, disability agency support person, specialized support personnel for Deaf-blind services, readers, or interpreters?)”

Challenges in addressing SGBV[62]

Barriers faced by women victims/survivors in accessing women’s health services and disclosing violence:

- Shame, guilt, and the feeling to be solely or partly responsible for the violence.
- Fear of reprisals from the perpetrator.
- Fear of stigma and social exclusion by their families and communities.
- Fear of social isolation and the feeling of having to deal with the experienced violence all by themselves.

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[57] Schraiber LB, Barros, Cláudia Renata dos Santos., Castilho EAd. Violence against women by intimate partners: use of health services. Revista Brasileira de Epidemiologia 2010 06;13:237.

[58] Wong SLF, Wester F, Mol S, Ramkens R, Lagro-Janssen T. Utilisation of health care by women who have suffered abuse: a descriptive study on medical records in family practice. The British Journal of General Practice 2006 09/25;57(538):396-400.

[59] Maniglio R. Child sexual abuse in the etiology of depression: A systematic review of reviews. Depress Anxiety 2010;27(7):631-642.

[60] World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non- partner sexual violence. 2013

[61] UNFPA. 2018. “Women and young persons with disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights.”

[62] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”

- Low self confidence and self-esteem.
- Lack of safe options for their children and fear of losing child custody.
- Fear of drawing attention to irregular immigration status or of losing status following separation from a violent spouse.
- Lack of realistic options (ex. for financial resources, housing, employment or safety).
- Lack of privacy during appointments and so unable to speak with heath professional alone.
- Concern over not being believed because of negative response of professionals in the past.

Additional barriers faced by women because of issues of diversity include:

- Lack of physical access to any health care services for women living in remote areas.
- Language and cultural barriers faced by migrant women and women belonging to ethnic minorities.
- Fear of drawing attention to irregular immigration status or of losing status following separation from a violent spouse.
- Concern over ongoing support if the perpetrator is the person who looks after the woman if she has a disability.
- Stigma or disbelief if a woman is in a same sex relationship.
- Incorrect assessment by health care professionals that some cultures and communities accept GBV.

Barriers faced by women victims/survivors with disabilities:

- Fear of loss of custody of their children.
- Economic dependence, particularly on caregiving.
- Fear of institutionalization.
- Communication barriers, which are often particularly acute for people with sensory and intellectual disabilities.
- Stereotypes and bias from service providers and support staff who do not recognize that people with disabilities are at risk of violence or do not view them as rights-holders. For example, provider misconception that persons with disabilities are not sexually active may result in the failure to identify SGBV victim/survivors.
- Isolation and lack of information in accessible formats about their rights to be free from SGBV, how to recognize forms of SGBV, and how to access protective services.
- Inaccessible intake forms and other communication barriers that prevent service providers and support staff from accurately identifying SGBV and assessing the health needs and risks for SGBV victims/survivors with disabilities.
- Physical barriers, such as lack of accessible transportation to services or inaccessible facilities[63].

To decrease some of these barriers, health care professionals should consider the following:

Let a woman know that she is not to blame or responsible for what is happening and that no one deserves to be treated that way. Tell her that she does not have to deal with the problem alone and that there are local organizations that have years of expertise in supporting women experiencing violence in relationships. Provide her the details when you discuss with her and provide her the local helpline number. The specialist organizations provide practical and emotional support and may have refuge space if a woman wishes to leave and has nowhere to stay. They can advise on legal matters and housing needs. The woman does not have to leave her home to be referred onto these organizations. Sometimes making contact or visiting the organizations gives women the support they want – or the familiarity to make leaving possible the next time violence occurs.

[63] UNFPA. 2018. "WOMEN AND YOUNG PERSONS WITH DISABILITIES Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights."

Provide ongoing support and keep the lines of communication open. Ask her how things are going at subsequent appointments and whether there is anything she is concerned about that she wishes to discuss. If possible, plan so that you see her for the remainder of her care. This will facilitate ongoing support and communication. You will also be able to keep track of any changes occurring, e.g., if the violence gets worse.

The woman must lead the process of change at her own pace and with support to outline her options and choices. All women's health staff have a responsibility to act in the woman's interest, but not to decide in her place. She is the only person who knows what is best for her. She is the only person who has all the information about her situation. If a woman decides to stay with her violent partner, you have not failed. By remembering that our intervention is only part of the process, we hopefully reduce the pressure on staff and prevent anyone feeling that they must try and immediately solve the situation.

If she discloses and her partner is waiting outside room:

- Do not discuss the violence in depth. The partner may become suspicious and walk in mid conversation.
- It is safer to limit the conversation, without making the woman feel as though you are not interested. Offer the woman referral information and arrange another appointment to discuss it fully, when it is safer. Try to arrange the next appointment at a time when her partner cannot make it.
- Find out how to reach her safely to discuss things further at another time. Perhaps there is a trusted friend or family member that could take a message for her. You could arrange to meet her at their home if she feels it is safer, but take into consideration the specificity of your setting, resources and/or existing services.
- Make sure the woman feels OK before inviting her partner into the room. Women who experience domestic violence often say that they fear that their partner will find out they have told someone, provoking further violence.
- Help her to prepare an answer in case her partner questions her about what was discussed during the confidential time. It is fine to make up a story with her - perhaps reference to a previous health concern. The important point is that the woman feels safe and prepared to carry on with the appointment.

IF SHE DISCLOSES, as a health care professional, DO NOT:

- Give her direct advice or tell her to leave him.
- Tell her to defend herself or hit him back.
- Take action without her consent - or discuss what she has said with other colleagues without her permission (except if child protection issues mean you need to contact a social worker; and then you can still inform her).
- Ask her why she puts up with it or what she has done to make him hit her.
- Trivialize the abuse or minimize the danger (by not taking her seriously or telling her she should not put up with it).
- Expect immediate results.
- Try to solve the woman's problem for her.
- Let the abuser know that your patient has disclosed abuse.

Mandatory reporting

Mandatory reporting laws can be categories into four main categories: laws that require reporting of injuries as a result of a crime of by use of a weapon, abuse and maltreatment of children, abuse or maltreatment of vulnerable adults and reporting of intimate partner violence. [64]

Mandatory reporting limits patient-doctor confidentiality, thus health care professionals must inform patients that in a case of disclosing SGBV cases, health care professionals have the obligations to report the case to the police. Health care professionals should be knowledgeable about national legislation on SGBV, including definitions of relevant criminal offences, about available protection measures and any reporting obligations on their part.

[64] Jordan E C, Pritchard J A. 2021. Mandatory reporting of Domestic Violence: What do Abuse Survivors Think and What Variables Influence those Opinions? J Interpers Violence. 36(7-8): NP4170-4190.

Module 2.
Essential health services addressing SGBV

Topic 2.1. Essential health services

First line support

First line support is the most critical care provided and should be offered as soon as a woman discloses violence. World Health Organization (WHO) states that first line support offers practical care and support by responding to all the needs of the woman without intruding on her privacy[65]. First line support needs to assure that examination and care of physical and emotional health should take place together.

There are four kinds of immediate needs that should be considered when offering first line support:

- Emotional/psychological health needs
- Physical health needs
- Safety needs
- Social support and mental health needs

According to the WHO Recommendations, first line support includes[66]:

- Being non-judgmental and supportive and validating what the woman is saying
- Providing practical care and support that responds to her concerns but does not intrude
- Asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved)
- Helping her access information about resources, including legal and other services that she might think helpful
- Assisting her to increase safety for herself and her children, where needed
- Providing or mobilizing social support
- Offering comfort and help to alleviate or reduce her anxiety
- Helping her to connect to services and social support.

Health care providers should conduct the consultation in private, and that confidentiality is respected throughout the entire support process. If health care providers are unable to provide first line support, they should ensure that someone else from the health care setting or another institution that is easily accessible is immediately available to do so[67].

The five essential steps representing first line support are known under the acronym "LIVES"[68]:

Listen – This step involves listening to the victim/survivor in a safe and private place, without judging and offering empathy. This step is essential in covering the emotional needs of the victim/survivor. Listening means more than just hearing the woman, and it should pay extra attention to the body language (facial expressions, eye contact, gestures).

Inquire – This step focuses on assessing and responding to the needs of the woman. It is crucial to learn her physical needs, emotional needs, or economic needs, practical needs (e.g. childcare), safety concerns, or social support.

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[65] WHO, UNW, and UNFPA. 2014. “Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.” Geneva.
[66] WHO. 2013. “Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines.” Geneva.
[67] WHO. 2013. “Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines.” Geneva.
[68] WHO, UNW, and UNFPA. 2014. “Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.” Geneva.

Validate – This step is important for assuring the victim/survivor that her feelings are normal, that it is safe to express them, that she has a right to live without violence and fear, and that she is not to blame. By doing so, the woman feels safe and knows that sharing her experience will not result in judgement and retraction of care from the health care provider.

Enhance Safety – This step helps the victim/survivor assess her situation and develop a plan for her future safety. Usually, this step is not just a one-time conversation but rather an ongoing process as violence is not likely to stop on its own. This can be done by discussing her particular needs and situation and exploring her options and resources each time she seeks care as her situation changes. However, if that is not possible, at least a safety discussion is required to assess the immediate risk of violence and take action towards protecting the woman. If it is not safe for the woman to return home, make appropriate referrals for shelter or safe housing (or another safe place she can go to), and work with her to create a safety plan.

Support – This step helps the victim/survivor to gather more information, services and social support with aid from the health care worker. The victim/survivor's needs generally are beyond what can be provided in the health care setting, but information about other sources of help, and assistance to get help should be offered (e.g. referrals).

SGBV may carry psychological and/or emotional consequences for victims/survivors (including persons with disabilities experiencing SGBV). Most of the time, they get minimized once the violent assault passes, but some victims/survivors will suffer more severely than others. Health care workers need to recognize emotional and mental health problems in order to offer first line support.

Basic psychological support and social support are essential in reducing the suffering of the victims/survivors. After a sexual and/or violent assault a victim/survivor might find it hard to go back to her regular routine, therefore basic psychosocial support should be offered for the first 1–3 months, while also monitoring the woman for more severe mental health problems[69]. Moreover, after a sexual and/or violent assault, victims/survivors often feel isolated from normal social circles or are unable to connect with them. Good social support is one of the most important protections for any woman suffering from stress-related problems by offering direct or indirect psychosocial support. It is essential for health care workers to help the victim/survivor identify past social activities (family gatherings, visits with neighbors, sports, community and religious activities).

Some useful advice health care workers (especially psychologists and social workers) can provide are[70]:

- Build on her strengths and abilities. Ask what is going well currently and how she has coped with difficult situations in the past.
- Continue normal activities, especially ones that used to be interesting or pleasurable.
- Engage in relaxing activities to reduce anxiety and tension.
- Keep a regular sleep schedule and avoid sleeping too much.
- Engage in regular physical activity.
- Avoid using self-prescribed medications, alcohol or illegal drugs to try to feel better.
- Recognize thoughts of self-harm or suicide and come back as soon as possible for help if they occur.

World Health Organization offers some practical advice for health care to aid women in coping with negative emotions, that can be observed in the figure below:

[69] WHO, UNW, and UNFPA. 2014. “Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.” Geneva.
[70] WHO, UNW, and UNFPA. 2014. “Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.” Geneva.

The feeling	Some ways to respond
Hopelessness	"Many women do manage to improve their situation. Over time you will likely see that there is hope."
Despair	Focus on her strengths and how she has been able to handle a past dangerous or difficult situation"
Powerless, loss of control	"You have some choices and options today in how to proceed."
Flashbacks	Explain that these are common and often become less common or disappear over time."
Denial	"I'm taking what you have told me seriously. I will be here if you need help in the future."
Guilt and self-blame	"You are not to blame for what happened to you. You are not responsible for his behaviour."
Shame	"There is no loss of honor in what happened. You are of value."
Unrealistic fear	Emphasize, "You are in a safe place now. We can talk about how to keep you safe."
Numbness	"This is a common reaction to difficult events. You will feel again – all in good time."
Mood swings	Explain that these can be common and should ease with the healing process.
Anger with perpetrator	Acknowledge that this is a valid feeling.
Anxiety	"This is common, but we can discuss ways to help you feel less anxious."
Helplessness	"We are here to help you."

Figure 8. Advice for health care to aid women in coping with negative emotions.

Helping women cope with negative feelings

Some women might develop more serious health-related problems, such as post-traumatic stress disorder (PTSD), moderate-severe depressive disorder, and even present self-harm or suicidal behaviors. If the health care worker suspects the victim/survivor is at immediate risk of self-harm or suicide, she should not be left alone but referred immediately to a specialist or emergency health facility[71].

Care of injuries and urgent medical treatment

Medical examination

Health care professionals need to obtain informed consent from the victim/survivor on all aspects of the consultation as a first step. If the victim/survivor cannot read and write, the informed consent statement will be read up to the victim/survivor and a verbal consent will be obtained (this will be mentioned in the informed consent form or health records). The informed consent procedure refers to asking permissions to share their personal information and details with others in order to facilitate the care process. The informed consent also refers to asking them to participate to the medical exams or to accept the received medical treatment. SGBV victims/survivors should not be pressured into offering their informed consent or participating in any medical examination. If the consent is attained from an SGBV victim/survivor, verbally or through a Consent form, the SGBV victim/survivor can still decide at any time to withdraw their consent. The informed consent needs to include the following aspects of consultation: medical examination, treatment, forensic evidence collection, the release of information to third parties, if the case (e.g. police and judicial courts). The health care professional

[71] WHO, UNW, and UNFPA. 2014. "Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook." Geneva.

needs to explain all aspects of the consultation to the victim/survivor so that she understands all her options and can make informed decisions about her medical care. In particular, health care professionals need to point out any limitations of confidentiality, such as any legal obligations to report GBV to the police or other authorities. If national legislation requires, the health care professional needs to ask the victim/survivor to sign or mark the consent form. Examining a victim/survivor without her consent may result in criminal prosecution of health care professionals. Further, in some jurisdictions, the results of an examination conducted without the consent of the patient cannot be used in legal proceedings[72].

The next steps in offering care SGBV victims/survivors consist of medical examination and care of physical and emotional health. A complete medical history needs to be recorded in order to include all events to determine what interventions are appropriate. The medical history should include a detailed description of the assault, its duration, whether any weapons were used (such as belts, household objects, knives or guns, as well as date and time of the assault)[73].

After taking the history, health care professionals should conduct a complete physical examination (head-to-toe). World Health Organization developed a physical examination checklist that can be observed in the next figure[74].

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

Figure 9. Physical exam checklist.

UNFPA suggest following the principles below when conducting a medical examination[75]:

- Explain the medical examination, what it includes, why it is done and how, to avoid the exam itself becoming another traumatic experience. Also, give the patient a chance to ask questions.
- Ask the patient if she wishes a female doctor (especially in cases of sexual violence).
- Do not leave the patient alone (e.g. when she is waiting for the examination).
- Ask her to disrobe completely and put on a hospital gown, so that hidden injuries can be seen (if the facility has hospital gowns available).
- Examine especially areas covered by clothes and hair.
- If she has experienced sexual violence, examine her whole body – not just the genitals or the abdominal area.
- Examine both severe and minor injuries.
- Note emotional and psychological symptoms as well.

[72] UNFPA-WAVE. 2014. "Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package."
[73] UNFPA-WAVE. 2014. "Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package."
[74] WHO, UNW, and UNFPA. 2014. "Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook." Geneva.
[75] UNFPA-WAVE. 2014. "Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package."

- Throughout the physical examination, inform the patient what you plan to do next and ask permission. Always let her know when and where touching will occur. Show and explain instruments and collection materials.
- Patients may refuse all or part of the physical examination. Allowing her a degree of control over the examination is important to her recovery.
- Both medical and forensic specimens should be collected during the examination (if the health care facility allows this). This should be done by a health care professional trained in forensic medicine. Providing medical and legal (forensic) services simultaneously, in the same place and by the same person reduces the number of examinations that the patient has to undergo and can ensure the patient's needs are addressed more comprehensively.

There is an agreed language for assessing for physical injuries in terms of words, descriptions and documentation. Any notes made must be clear for all other health care professionals to understand in the future. The key elements of best practice are outlined below[76]. An extensive guide from WHO offers extensive knowledge and examples on how injuries should be recorded and classified[77]:

- Document everything you see. Some things may not be related to the assault, and it is not for you to decide this.
- Always use accepted medical descriptions, e.g. abrasion.
- Always use standard anatomical nomenclature, e.g. left iliac fossa.
- Use anatomical body sketches or diagrams to record injuries.
- Measure the injury, mark it on the diagram and describe it, e.g. round yellow bruise 2.8x2.8cm, 5cm above the olecranon on the posterior aspect of the right arm.
- There are often no physical injuries following sexual assault, document the absence of injuries.
- Take your time.

Do not under-estimate the shock the patient may be in. She may need emotional support as well a care around physical injuries. Do not under-estimate the effect that this sort of consultation may have on the health care professional involved in the case.

Treatment

Patients with life-threatening or severe conditions need to be referred immediately for emergency treatment. Complications that may require urgent hospitalization[78]:

- Extensive injury (to genital region, head, chest or abdomen)
- Neurological deficits (for example, cannot speak, problems walking)
- Respiratory distress
- Swelling of joints on one side of the body (septic arthritis).

Patients with less severe injuries, for example, cuts, bruises and superficial wounds, can usually be treated by the examining health care worker or other nursing staff. Any wounds should be cleaned and treated as necessary[79].

[76] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”
[77] WHO. 2003. “Guidelines for Medico-Legal Care of Victims of Sexual Violence.” Geneva.
[78] UNFPA-WAVE. 2014. “Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package.”
[79] UNFPA-WAVE. 2014. “Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package.”

The following medications may be indicated:

- Antibiotics to prevent wounds from becoming infected
- A tetanus vaccine (according to local protocols)
- Medications for the relief of any symptoms of pain, anxiety or insomnia.

Psychological/mental health interventions

Where referral possibilities are available, health care professionals should refer victims/survivors with pre-existing diagnosed or gender-based violence-related mental disorders to specialist health care providers for psychological/mental health care interventions[80].

In health care settings with limited or no referral possibilities, psychological first aid provides basic psychological support. Psychological first aid involves[81]:

- Providing practical care and support, which does not intrude
- Assessing needs and concerns
- Helping victims/survivors to address basic needs (for example, food and water, information)
- Listening to victims/survivors, but not pressuring them to talk
- Comforting victims/survivors and helping them to feel calm
- Helping victims/survivors connect to information.

For women who are either breastfeeding or pregnant, the use of psychotropic medicine requires specialist knowledge and should be provided in consultation with a specialist. Moreover, children who are exposed to intimate partner violence should be offered a psychotherapeutic intervention, including sessions with and sessions without the presence of their mother[82].

[80] WHO. 2013. "Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines." Geneva.
[81] Idem.
[82] Idem.

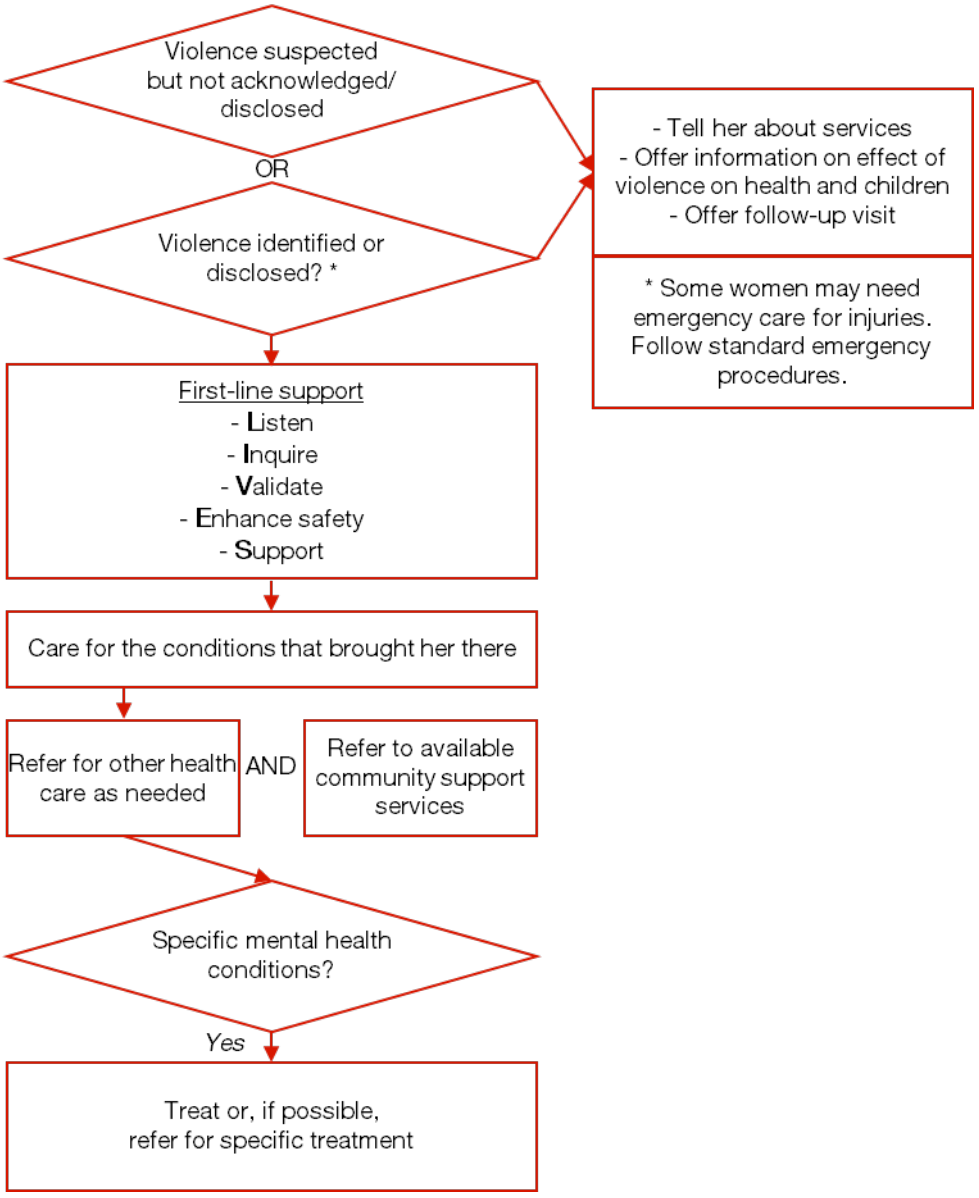

Figure 10. Pathway for care for violence by intimate partner[83].

Sexual assault examination and care

Medical examination

In cases of sexual violence, all the steps presented above should be followed. For the cases of sexual violence, the medical history should additionally include[84]:

- Time since assault and type of assault
- The risk of pregnancy
- Risk of HIV and other sexually transmitted infections (STIs)
- The woman's mental health status

[83] WHO, UNW, and UNFPA. 2014. "Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook." Geneva.
[84] WHO. 2013. "Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines." Geneva.

According to WHO recommendations presented in the next table, a complete medical examination from head to toe should be offered to victims/survivors of sexual violence, including extra information about the patient's genitalia[85].

Genitals (external)	Active bleeding
Genitals (internal examination, using a speculum)	Bruising
Anal region (external)	Redness or swelling
	Cuts of abrasions
	Foreign body presence

Figure 11. Genito-anal examination.

Depending on the local facilities available, a patient who is assumed to be sexually abused or assaulted should be referred to a special center for forensic examination. A forensic examination aims to offer a detailed history and physical examination and carefully collects information and elements referring to the perpetrator. This examination is different from other types of examinations that occur elsewhere in medicine. According to the local regulations, particular forms and recording procedures should be followed to record the sexual assault. Care providers need to be familiar with local provisions and centers[86].

Treatment

Health care professionals should offer emergency contraception to victims/survivors of sexual assault, based on the following guidelines[87]:

- Emergency contraception should be initiated as soon as possible after the assault. It is more effective if given within 3 days but can be given up to 5 days (120 hours).
- Health-care providers should offer levonorgestrel (recommended: a single dose of 1.5 mg).
- If levonorgestrel is not available, the combined estrogen–progestogen regimen may be offered, along with anti-emetics to prevent nausea, if available.
- If oral emergency contraception is not available and it is not feasible, copper-bearing intrauterine devices (IUDs) may be offered to women seeking ongoing pregnancy prevention. Taking into account the risk of STIs, the IUD may be inserted up to 5 days after sexual assault for those who are medically eligible.

Safe abortion should be offered following national law, if[88]:

- A woman presents after the time required for emergency contraception (5 days)
- Emergency contraception fails, or
- The woman is pregnant as a result of rape.

Health care professionals should consider offering HIV post-exposure prophylaxis (HIV PEP) for women presenting within 72 hours of a sexual assault. The victim/survivor should be informed and consulted in order to determine whether HIV PEP is appropriate for her. It is recommended that victims/survivors of sexual violence undergo HIV testing prior to giving PEP, but should not preclude PEP from being offered. Persons with HIV infection should not use PEP; instead, they should receive

[85] WHO, UNW, and UNFPA. 2014. “Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.” Geneva.
[86] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”
[87] WHO. 2013. “Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines.” Geneva.
[88] UNFPA-WAVE. 2014. “Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package.”

care and antiretroviral therapy[89]. WHO formulated various situations for post-exposure prophylaxis (PEP) that can be observed in the next table[90].

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 and make follow-up appointment
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

Figure 12. Post-exposure prophylaxis.

Apart from HIV, and depending on the prevalence, health care professionals should offer victims/survivors of sexual assault post-exposure prophylaxis for the following sexually transmitted infections:

- Chlamydia
- Gonorrhea
- Trichomonas
- Syphilis
- Hepatitis B

The choice of drug and regimens should follow national guidance.

Follow-up after sexual assault

For victims/survivors of sexual assault, follow-up visits should ideally happen at 2 weeks, 1 month, 3 months and 6 months after the assault.

WHO developed follow-up check lists that aid health providers at each visit (see next table)[91].

[89] UNFPA-WAVE. 2014. “Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package.”
[90] WHO, UNW, and UNFPA. 2014. “Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.” Geneva.
[91] WHO, UNW, and UNFPA. 2014. “Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.” Geneva.

2-week follow-up visit		
Injury	Check that any injuries are healing properly.	☐
STIs	Check that the woman has completed the course of any medication given for STIs.	☐
	Check adherence to PEP, if she is taking it. Discuss any test results.	☐
Pregnancy	Test for pregnancy if she was at risk. If she is pregnant, tell her about the available options. If abortion is permitted, refer her for safe abortion.	☐
Planning	Remind her to return for further hepatitis B vaccinations in 1 month and 6 months and HIV testing at 3 months and 6 months, or else to follow up with her usual health-care provider.	☐
	Ask her to return for follow-up if emotional and physical symptoms of stress have emerged or become more severe, or if there is no improvement at all by 1 month after the event.	☐
	Make next routine follow-up appointment for 1 month after the assault.	☐
1 month follow-up visit		
STIs	Give second hepatitis B vaccination, if needed. Remind her of the 6-month dose.	☐
Planning	Make next routine follow-up appointment for 3 months after the assault.	☐
3-month follow-up visit		
STIs	Offer HIV testing and counselling. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment and care.	☐
Planning	Make next routine follow-up appointment for 6 months after the assault. Also, remind her of the 6-month dose of hepatitis B vaccine, if needed.	☐
6-month follow-up visit		
STIs	Offer HIV testing and counselling if not done before. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment and care.	☐
	Give third dose of hepatitis B vaccine, if needed.	☐

Testing schedule

	Schedule	
Test for:	Initial test	Retest
Pregnancy	At 2 weeks	None
Chlamydia, gonorrhea, trichomonas	At 2 weeks	None
Syphilis	At 2 weeks	At 3 months
HIV	On first visit if she is willing*	At 3 and 6 months
Hepatitis B	At first visit**	None

*If the woman tests positive for HIV at first visit, do not give PEP. If she is unwilling to test and her HIV status is unknown, offer PEP.

**Test if the woman is uncertain whether she has received all 3 hepatitis B vaccinations. If testing at first visit shows that she is already immune, no further vaccination is required.

Figure 13. Checklist for follow-up after sexual assault.

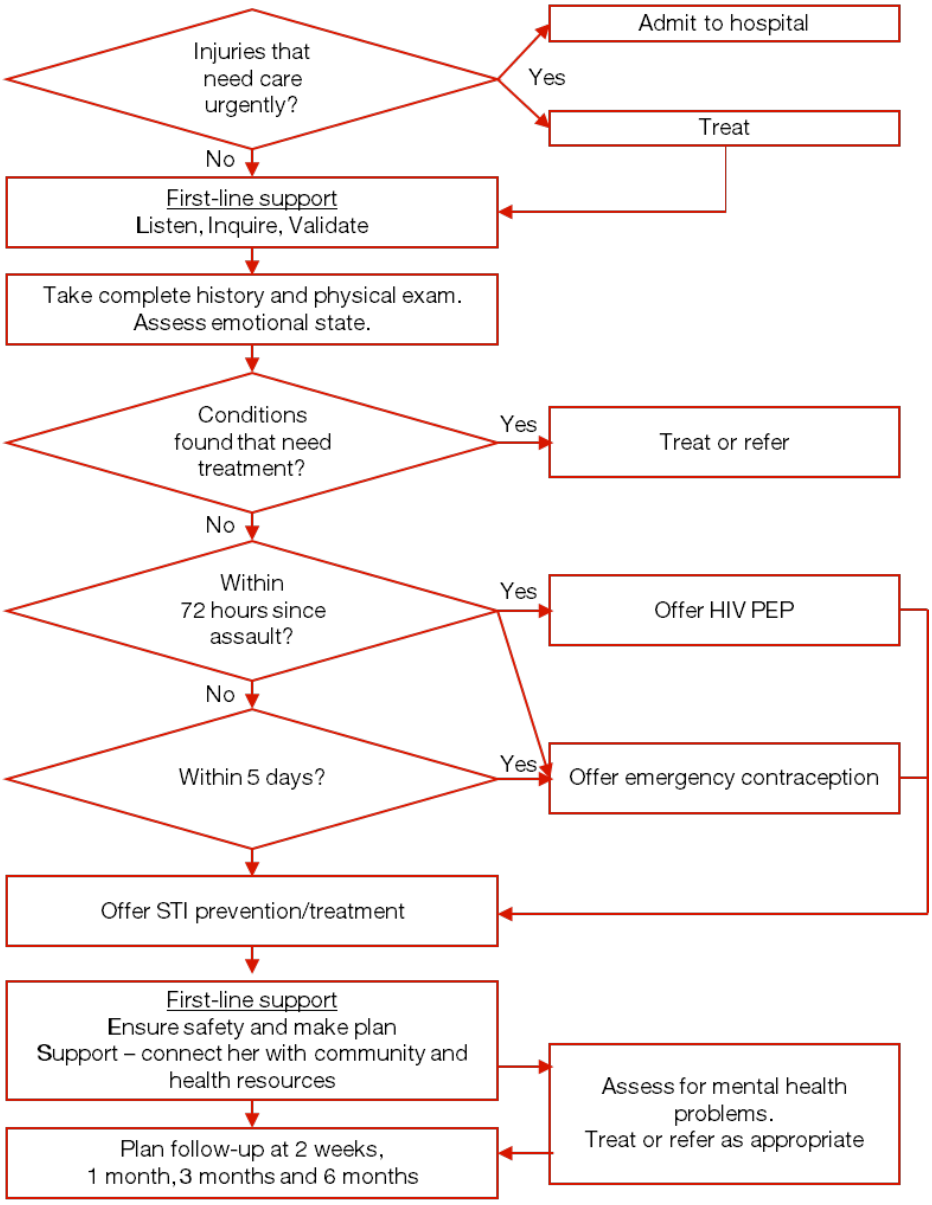

Figure 14. Pathway for initial care after assault[92].

Mental health assessment and care

Medical examination

An assessment of mental status should be conducted simultaneously with the physical examination to assess for immediate risk or self-harm, suicide, alcohol and drug use problems, moderate-severe depressive disorder, and PTSD[93]. All identified issues should be treated accordingly, using the mhGAP intervention guide, covering WHO evidence-based clinical protocols for mental health problems[94].

[92] WHO, UNW, and UNFPA. 2014. "Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook." Geneva.
[93] WHO, UNW, and UNFPA. 2014. "Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook." Geneva.
[94] WHO. 2013. "Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines." Geneva.

Treatment

For victims/survivors of sexual assault, basic psychosocial support may be sufficient for the first 1-3 months while monitoring for more severe mental health problems. If more severe mental health problems arise after assessing mental status three months post-trauma, the victim/survivor should be referred to a mental health provider. Cognitive behavioral therapy or eye movement desensitization and reprocessing interventions in case the woman is incapacitated by the post-rape symptoms (i.e. she cannot function on a day-to-day basis), are recommended to be provided by a health care provider with a good understanding of violence[95].

Follow-up after for mental health

The follow-up related to mental health is tightly connected to the one recommended for sexual assault, and it is described in the same section.

2-week follow-up visit		
Mental health	Assess the patient's emotional state and mental status. If any problems, plan for psycho-social support and stress management, such as progressive relaxation or slow breathing	☐
1 month follow-up visit		
Mental health	Continue first-line support and care.	☐
	Assess her emotional state and mental status. Ask if she is feeling better. If new or continuing problems, plan for psycho-social support and stress management.	☐
	For depression, alcohol or substance abuse, or post-traumatic stress disorder refer for specialized care to a specifically trained health-care provider with a good understanding of sexual violence.	☐
3-month follow-up visit		
Mental health	Continue first-line support and care.	☐
	Assess the patient's emotional state and mental status. If new or continuing problems, plan for psycho-social support and stress management.	☐
	For depression, alcohol or substance abuse, or post-traumatic stress disorder refer for specialized care to a specifically trained health-care provider with a good understanding of sexual violence.	☐
6-month follow-up visit		
Mental health	Continue first-line support and care.	☐
	Assess the patient's emotional state and mental status. If there are new or continuing problems, plan for psycho-social support and stress management.	☐
	For depression, alcohol or substance abuse, or post-traumatic stress disorder, refer if possible for specific care to a specifically trained health-care provider with a good understanding of sexual violence.	☐

Figure 15. Checklist for follow-up for mental health.

[95] WHO. 2013. "Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines." Geneva.

Topic 2.2. Documenting SGBV

Recording and classifying health consequences of SGBV

Health care professionals should carefully describe any injuries assessed. The description should include the type and number of injuries and their location, using a body map. If a victim/survivor does not disclose specific injuries, health care professionals should note whether the injuries are compatible with her explanations. This may help clarify the situation at a future visit and provide documentation if she decides to pursue legal action. Interpretation of injuries for medico-legal purposes is a complex and challenging matter. In practice, clinicians and pathologists are often asked by police, courts or lawyers to determine the age of an injury, how it was produced, or the amount of force required to produce the injury. This requires proven expertise on the practitioners performing it[96].

Mechanisms for documenting consultations include hand-written notes, diagrams, body charts and photography. Through the entire process of documentation, health care professionals should ensure the patient's informed consent[97].

In some countries, health care authorities provide standard documentation forms, the use of which may be obligatory. If no standard documentation forms are in place, the forms developed by WHO should be used[98].

Using photography for recording injuries

Photography is an important tool that should be used by all health care providers – specialized and non-specialized in forensic medicine - to document injuries resulting from GBV, as photos are important evidence in possible future criminal proceedings instituted against the perpetrator. However, when using photography, it is important to keep in mind that photos may supplement, not replace, the other methods of recording findings mentioned above[99]. However, national legislation on taking and using photographs to record injuries need to be taken into account first.

Consider the patient and obtain informed consent	Many victims/survivors will be uncomfortable, unhappy, tired or embarrassed. Communicate the role of photography and obtain informed consent for the procedure.
Identification	Each photograph must identify the subject, the date and the time that the photograph was taken. The photographs should be bound with a note stating how many photographs make up the set. Ideally, a new roll of film should be used for each subject; alternatively, there should be a clear indication of where a new series commences.

[96] UNFPA-WAVE. 2014. “Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package.”
[97] WHO. 2013. “Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines.” Geneva.
[98] WHO. 2003. “Guidelines for Medico-Legal Care of Victims of Sexual Violence.” Geneva.
[99] UNFPA-WAVE. 2014. “Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package.”

Scales	A photograph of the color chart should commence the sequence of photographs. Scales are vital to demonstrate the size of the injury. They may be placed in the horizontal or vertical plane. Photographs should be taken with and without scale.
Orientation	The first photograph should be a facial shot for identification purposes; this may not be required if the photographs have been adequately identified (see above). Subsequent shots should include an overall shot of the region of interest followed by close-up shots of the specific injury or injuries.
Chain of custody	This should be logged as for other forensic evidence.
Security	Photographs form part of a patient record and as such should be accorded the same degree of confidentiality. Legitimate requests for photographs include those from investigators and the court. If, however, a copy is made for teaching purposes, the consent of the subject or his/her parents/guardian should be obtained
Sensitivity	The taking of photographs (of any region of the body) is considered to be inappropriate behaviour in some cultures and specific consent for photography (and the release of photographs) may be required. Consent to photography can only be obtained once the patient has been fully informed about how, and why, the photographs will be taken. The briefing should also explain how this material may be used (e.g. released to police or courts and cited as evidence).

Figure 16. Checklist for using photography to document findings[100].

Documenting SGBV cases: checklist for health workers

The following checklist is intended to assist health workers develop their documentation skills: [101]

- Record the extent of the physical examination conducted and all “normal” or relevant negative findings.
- Document all pertinent information accurately and legibly.
- Notes and diagrams should be created during the consultation; this is likely to be far more accurate than if created from memory.
- Notes should not be altered unless this is clearly identified as a later addition or alteration. Deletions should be scored through once and signed, and not erased completely.
- Ensure that the notes are accurate; deficiencies may cast doubts over the quality of the assessment.
- Use the victims/survivors’ own words in quotes, whenever possible. This is preferable to writing down your own interpretation of the statements made. For example, write “My husband hit me with a bat” instead of “Patient has been battered.”
- Use neutral language, such as “Ms Smith says…” rather than “The patient alleges.”
- Do not exclude information that is extraneous to the medical facts, such as “It was my fault he hit me, because…” or “I deserved to be hit because I was…”
- When documenting referrals, names, addresses or phone numbers of shelters given to the patient should not be noted, in the interest of the patient’s safety.

[100] WHO. 2003. “Guidelines for Medico-Legal Care of Victims of Sexual Violence.” Geneva.
[101] WHO. 2003. “Guidelines for Medico-Legal Care of Victims of Sexual Violence.” Geneva.

An essential part of best clinical practice and exemplary patient care is documentation. Notes and records must be clear and precise in order to provide an 4accurate understanding of what happened during consultation in terms of history, who said what, who was present, health findings both negative and positive, the medical care plans, and how concerns were addressed[102].

Examples of questions to obtain information:

> "That looks painful. How did that happen?"
>
> "Has someone hurt you? Please tell me some more about that"
>
> "Has anyone threatened you?"

When recording these answers, remember that these notes might help if a statement will be required or as evidence in court.

DO	DON'T
Write notes at the time of immediately after the consultation	Leave writing notes until the end of shift
Write clearly and legibly	Take detailed history. Stick to the facts.
Stick to the facts and be objective	Ask leading questions
Explain confidentiality to your patient and the limits of confidentiality, e.g. if a safeguarding risk is disclosed; that everything you are told, could be disclosed in court	Be selective about what you write down. Document all detail you are told in response to your questions.
Concentrate on what was done, where, when and by whom	Use non-approved abbreviations or write illegibly. You or another person will struggle to understand the notes if they are required for future statements or court.
Record information from third parties, e.g. "The patient's mother told me that..."	Be judgmental or paternalistic.
Record relevant information verbatim, "He punched me in the face and my nose began to bleed."	
Document who was present at the time of the consultation.	
Sign all notes	
Date all notes	
Document a clear management and care pain.	
Treat your patient with care and sensitivity.	

Figure 17. Skills health care professionals need when documenting a consultation with a victim/survivor of abuse[103].

A patient considered to be assaulted or sexually abused might be referred to a center for forensic examination. A forensic examination is aimed to gather a detailed history and physical inspection and collect information about the perpetrator - particular forms and recording procedures should be followed[104].

[102] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services."
[103] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services."
[104] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services."

There is an accepted language when evaluating a patient for physical injuries in terms of words, descriptions and documentation. The notes must be clear for all other health care professionals to understand in the future. The key elements for best practice are described below[105]:

- Document everything you see. Some things may not be related to the assault, and it is not for you to decide this.
- Always use accepted medical descriptions, e.g. abrasion
- Always use standard anatomical nomenclature, e.g. left iliac fossa
- Use anatomical body sketches or diagrams to record injuries
- Measure the injury, mark it on the diagram and describe it, e.g. round yellow bruise 2.8x2.8cm, 5cm above the olecranon on the posterior aspect of the right arm
- There are often no physical injuries following sexual assault; document the absence of injuries
- Take your time
- Do not underestimate the patient's shock and the effect of this sort of consultation on the health professional involved in the case[106]
- Describe collection of data of SGBV incidents for analysis and to improve SGBV responses
- Discuss data protection.

Collecting medico-legal evidence

When a woman consents to forensic evidence collection, it is critical that the chain of custody evidence is maintained and that everything is clearly labelled. A forensic examination is defined as a "medical examination conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion"[107].

The primary aim of a forensic examination is to collect evidence that may help prove or disprove a link between individuals and/or between individuals and objects or places[108].

In all cases involving GBV, where a criminal offence has been committed, as in any other criminal investigation, the following principles for specimen collection should be strictly adhered to[109]:

- Collect carefully, avoiding contamination
- Collect specimens as early as possible; 72 hours after the assault, the value of evidentiary material decreases dramatically
- Label all specimens accurately
- Dry all wet specimens
- Ensure specimens are secure and proofed against tamper
- Maintain continuity; and
- Document details of all collection and handling procedures.

A list of forensic specimens that are typically of interest in cases of sexual violence, together with notes on appropriate collection techniques and comments on their relevance is presented in chapter 5.2 from WHO guidelines[110].

[105] Idem.
[106] Idem.
107 UNFPA-WAVE. 2014. “Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package.”
[108] Idem.
[109] Idem.
[110] WHO. 2003. “Guidelines for Medico-Legal Care of Victims of Sexual Violence.” Geneva.

Health care professionals may be called upon to give evidence, either in a written report or as expert witnesses in a court of law. Ideally, health care providers should undergo training in such matters. In the absence of specific training in medico-legal service provision, health professionals are advised to confine their service delivery to the health component and defer from offering an opinion. Therefore, they need to show knowledge to[111]:

- Be familiar with the legal system
- Know how to write a good statement
- Document injuries in a complete and accurate way
- Make sound clinical observations
- Reliably collect samples from victims/survivors for when they choose to follow a legal recourse.

When writing reports or giving evidence in court, health care professionals must aim to convey the truth of what they saw and concluded impartially and ensure that a balanced interpretation of the findings is provided. WHO developed a series of guiding principles for writing reports and giving evidence.

Writing reports	Giving evidence
Explain what you were told and observed.	Be prepared.
Use precise terminology.	Listen carefully.
Maintain objectivity.	Speak clearly.
Stay within your field of expertise.	Use simple and precise language.
Distinguish findings and opinions.	Stay within your field of expertise.
Detail all specimens collected.	Separate facts and opinion.
Only say or write what you would be prepared to repeat under oath in court.	Remain impartial.

Figure 18. Providing evidence in sexual violence cases: guiding principles for health professionals[112].

Management of data

Data collection and information management

The accurate collection of data about the services provided to girls and women is essential in maintaining their constant improvement[113]. Services must have clear and documented recording processes and need to be stored confidentially and securely. Data collection and documentation must be done in a manner that does not re-victimize and presents the least risk to persons. Basic care and support for SGBV victims/survivors must be offered before initiating any further step that may involve information disclosure about an SGBV experience/incident. Prior to any data collection, informed consent should be obtained from the GBV victim/survivor. The professionals involved in data collection must receive relevant and sufficient training in gathering information about SGBV incidents/cases and ongoing support.

[111] UNFPA-WAVE. 2014. “Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package.”
[112] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”
[113] UN Women, UNFPA, WHO, UNDP, UNODC. 2015. “Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines.”

Minimum guidelines for protecting the confidentiality of personal data implies that[114]:

- A documented and secure system for collecting, recording, and storing all information and data exists.
- All information about women and girls accessing services is stored securely, including client files, legal and medical reports, and safety plans.
- Accurate data collection is ensured, by encouraging staff to use the data collection guidelines and adequately implementing them.
- Data are only distributed using agreed protocols among organizations.
- Data collection is analyzed to better understand the prevalence of violence, evaluate existing services, and inform prevention measures.
- Systems for the recording and reporting of data exists.

The guidelines for creating consistent mechanisms and processes for accountable response to AGBV include essential actions for having an effective and secure system for recording and reporting of SGBV data[115]:

- Agree on common terminology for all recording and reporting.
- Require each agency to maintain data for monitoring and evaluation.
- Obtain the consent from victims/survivors before recording personally identifiable information (PII).
- Protect confidentiality and privacy of victims/survivors when collecting, recording and reporting PII.
- Allow access to PII only to individuals and entities with demonstrated need.
- Keep PII data secure.
- Anonymize data used for monitoring and evaluation purposes.

Data protection

Confidentiality is very important to protect the victim/survivor and also the medical provider. Information should only be shared in situations that are either necessary or requested by the circumstance and they cannot be used without the permission of the victim/survivor. If information is shared with other colleagues/professionals for medical reasons, it must only happen after the victim/survivor agrees[116].

All collected data needs to be stored in secure spaces, with restricted access to it so the victim/survivor is protected from further violence by parties who may gain access to information about the case. Personal data collected from SGBV victims/survivors should not be transmitted openly. Regardless of the purpose of the transmission of data (when reporting a case/incident to another service provider or for statistical purposes), the set of information/indicators should be agreed with the SGBV victim/survivor and will be limited to relevant and/or mandatory reported information. Security measures should be followed to protect the identity of SGBV victims/survivors.

[114] UN Women, UNFPA, WHO, UNDP, UNODC. 2015. “Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines.
[115] UN Women, UNFPA, WHO, UNDP, UNODC. 2015. Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines, Module 5.
[116] Idem.

Topic 2.3. Management of risk

Understanding risk and carrying out a risk assessment

Health workers have an essential role to refer a patient towards a social worker with experience in risk assessment and safety planning. If the legislation and organizational structures allow, the social worker should work in close cooperation with special GBV support services to develop a risk assessment and safety plans[117].

Important!

The safety of patients experiencing SGVB must be a priority and at the center of any health sector information. What the patient mentioned to the health workers a day or an hour ago might have changed several times already might be in greater risk of violence. It is important for the health professional to ask the patient about safety at every risk or consultation. The majority of murders happen when a female victim/survivor attempts to leave a violent perpetrator[118].

There are a series of risk factor to consider when discussing about risk[119]:

- Previous acts of violence against the woman, the children or other family members, as well as former partners
- Previous acts of violence outside the family
- Is there to be or has there been a recent separation or divorce
- Acts of violence committed by other family members used to control the victim/survivor.
- Possession and/or use of weapons
- Abuse of alcohol or drugs may disinhibit a perpetrator already using violence
- Threats should always be taken seriously. In many cases of women being killed by intimate partners, they had been repeatedly threatened with murder before being killed.
- Extreme jealousy and possessiveness
- Extremely patriarchal concepts and attitudes
- Persecution and psychological terror (stalking), including via email, text, social media
- Danger for children, including threats to remove, harm, kill them
- Non-compliance with restraining orders by courts or police

Other possible triggers for violence might be because of a sudden change in relationship status, for example receiving a new job against partner's will, leaving the household, or filling for divorce[120].

[117] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services."
[118] Idem.
[119] Idem.
[120] Idem.

Carrying out a risk assessment – healthcare professional (doctors, midwives, nurses)

Risk assessments are used by health professionals to understand if their patients are at immediate risk of violence. Health professionals usually do not carry out a full and very detailed risk assessment due to lack of time. Risk assessment should be based on the evaluation of the evolution or escalation of violence, patients' view on safety, some systematically asked questions on perpetrator behavior and context, and finally the collaboration to care, proposed by the social worker in partnership with women's specialist services. However, the healthcare professional can ask a set of question to assess of the patient is at risk of immediate violence and based on the response they receive, they can follow the emergency care and referral pathway or refer in to the social worker[121].

Questions the healthcare professionals can use for risk assessment [122]

- Do you feel safe to go home?
- What are you afraid might happen?
- Has your partner/abuser threatened you?
- What about threats or risks to the children, newborn baby, fetus?

Carrying out a risk assessment – social workers

Experienced social workers usually carry out a more detailed risk assessment. These social workers can be represented by psychologists, GBV advocates, support workers who are specialized in SGBV. Each country or organization usually has a standard risk assessment form that they use[123].

An example of an assessment risk form that can be used in case the country/organization does not have one is the SafeLives Risk Indicator Checklist (RIC)[124]. RIC is a series of questions asked by a professional trained in using the tool to assess the GBV risk. Additional to the score form the question, the professional's judgement is taken into account; therefore, the person asking the questions needs appropriate training in using the tool.

[121] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services."
[122] Idem.
[123] Idem.
[124] SafeLives Risk Indicator Checklist (RIC) available here: https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

Supporting the victim/survivor to develop a safety plan

Due to the constant change in risk of violence, a safety plan will help the patient to plan in advance for the possibility of future violence and abuse[125].

Important!

- A safety plan can be a useful resource.
- It is a patient-led activity that the patient can complete outside of consultation time. The patient can take the safety plan away if it is safe for them to do so.
- The plan includes what to do in an emergency, helplines and sources of advice. [126]

Below is a safety checklist that is essential in developing a safety plan together with the victim/survivor[127].

Safety in the relationship	
Places to avoid when abuse starts	Example: kitchen, where there are many potential weapons
A potential exit from the home if abuse escalates	Example: and unlocked window/door)
People to turn to for help or let know that they are in danger	Example: parents, sister, or other friends or neighbors that can call the police if they hear anything to suggest a woman or her children are in danger
Places to hide important phone numbers, such as helpline numbers	Example: sock drawers, food boxes
How to keep the children safe when abuse starts	Example: send them to a neighbor, teach them to call a helpline number or the police
Keeping important personal documents in one place so that they can be taken if a woman needs to leave suddenly	Example: purse or somewhere close to the shoe drawer
Letting someone know about the abuse so that it can be recorded (important for cases that go to court or immigration applications, for example).	Example: parents, friends, neighbors or siblings
Leaving in an emergency	
Packing an emergency bag and hiding it in a safe place in case a woman needs to leave urgently.	Example: packing the essentials such as documents, medication, keys, money (of available) or a photo of the abuser (useful for serving court documents) - for children as well (including toys and toiletries)
Plans for who to call and where to go	Example: domestic violence refuge (if existent) or police
Access to a phone/address book	Example: make a plan where a phone can be found in case of an emergency

[125] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”
[126] Idem.
[127] Idem.

Plans for transport	Example: make a route of transport ahead of time and learn the schedule and stations of public transportation
Taking any proof of the abuse	Example: photos, notes or details of witnesses (such as contact information)
Safety after ending a violent relationship/marriage	
Get in contact with professionals who can advise or give vital support.	Example: social workers that can offer support
Cut all ties with the abuser	Example: change landline and mobile phone numbers
Awareness of social media accounts	Example: consider security settings on social media and take care if posting anything on social media that can give out your location. Change email address if possible.
Keep location safe from abuser	Example: not telling mutual friends or people who might be in contact with the abuser the current living arrangements.
Keep distance from the abuser	Example: getting a non-molestation or exclusion or a restraining order.
Stay safe	Example: make plans to keep children safe and teach them what to do in case of an emergency or discuss with employer and ask how to stay safe at work.

Figure 19. Safety checklist in developing a safety plan.

Topic 2.4. Providing health support to vulnerable groups experiencing SGBV

Guidelines for service providers and support staff working with women and young persons with various disabilities

Persons with disabilities

Persons with disabilities are three times more prone to experience sexual violence, physical violence, or emotional violence, and women are up to ten times more likely to experience sexual violence[128]. Women with disabilities are also more likely to experience poverty and isolation, even in countries with a higher standard of living, and this can lead to minimized access to helping services. At the same time, boys and men with disabilities are twice as likely as those without disabilities to be sexually abused in their lifetime. Similarly, UNICEF observed that children with disabilities are 1.7 times more at risk of violence than children without disabilities[129].

Reasons for these higher rates of violence include discrimination, stigma, negative traditional beliefs, lack of knowledge about disability, lack of support for caregivers, increased vulnerability due to care needs, impunity, and dependence. Women and young persons with disabilities are often denied the opportunity to learn about SGBV, how to develop healthy relationships and other fundamental aspects of prevention like: what appropriate touch constitutes and how to avoid, recognize and report cases of abuse, exploitation, and violence[130].

The lack of accessible prevention services and initiatives for persons with disabilities can keep women and young persons with disabilities from being screened for, recognizing, or reporting GBV[131].

General guidelines

Service providers and support staff must speak directly to the woman or young person with a disability and not to the person's accompanying family member or caregiver. Providers should offer reasonable accommodations and supported decision-making for women and young persons with disabilities who require such assistance. This should be done rather than relying on guardians for substituted decision-making. Deliver supported decision-making services in a way that protects the woman or young person's privacy[132].

Providers must maintain and guarantee service recipient's privacy and confidentiality. At the reception area, ensure that service recipients have an option to state the reason for their visit privately. If a person arrives with a companion, providers should ask the person with the disability in a

[128] UNFPA. 2018. "Women and young persons with disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights."
[129] Idem.
[130] Idem.
[131] Idem.
[132] Idem.

private setting whether they wish to waive their confidentiality by having their companion join them while they receive services (even if the person is less than 18 years old). Providers should not rely on companions to interpret for service recipients with disabilities. They must ensure that this process is completed with sensitivity and is directed by the person with the disability. Being separated from a companion may cause the person anxiety. Providers must also obtain releases to share a person's private information, including for referrals to other services.

Women and girls with physical disabilities:

- Do not assume because of the person's physical disability that the service recipient also has an intellectual disability
- Sit at eye level with service recipient when possible
- Do not move any crutches, sticks, walkers, or wheelchairs without the person's permission or without arranging for their return
- Do not lean on or touch a wheelchair without permission from the person who uses the wheelchair
- Take directions from the person with the disability on how to conduct a transfer to an examination bed or machine

Women and girls with sensory disabilities

For a woman or girl who is deaf or hard of hearing:

- Make sure you have the person's attention before speaking
- If the service recipient is not facing you, touch the person gently on the shoulder
- Do not shout or exaggerate your speech
- Look directly at the service recipient, and do not cover your mouth
- Ascertain and document as soon as possible the person's preferred method of communication
- Use slow and clear speech to aid lip-reading for those who require it
- Have an on-call or pre-arranged CART translator or sign language interpreter.

For a woman or girl who is blind or has difficulty seeing:

- Do not touch the person before announcing yourself
- Do not assume the service recipient cannot see you at all
- Speak in your normal voice
- Allow the person's service animal to accompany them at all times
- Do not take away a cane or other mobility tool from the service recipient at any time
- Say goodbye before walking away or leaving
- Have large print, audio, or Braille-formatted information for those who require it
- Provide information in digital formats in advance for a person to read with a screen-reader before their appointment
- Use visual and technical aids for those who require them.

For a person who does not speak clearly:

- Do not assume because a service recipient's speech is slow or difficult to understand that the person has any difficulties learning or understanding
- Ask the person to repeat anything you do not understand
- Ask questions the person can answer by "yes" or "no."
- Let the person take as much time as needed to explain their problem.
- Be patient.

Women and girls with intellectual disabilities:

- Use simple words and short sentences
- Repeat instructions and important information in various ways, utilizing different learning tools to help the service recipient understand (e.g., anatomically correct models or dolls, role-play scenarios)
- Offer the person simple instructions and information guides to take home with them for reference (e.g., plain language, easy read, pictorial guides, video instructions)
- Be patient
- Do not treat the person as a child
- Provide the service recipient with a phone number or way to contact the provider again with follow-up questions.

Women and girls with psychosocial disabilities:

- Emphasize and take steps to foster and develop trust between yourself and the service recipient
- Offer training for all providers, staff, and family members to increase acceptance, change attitudes, and foster trust
- Improve communication between GBV and SRHR service providers and mental healthcare service providers
- Offer support groups
- Ensure that you and all support staff always treat service recipients with respect and acknowledge their strengths
- Offer information and referrals about supported decision-making mechanisms and a healthcare proxy, if available. A person designates a healthcare proxy to make healthcare decisions for them when they are unable to make decisions for themselves; it is a mechanism to ensure that a person's wishes are followed.

Obtaining informed consent from persons with disabilities

Persons with disabilities experiencing SGBV have the same rights to make their own decisions as everyone else. Service providers and support staff must understand that just because a person has an intellectual disability or cannot communicate verbally does not mean that they cannot give their informed consent[133].

While the process of obtaining informed consent may be difficult and time-consuming, particularly when there are communication difficulties, this does not absolve a service provider of their obligation to obtain informed consent. Moreover, only the service recipient can provide informed consent, regardless of family member's or advocate's opinions.

Appropriate measures need to be taken to support them to exercise their legal capacity[134]. It is the service provider's obligation to ensure that the rights of the woman or young person with the

[133] UNFPA. 2018. "Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights."
[134] Idem.

disability are respected by a communication process that leads to the provision or withholding of informed consent. Consent can also be withdrawn at any time[135].

Victims/survivors who lack capacity to provide informed consent have a right to information and play a role in decision-making. Caregivers should share information, listen to what they have to say, and explain how and why decisions about their health have been made[136].

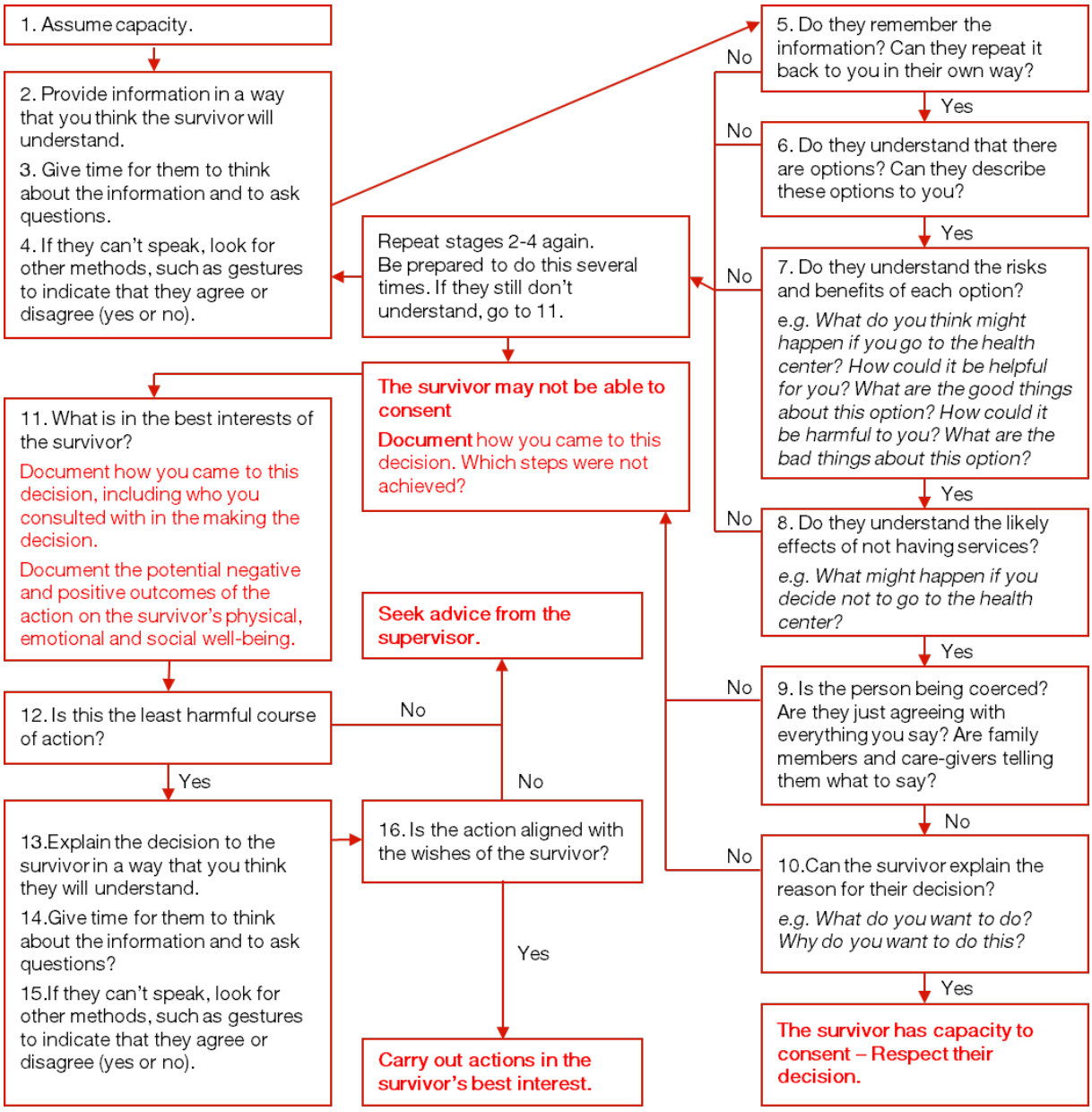

Figure 20. Flowchart for inform consent of persons with disabilities.

Health care workers should always seek informed assent from the victim/survivor. If a determination is made that a person lacks capacity to provide informed consent, the provider must seek to obtain informed assent, which is the victim/survivor's expressed willingness to participate in the services or

[135] FIGO Committee, 2012. Ethical issues in obstetrics and gynecology by the FIGO Committee for the study of ethical aspects of human reproduction and womens health. Ethical Issues Obstet Gynecol, 91.
[136] WRC. 2015. "Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings." https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-disability-Toolkit-all-in-one-book.pdf.

activities proposed. Pictures and hand gestures or symbols can be used to ask if someone is willing to participate in an activity or access a service. Also, signs of agitation, anger, or distress should be assessed. They usually may indicate that the individual is not happy with something being discussed or an activity being undertaken[137].

Service providers and support staff may encounter service recipients who are unable to provide informed consent even with the necessary supports. Women's Refugee Commission developed a flowchart that helps caretakers to make this determination navigate the informed consent procedure when in involves persons with disabilities experiencing SGBV. This flowchart can be applied to elder SGBV victims/survivors[138].

Health care to elderly experiencing SGBV

SGBV in older women

Older women may suffer multiple forms of discrimination based on gender and age. Older women are at greater risk of violence because of age-specific factors such as physical vulnerability, isolation, dementia, possible illness or dependence on the family or social care workers. Moreover, they might experience severe consequences such as fear, anger, exacerbating existing disease, depression and distress[139].

Further, they are especially vulnerable to economic abuse, especially in deferring their legal capacity to somebody else. Older women can also not recognize abusive behaviour like domestic violence. Ageism is “the systemic stereotyping of and discrimination against people because they are considered old” and can lead to further violence for elder women. Moreover, sexual health of older women is often ignored, marginalized, and stigmatized, impeding access to preventive services and care for interpersonal violence and sexually transmitted infections”[140].

Older women are more likely to know their perpetrators and depend on them, limiting their access to appropriate services. Other obstacles include lack of information about services, lack of resources, age, and fear that they will not be believed (will be considered amnesic or mentally ill)[141].

SGBV campaigns are rarely designed and delivered to reach elder women and young persons with disabilities. Some of the reasons are lack of knowledge about the nature of violence, prejudice and the absence of promising practices[142].

Elder women experiencing SGBV should be offered the same services that are provided for younger women experiencing SGBV, but being mindful of their particularities.

In providing services to elder victims/survivors of SGBV professionalism is key!

Patients should be treated in a non-discriminatory and non-judgmental manner, with empathy and taking care not to discredit the victim/survivor’s report of abuse[143].

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[137] WRC. 2015. “Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings.” https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-disability-Toolkit-all-in-one-book.pdf.
[138] Idem.
[139] Idem.
WAVE. 2014. “Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia A Resource Package.”
[140] Idem.
[141] Idem.
[142] UNFPA. 2018. “Women and young persons with disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights.”
[143] Idem.

Topic 2.5. Communication and referral skills for health care providers

Adapting principles of Motivational Interviewing to facilitate patient communication

Health care providers are instrumental in offering support to victims/survivors of GBV in order to disclose experiences of GBV. The communication process aims to support SGBV victims/survivors and should facilitate change and health care professionals can actively promote SGBV behavioral and social change. As simple as communication towards changing behaviors might seem, there are certain roadblock in communications that health care workers should avoid when discussing with SGBV victims/survivors. These roadblocks are presented below.

Roadblocks in health care provider-patient communication[144]:

- Ordering, directing, or commanding
- Warning or threatening
- Giving advice, making suggestions, or providing solutions
- Persuading with logic, arguing, or lecturing
- Moralizing, preaching, or telling clients what they “should” do
- Disagreeing, judging, criticizing, or blaming
- Agreeing, approving, or praising
- Shaming, ridiculing, or labelling
- Interpreting or analyzing
- Reassuring, sympathizing, or consoling
- Questioning or probing
- Withdrawing, distracting, humoring, or changing the subject

There are multiple communication models existent and recommended for SGBV victims/survivors and all revolve around the idea that communication with SGBV victims/survivors should be based on strengths, should increase motivation and should involve behavioral change[145].

Motivational interviewing

Motivational Interviewing (MI) is a new counseling approach used in the SGBV field. MI techniques increase patients’ trust and helps health practitioners to have open discussion with their patients in a non-intrusive way. Using all of the elements of MI when working with SGBV patients might be a challenge as most health care providers are not trained in this communication method. MI was build starting from the Stages of Change theory, which assesses in which stage the patient is and what would it take to implement a change. MI adds several important aspects to the Stages of Change theory and it is defined as “ a collaborative, person-centered form of guiding, to elicit and strengthen motivation for change”[146]. MI was developed by psychologists for counselling purposes, and partly to be used for training in general practice. Health care providers can use motivational interviewing in their own daily practice to help patients find their motivation to change behaviors in the interest of

[144] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”
[145] Idem.
[146] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. “RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women’s Health Services.”

their own health. Training in MI techniques is recommended before working with SGBV victims/survivors and, if possible, experienced counsellors in MI should be involved in managing violence cases[147].

Motivational interviewing can be used to support SGBV victims/survivors in the following ways[148]:

- Managing their health outcomes
- Seeking help and accessing support services
- Starting safety planning
- Seeking social support
- Reducing any addictions used as coping mechanisms
- Getting and keeping a job
- Improving their self-efficacy
- Ameliorating associated mental health problems.

One important and useful aspect of MI is that it does not require extensive time to be spent with the patient since its communications skills can be applied during the consultation and they can be applied as a communication tool that relaxes the atmosphere and makes GBV victims/survivors feel comfortable during consultations. Health care providers in women's health services can use concepts of motivational interviewing to increase referrals to specialist services. No matter if they have 10 minutes – 30 minutes – 1 hour time for consultation, communication skills can be applied.

MI is a collaborative process that is done for patients and not to them. MI aims to facilitate trust and helps health providers to engage patients in the conversation. Johnson et al., developed a set of motivational interviewing principles that health care providers can use in order to establish a collaborative partnership with the patients, evoke patients' reasons for change, emphasize their autonomy, and express compassion[149].

COLLABORATION	COMPASSION
Collaborate with the patients	Promote patients' welfare
Consider patients as experts	Prioritize patients' needs
Put first what patients know about themselves	Accept patient's choices
Explore interests rather than persuade	Respect emotional difficulties patients encounter
Avoid being the expert	Seek to understand patients' experiences, values and motivations
Avoid considering patients as passive recipients	Avoid explicit and implicit judgement
Avoid confronting patients	
Avoid imposing your ideas	
EVOCATION	**AUTONOMY SUPPORT**
Draw out patients' reason for change	Empower patients in making the change
Avoid imposing your reasons for change	Make patients responsible for their actions
Avoid convincing patients of the need to change	Encourage patients to develop strategies for change
Avoid telling patients what to do and why	

[147] Idem.
[148] Idem.
[149] Idem.

Principles of motivational interviewing

There are four main principles of MI, gathered under the acronym of RULE[150]:

Resist the righting reflex.

Understand your patient's motivations.

Listen to your patient.

Empower your patient.

Resist the righting reflex
Health care providers need to resist the reflex of fixing or protecting a patient, before the patient asks for help. Persuading SGBV victims/survivors to report or leave their abusive partners, may have the opposite effect, with victims/survivors tending to protect their partners and to avoid help seeking. Moreover, when health providers try to persuade the SGBV victims/survivors saying „I think you need to do something about this. The situation looks bad and you're in danger!", the natural response of SGBV victims/survivors is to bring a counter-argument such as „I'm fine, it's not that bad."
Understand your patients' motivation
When we want to change our behaviors, our reasons for change are triggering behaviour change. In MI, motivation for change comes from patients, not from health practitioners. Thus, health practitioners need to evoke and explore SGBV victims/survivors' motivations for change instead of presenting their own thoughts on why patients should change.
Listen to your patient
In listening to patients' change talk it is important to ask open questions to elicit their personal views on change, accept periods of silence and show empathy.
Empower the patient
Exploring SGBV victims/survivors' ideas on how they can change, favors their empowerment to action. Consider patients as their own experts for change.

Motivational Interviewing techniques[151]

The main techniques used in MI are the following: ask, listen, inform.

Ask – The health care workers needs to make sure to ask the right questions by using open-ended questions.

Ask open-ended questions	How are you feeling today? What would you like to talk about today? How are things going with your partner? What things worry you about your relationship? What would be the things you would like to change in your relationship?

Listen – MI techniques specify that health care providers should spend 80% of the time listening and 20% of the time talking. When listening, health care providers need to identify what MI calls "change talk". "Change talk" represents the vocabulary that patients use when expressing desire, ability, reason and need for change. At the same time, patients can talk about commitment to change, activation for change and taking steps. DARN-CAT is an acronym to remember what health care providers need to listen to during their consultations.

[150] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services."
[151] Idem.

Listening to "change talk" **Preparatory change talk**	Desire	"I want to…" "I would like to…" "I wish…"
	Ability	"I could…" "I can…" "I might be able to…"
	Reasons	"I want to do this because…" "It would probably be better if…"
	Need	"I ought to…" "I have to…" "I really should…"
Implementing change talk	Commitment	"I am going to…" "I will…" "I intend to…"
	Activation	"I am ready to…" "I am prepared to…" "I am willing to…"
	Taking steps	"I did …" "I started to…"

Inform - In daily practice, health practitioners are used to providing information to patients. When applying MI, informing patients becomes different, as practitioners are not providing information but *exchanging* information with the patients. Before providing information, health care professionals are encouraged to ask for permission. After exchanging information, health care providers are encouraged to ask for patients' feedback on what they just shared with them.

Exposure to GBV can lead to difficulties in establishing trust with health care providers. By using appropriate communication methods presented in MI, health care providers can increase referral of GBV in women's health settings.

Communication for people with disability[152]

The United Nations (UN) developed the Convention on the Rights of Persons with Disabilities (CRPD), which represents a useful guide to using terms about disability that are both sensitive and appropriate. Some examples can be seen in the table below:

Avoid…	**Consider using…**
Emphasize a person's impairment or condition For example: Disabled person	Focus on the person first, not their disability For example: Person with disabilities (CRPD language)
Negative language about disability For example: "suffers" from polio "in danger of" becoming blind "confined to" a wheelchair "crippled"	Instead use neutral language For example: "has polio" "may become blind" "uses a wheelchair" "has a disability"
Referring to persons without disabilities as "normal" or "healthy"	Try using "persons without disabilities"

[152] WRC. 2015. "Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings." https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-disability-Toolkit-all-in-one-book.pdf.

When communicating with persons with disabilities experiencing SGBV, a strengths-based approach is recommended to be used. A strengths-based approach means focusing on what the person can do, not what they cannot do because of their disability. Therefore, health care providers are advised not make assumptions about the skills and capacities of persons with disabilities but rather assess when they can do.

Service providers and support staff must speak directly to the person with a disability and not to the person's accompanying family member or caregiver. When possible, caregivers should place themselves at eye level with the person if they are not already at the same height. MI techniques can be used for persons with disabilities experiencing SGBV and should be coupled with a strengths-based approach.

The following checklist can help to identify potential communication methods with persons with disabilities[153].

Communication	
Is the person with disabilities able to tell you their name?	☐
How do family members and caregivers communicate with them?	☐
Can they answer simple yes/no questions? Maybe using head or hand gestures?	☐
How do they express if they are happy or sad? Watch for facial expressions that may indicate that they are happy or sad during your consultation.	☐
Can they write or draw? Have some paper and let them have a try as well.	☐
How do the caregivers and family members engage them? Do they talk to them directly? Do they use signs and gestures?	☐

[153] WRC. 2015. "Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings." https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-disability-Toolkit-all-in-one-book.pdf.

Module 3.
Multi-sectorial coordinated response to SGBV

Topic 3.1. Referral system

Referral process and pathway

Health care professionals are often the first point of contact for SGBV victims/survivors. Therefore, they are well positioned to identify SGBV and provide victims/survivors with first-line support which includes immediate medical care and referral to other/if existing support services as well as reporting to the police, if the legislation requires for mandatory reporting. Other necessary referrals might include referrals to other health professionals within the same or at another health facility; for example, to mental health care providers or HIV specialists, and referrals to other services, such as shelters or organizations providing psychosocial or legal counselling, if available. In turn, health care professionals may also receive referrals for women victims/survivors, for instance from police, women's shelters or other health care professionals to provide immediate medical care and treatment of injuries as a consequence of a violent event[154].

The referral process starts with asking the possible victim/survivor about SGBV. Discussing and asking about SGBV should be performed in safe environment where confidentiality should be explained to the patient, including the limitations of the confidentiality if a SGBV situation is disclosed, taking into consideration each countries' legal requirements. The following scheme, adapted from the RESPONSE Manual[155] shows the pathway of asking about SGBV using a victim-centered approach:

Referral network

Violence crosses many domains, therefore a system of integrated care which includes different sectors, disciplines, and professions is critical both to fully understand the problem and effectively act to prevent it. The major sectors which should be represented in the integrated system for care of SGBV victims/survivors are health services, social services and support agencies, police and judiciary authorities, and local authorities, including local government structures, public health authorities and educational facilities.

The 2014 FRA survey provided the percentage of women in the EU who contacted police or other services after experiencing some form of physical and/or sexual violence. These figures demonstrate that of all the services, women are most likely to contact a doctor or health care facility, followed by the police and hospital. Reasons for not contacting an organization vary, however the primary reasons as indicated in the FRA survey are that: women feel they would rather deal with the situation alone or involve someone close to them such as a family member or friend; they feel the situation is too minor or it just never occurred to them to contact an organization for help; they did not know where to turn to; and there were no services available[156].

[154] RESPONSE Manual. Johnson, Medina, Diana Dulf, and Alexandra Sidor. 2017. "RESPONSE Training Manual for Reporting of. Gender-Based Violence in Women's Health Services." page. 30
[155] Idem, pages 62-65.
[156] FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 66.

Service	PARTNER		NON-PARTNER	
	Physical	Sexual	Physical	Sexual
Police	14%	15%	13%	14%
Hospital	11%	12%	9%	12%
Doctor/health center or other healthcare institution	15%	22%	10%	16%
Women's shelter	3%	6%	(0)	(1)
Victim/survivor support organization	4%	4%	1%	4%

Figure 21. Women who contacted organizations or services after serious incidents of violence since the age of 15 (EU28).

In line with the points of access mentioned above and the different sectors women confronted with SGBV address for care and well-being, we define women's referral network as a core group of service providers who collaborate in order to support women experiencing SGBV in receiving the best of care they require. Referral network's goal is to address the immediate and multiple needs of the patient who is confronted with SGBV in a manner that will ensure the safest and most effective way for reporting, taking into consideration the victim/survivor's preferences for care and treatment, [157] and providing the victim/survivor with the necessary information regarding mandatory reporting depending on the type of SGBV she is confronting with. A referral network should be ideally organized at local level and should be mandated and explicitly stated in the members policy and procedures, for e.g., hospital should include this information in their organizational procedures and actions with specific responsible and core responsibilities.

A best practice example of a referral network which is organized and provides responsibilities to the health care sector, is the case of Austria, where hospitals have established by law [158] "Victim Protection Groups". This best practice has been established in hospital settings where a team of trained health professionals (obstetrics, emergency room, midwives, etc.) is called upon for any potential victims/survivors of GBV, in order to facilitate support regarding referral to police services and specialized support services such as a specialist intervention center or women's shelters [159].

Since the beginning of 2011 there is a legal mandate in Austria, to deliver victim/survivor protection groups in health care systems. According to law, health care systems need to have in place victim/survivor protection groups for children as well as adults. One of the key components is to recognize early signs of domestic violence and any suspicion of violence in order to strengthen sensitization of the staff on the issue of domestic violence.

The group should have as members at least two specialists for the emergency department and gynecology, as well as further nurses and a lead person responsible for psychological and psychotherapeutic treatment in the hospital.

[157] UNFPA EECA RO, EEIRH (2015). Multi-sectorial response to GBV – an effective and coordinated way to protect and empower GBV victims/survivors.

[158] Austrian Federal Law for the implementation of victims of gender-based violence in public health care systems, (2010), Bundesgesetz u

Role of Victim Protection Groups:

- Victims/survivors of gender-based violence receive extensive and appropriate support
- The entire clinical staff team is asked to participate in training and education initiatives around GBV
- Intensified multi-agency working and cooperation between the medical and the nursing sector, victim/survivor protection groups, women's shelters, police and registered doctors
- Regulated financial and personal resources to increase victim/survivor protection, and support disclosure of GBV.

At local level, the hospital/clinic together with police services and specialized support services (here the support services might differ depending on availability at local level): social services, women's shelters, and/or NGOs who provide support to victims/survivors of SGBV, form a multi-sectorial group who provide care and support to women victims/survivors of SGBV.

Medical facilities are mandated to convey the Victim Protection Group for all those affected by domestic violence. The groups are responsible for the early screening of domestic violence and in particular, the sensitization of different medical specialists on the impact and effects of domestic violence. This law has been an important improvement for the support of those with experience of GBV and who require support in the health care facilities.

As part of the referral network, health care providers have the following responsibilities:

- Identify victims/survivors of SGBV
- Provide medical treatment where required
- Document the signs and injuries that could indicate the abuse as thoroughly as possible and respecting the legislation in place
- If the SGBV event was disclose, inform the victim/survivor about the legal requirements of police reporting (depending on the type of SGBV and the legal obligations specific to your country)
- Participate to trainings and group meetings where SGBV cases are discussed.

It is important that members of the referral network: [160, 161]

- Understand the phenomenon of violence and the spiral of violence
- Recognize the manifestations of trauma
- Actively listen and discuss topics of violence with possible victims/survivors
- Conduct follow-up
- Cooperate with other professionals and experts
- Share resources and common goals on the topic of GBV
- Exchange information and activities on the topic if GBV.

[160] PRO TRAIN, "Improving Multi-Professional and Health Care Training in Europe – Building on Good Practice in Violence Prevention, Health Care Sector, Training Programme". (2007-2009), p. 3.
[161] UNICEF, "Handbook for Coordinating Gender-based Violence Intervention in Humanitarian Settings". (2010), p. 110.

Services provided by other key sectors

Role of social workers/support workers as specialists working in the field of SGBV:

- Can carry out full risk assessment and safety planning
- Support victims/survivors of SGBV to create a safety plan and talk through options around their care and decisions
- Be connected to local support services and be able to support victims/survivors in accessing additional care depending of the available resources
- Be able to support planning including onwards reporting to police or other mandated institutions with responsibility in documenting and reporting of SGBV cases
- Understand their role in relationship to other key stakeholders, mainly health care professionals and police.

Role of the police department:

- Investigate and prosecute cases of SGBV
- Support victims/survivors of SGBV to document and report perpetrators
- Assure victims/survivors of SGBV of their protection
- Provide victims/survivors of SGBV access to appropriate protection, free legal aid and be treated and interrogated in a sensitive, respectful way to avoid the risk of further trauma
- Participate in training on identification and reporting of SGBV, using a victims-centered approach.

Police and the criminal justice system are responsible to investigate and prosecute cases of SGBV that constitute criminal offences under the respective national laws and to determine the criminal liability of the defendant. In some countries, police have the legal mandate to issue and enforce restraining orders. Civil courts decide on divorce and child custody proceedings and, in some countries, can issue protection orders that prohibit perpetrators from approaching the victim/survivor. Depending on the circumstances of the individual case, claims for compensation for damages suffered by the victim/survivor as a result of GBV may be decided before civil and/or criminal courts[162].

[162] UNFPA-WAVE “Strengthening Health System responses to gender-based Violence in Eastern Europe and Central Asia” (2014), p. 93.

Topic 3.2. Multi-sectorial response to SGBV

Functions of multi-sectoral response to SGBV

A multi-sectorial response to SGBV is a coordinated group of professionals, mainly but not limited to public and non-governmental institutions with functions/roles in the prevention of SGBV with the purpose of harmonizing and correlating programmes and actions developed and implemented for the prevention and control of SGBV. Usually, members of the multi-sectorial response to SGBV group work in the areas of psychosocial welfare, law enforcement (police, prosecutors and justice departments), health and public health. A multi-sectoral response to SGBV is based on inter-institutional partnership and cooperation, requires a common philosophy for addressing SGBV and follows the principles and standards determined by the partners involved[163].

At international level, multi-sectorial response to SGBV actions is encouraged and stipulated in the Istanbul Convention. The Istanbul Convention is the first legally binding instrument in Europe to create a comprehensive legal framework to protect women from acts of violence as well as prevent, prosecute and eliminate all forms of violence against women. The Istanbul Convention focuses on four major themes: prevention, protection, prosecution, and monitoring. In article 18, The Istanbul Convention encourage signatory parties (adopted in 11 May 2011, entered into force in 1 August 2014 (in EECA the Convention was ratified by Albania, the Former Yugoslav Republic of Macedonia, Serbia and Turkey; and signed by Georgia, Romania and Ukraine)) are encourage to implement appropriate mechanisms to support effective co-operation between all relevant state agencies along with non-governmental organizations and other relevant organizations and entities with the primary scope to protect and support victims/survivors of SGBV and witnesses of all forms of violence, including children, as covered by the Convention[164].

The role of health professionals in preventing and combating SGBV should be included in national/local and/or institutional policies. Along with the role of health professional, a list of relevant health professionals which are more likely to treat and refer patients who suffer SGBV and their specific responsibilities should be included: emergency room personnel, general practitioners, midwives and obstetric health team.

The guiding principles of a multi-sectorial response to SGBV group should include[165]:

Victim-centered approach. All institutions and services represented in the group should prioritize the rights, needs and wishes of the victim/survivor.

Partnership and collaboration. The multi-sectoral response to SGBV implies good cooperation and coordination of represented institutions and services.

Communication transparency. Coordinating the exchange of information between professionals: developing mutual understanding of confidentiality rules and information in order to be shared between different institutions and organizations.

[163]UNFPA EECA RO, EEIRH (2015). Multi-sectorial response to GBV an effective and coordinated way to protect and empower GBV victims/survivors.
[164] Idem.
[165] Adapted from UNFPA EECA RO, EEIRH (2015). Multi-sectorial response to GBV an effective and coordinated way to protect and empower GBV victims/survivors.

Good governance and management. The rules regarding the multi-sectoral intervention and referral, the strategies and action plans, including planning, implementing, monitoring and evaluating programmes should be done in a participatory manner, including the input of beneficiaries (if applicable).

Strategic planning. The policies that address SGBV phenomenon should be translated in inter-institutional common strategies, with specific objectives and activities.

Integrated services. The procedures for intervention and referral as well as the protection measures require a multi-disciplinary approach based on unified work methodology. Services should also take into consideration the need to prevent harm to children.

Prevention and control. An effective integrated approach sets as a priority also the prevention of SGBV. Therefore, partner institution should militate for the prevention of SBGV and provide tools and mechanisms for the control of existing cases of SGBV. This includes data collection and data sharing mechanisms.

Specialized training. Training of professionals working in identification and reporting of SGBV must be mandated and explicitly stated in the partner institution policy and procedures.

Accountability. All institutions and organizations have to clarify each of their role in the group, as well as the role of the staff to implement and respect the agreed programs/rules and to follow these guiding principles in their work. Monitoring and reporting actions are part of the accountability of each institution and organization.

Sustainability. Despite the political changes or staff turnover/demotivation, once the multi-sectoral response to GBV is assumed, the institutions/organizations should ensure all conditions to implement and sustain this approach. The involvement of strategic leaders can ensure the sustainability and accountability of the group as they can become the figures of support and promotion, providing legitimacy to the group.

Promotion and advocacy. Ongoing activities to increase the likelihood of women to become more aware about the role of each institution or organization in the prevention and control of SGBV as well as the promotion of existing services and programs, and their capacity to support women in reporting SGBV.

"Talking about the violence and making it visible is one good way to prevent the violence. Violence prevention should be incorporated into every branch of social services, at all levels of administration, and into the missions, policies, and procedures of operational units" [166].

The following **six functions** should be integrated when creating a mechanism to support multi-sectorial response to SGBV[167]:

Coordination includes the following sub-components: a) mechanisms for the coordination of a multi-sectoral response to GBV, information management and exchanges between the institutions/organizations involved, and ongoing programmed planning and development; b) designated bodies for coordination of multi-sectoral responses to GBV; and c) financing. Partnerships are critical to the success of multi-sectoral responses to GBV because they offer a wide safety net for support and referral; public authorities must be part of the process. Monitoring and evaluation is an important issue for effective coordination and implementation.

[166] Pro Train, "Improving multi-Professional and Health Care training in Europe – Building on good Practice in Violence Prevention, Health Care Sector, training Programme" (2007-2009), p. 2–3.

[167] UNFPA EECA RO, EEIRH (2015). Towards a Multi-sectoral Response to Gender-Based Violence. Mapping the Current Situation in the Eastern Europe and Central Asia Region, https://femroadmap.eu/UNFPA_EECA_RO_Survey_report_on_Multi-sectoral_Response_to_GBV.pdf

Interventions/essential services to limit the consequences of GBV and to prevent further incidents/harm. Service provision refers to services for GBV victims/survivors, as well as services for perpetrators, both of which would be governed by specific protocols, procedures and quality standards. Different services could be available for GBV victims/survivors: responses by key sectors (law enforcement, judicial, social protection/assistance, child protection and health care), specialized services and general services. All partners must be aware of the roles, responsibilities and limitations with respect to the intervention of each service provider. Services and programmes for GBV perpetrators must focus primarily on making them accountable; on ending physically, sexually and psychologically abusive behaviors; and they must be based on strategies that do not blame the victim/survivor or imply that the victim/survivor shares any responsibility for any abuse that occurred.

The existence of a reporting and referral systems. In addition to case review, monitoring and follow-up support, referrals are an important step in case management as part of a multi-sectoral response. Clear reporting and referral procedures, agreed by all institutions, facilitate a multi-sectoral response to GBV and better meet the needs and wishes of victims/survivors.

Training programmes for all professionals, from all sectors and at all levels are essential for improving the quality and management of a multi-sectoral response to GBV and for ensuring ongoing capacity development. Training programmes should focus not only on building the skills needed for an effective response to GBV and setting the stage for accountable service provision, but also on changing attitudes and behaviour in relation to GBV.

SGBV Surveillance System. Data management includes documenting and registering GBV incidents and cases, standardized forms and software for registering and reporting data to a higher-level institution that can generate a centralized database which can serve as an ongoing SGBV Registry. Good data collection system can support the development of research evidence to increase the evidence-based decision-making in the field of SGBV prevention and control.

Prevention and awareness-raising activities. Prevention is aimed at stopping GBV before it occurs by addressing its root causes. The common elements that need to be addressed are one individual's power and control over another individual, as well as gender inequality and discrimination. Prevention requires longer-term planning and implementation to envisage substantive changes of the economic, social and political status of GBV victims/survivors and changes in social norms that tolerate abusive behaviors. Awareness-raising activities are considered part of the intervention component because they may a) raise the level of understanding of the various forms and consequences of GBV, b) change perceptions of GBV, and c) directly influence the addressability of victims/survivors to available services.

Multi-sectoral coordination

Successful multi-sectoral cooperation increases the likelihood of women becoming aware of services made available to them in their own community, which helps in awareness-raising and increases the chances of women reporting GBV.

The more cooperation and specialized training between the health sector, police, courts, and women's organizations means the greater likelihood that women will not only become more aware of services available, but also feel more confident in these services capacities to meet their needs[168, 169].

[168] FRA, " Violence against Women: An EU-wide survey". Brussels, FRA. (2014), p. 70.
[169] Blank K, Rosslhumer, M, "IMPLEMENT Training Manual on gender-based violence for health professionals". (2015), p. 38.

There are eight stages that are essential for developing cooperation[170]:

1. Creating a shared philosophy of cooperation, along with principles and goals: safety of the victims/survivors, responsibility of the perpetrator and avoidance of victim/survivor blame
2. Creating agreed-on procedures: sensitivity to the victim/survivor's experiences
3. Monitor/track cases to ensure accountability of the professionals: clarify roles of each professional group
4. Coordinating the exchange of information between professionals: developing mutual understanding of confidentiality rules and information
5. Providing resources and services for victims/survivors
6. Ensuring sanctions, restrictions, and services for perpetrators
7. Developing actions to prevent harm to children and develop therapeutic work for children's traumatic experiences
8. Ongoing specialized training for professionals working with SGBV victims/survivors.

[170] PRO TRAIN, "Improving Multi-Professional and Health Care Training in Europe – Building on Good Practice in Violence Prevention, Health Care Sector, Training Programme". (2007-2009), Module 5.

Part 2.
Training implementation guide

Introduction to the workshop

Objectives

In this session the trainers should get to know their audience (workshop participants). If possible, some of the information obtained in this session should be obtain prior to the training (2-3 weeks before) to allow the trainer to make any necessary adjustment to the content and exercises to support the participants main expectations and needs. From the introduction session, the trainer should be able to answer the following questions: who are the participants? And what is their background? This will include education, religion, political beliefs, in short, anything that tells you a little about who these people are. If they have attended previous training on the topic or have any previous knowledge about the topic; will some of the participants need more training than others?

By the end of this session, trainees will be able to understand the role of the training in their everyday work with patients confronting with SGBV, and the trainer will be able to identify the expectations and needs of the training participants.

Content covered

- Welcome and introduction
- Participants' background and expectations
- Goals of the training
- Rules of working together

Learning activities, methods, and time

Activity	Method	Time (min)
Participants' introduction and expectations	Plenary work	30
Goals of the training workshop	Presentation	10
Rules for working in group	Plenary work	5
Pre-test	Test	15
	Total time	**60**

Learning outcomes

Participants will familiarize with the training rules and expectations. At the end of the session, we expect participants to familiarize with the trainer, the methods used to conduct the training and the proposed learnings of the training.

INT/A1/Plenary work

Participants' introduction and expectations

30 min.

Welcome the participants and make a short introduction of yourself and about the training – 10 min

Thank the participants for their willingness to reduce SGBV, their interest and engagement to the training. Introduce yourself and the co-trainer in a respectful and humble way and briefly describe your background. If you use translators, be sure to introduce them.

Introduce the training, its purpose, and the reason for having them as participants.

Comment on the sensitive nature of the training.

Split the participant in pairs – 2 min

Instructs participants to make pairs and to introduce each other in pairs for the next 5 minutes. During the short introduction they should mention the name, occupation, workplace, and main expectations they have from the training.

This exercise encourages participants to listen to each other and to interact with each other.

Allow the pairs to introduce themselves – 5 min

Pairs' members will present to the larger group what they learnt about their pair participants, mentioning the expectations from the training.

Note on flipchart the main expectations.

Summarize the expectations – 5 min

After the pairs' presentations, summarize the expectations, emphasizing similarities and differences. Comment on the topics that are introduced in the agenda of the training, as well as expectations that will not be addressed during the training and the reason for this.

INT/A2/Presentation

Goals of the training workshop

10 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

INT/A3/Plenary work

Rules for working in group

5 min.

Explain that to achieve the objectives of the training and protect the well-being of everybody, participants and trainers will have to follow certain rules.

Ask the participants to brainstorm for some group rules. The trainer may propose certain rules and ask participants how they feel about that. Each suggestion is discussed, and the agreed form is written on a flipchart sheet.

Some group rules might be:

- Respect the opinion and experiences of other participants and the trainers
- Maintain confidentiality of any personal information shred during the training
- Turn off cell phones
- Respect start and end time
- Talk one at a time and in a respectful manner
- Participate!
- Have fun!

Dealing with the topic of SGBV can be emotionally triggering for participants, so rules related to disclosure of sensitive information, respecting personal boundaries, how to communicate need for time-out or additional support are essential. Explain that as SGBV is such a wide-spread reality, it is possible for the participants to remember personal traumatic events or to realize that certain situations from their past that qualify as SGBV. It is important to create a safe space for participants that may be experiencing personal difficulties with the topics covered.

Some examples of rules that help:

- When giving examples from personal experience, be mindful of confidentiality and do not disclose details that may be disturbing for others
- When a participant needs to take time out during the training or to receive additional support in private, agree on a way to communicate this without exposing the participant in a negative way
- Be mindful of differences of opinion that may occur during group discussion. When defending a point of view, challenge the ideas, not the persons.
- Leave space for others to express their opinions and avoid monopolizing the discussion

Post the group rules in a visible place in the training room throughout the training workshop.

INT/A4/Test

Pre-test

15 min.

Print enough copies of the pre-test before the training workshop begins.

Tell the participants that before the training workshop begins, they need to complete a short pre-test.

At the end of the training workshop, they will then complete a post-test.

Explain the participants that this will help you to understand their level of knowledge at the beginning of the training workshop (and adjust the content if necessary) and to measure at the end if the training achieved the planned learning objectives.

Tell that there is no need to put their names on the test sheet as this exercise is not an individual but group knowledge evaluation. If you decide that you want to know on the individual progress, ask the participants to mark their pre-test sheet with a sign they will use to mark the post-test as well. In this way, their confidentiality will be protected.

Handle each participant one copy the pre-test (INT/A4/H1).

Ask the participants to take 10 minutes to write down their answers to the questions.

Collect the pre-tests which you can check through during the lunch break or at the end of the first day of training.

Answer to all questions that might arise at this point.

INT/A4/H1

Pre-test

It is important for us to collect feedback and comments from the participants in this training. By telling us what you think, we can make sure that the training we offer is suited to your needs and requirements. The information you give is confidential and you do not have to put your name on the form.

1. What is your job title? Please circle.

- Doctor
- Nurse
- Midwife
- Social Worker
- Psychologist
- Other, please specify_____

2. Have you had previous training on gender-based violence (physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life)?

- No
- Don't know
- Yes. Estimated total number of hours ____

3. How prepared you feel to….

Mark the number which best describes how prepared you feel.

	1 Not prepared	2 Slightly	3 Moderately	4 Fairly well	5 Well prepared
Ask questions to promote disclosure of sexual and gender-based violence with your patients					
Ask questions to promote disclosure of sexual and gender-based violence with your patients					
Appropriately respond to disclosures about sexual and gender-based violence in your patients					
Identify signs and symptoms associated with sexual and gender-based violence based on patient history and physical examination					
Perform a risk assessment on a patient					
Document violence history and physical examination findings in patient's record					
Make appropriate referral for a patient					

4. How many new diagnoses (picked up an acute case, uncovered ongoing abuse, or had a female patient disclose a past history) of gender-based violence would you estimate you have made in the last 6 months?

Number_____

5. Which of the following actions have you taken when you identified gender-based violence in a patient in the last 6 months? (Mark all that apply)

	Always	Mostly	Sometime	Almost never	Never
Referral to a social worker					
Referral to violence prevention services					
Referral to a shelter					
Referral to the police					
Referral to the court					

6. What are the four main forms of SGBV?

- Sexual
- Physical
- Psychological
- Social
- Denial of resources/access to services
- Educational

7. Which are the four Guiding Principles for engaging with victims/survivors of SGBV?

- Show respect
- Work together
- Maintain confidentiality
- Ensure the safety of the victim/survivor
- Refer all victims/survivors
- Non-discrimination

8. What services do victims/survivors of sexual violence and gender-based violence require? Choose only one answer.

- Health care
- Psychosocial support
- Security
- Legal aid
- All of the above
- None of the above

9. What type of medical care should be offered for SGBV victims/survivors. Choose the correct answers

- Physical assessment
- Financial assessment
- Sexual assault examination
- Living conditions assessment
- Mental health assessment

10. Persons with disabilities are not vulnerable to domestic violence:

- True
- False

11. SGBV victims/survivors with disabilities should go to separate, more specialized services designed for persons with disabilities.

- True
- False

12. Any comments to share:

_____
_____
_____
_____
_____
_____
_____

Thank you for completing this form!

Module 1.
SGBV core concepts and health care practices

Session 1.1: Sexual and gender-based violence core concepts

Objectives

By the end of this training session, participants will be familiarized and have an increased understanding of the sexual and gender-based violence core concepts.

Content covered

- Definitions and terms of SGBV
- Forms of SGBV
- Prevalence of SGBV and dynamic of violence
- SGBV as a health concern and a public health problem
- Causes and impact of SGBV.

Learning activities, methods, and time

Activities	Method	Time (min)
SGBV definitions and terminology used during the training	Presentation	10
Forms of SGBV	Presentation	5
The most prevalent forms of SGBV encountered by the participants	Discussion	15
Prevalence of SGBV and dynamic of violence	Presentation	20
Power and control wheel	Group work	35
SGBV as a health problem	Presentation	5
Medical causes and impact of SGBV	Presentation	10
Problem Tree	Practical activity	30
	Total time	**130**

Learning outcomes

At the end of the session participants with be able to:

- Define SGBV
- List forms of SGBV
- List causes and impact of SGBV

M1/S1/A1/Presentation

SGBV definitions and terminology used during the training

10 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S1/A2/Presentation

Forms of SGBV

5 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S1/A3/Plenary work

The most prevalent forms of SGBV encountered by the participants

15 min.

Ask participants to share the most prevalent forms of SGBV they encountered in their professional life.

Discuss what are the reasons for considering some forms of SGBV more challenging than others.

Answer to any questions that might arise during the discussions.

Connect the most prevalent forms of SGBV reported by the participants to the next slides on prevalence of SGBV globally, regionally and country level.

M1/S1/A4/Presentation

Prevalence of SGBV and dynamic of violence

20 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S1/A5/Group work

Power and Control Wheel [1]

35 min.

Print enough copies of the incomplete medical power and control wheel (M1/S1/A5/H1) and incomplete advocacy wheel (M1/S1/A5/H2) before the training workshop begins.

Divide the participants in two groups.

- The incomplete medical power and control wheel is handed out to one group
- The incomplete advocacy wheel is handed out to the other group.

Allow the two groups to fill out the two wheels according to the best of their knowledge (15 min).

The group with the power and control wheel must consider how the response of the health care professional can collude with the perpetrator, disempower the victim/survivor, prevent the victim/survivor from seek support, etc. The group should give examples to complete a couple of segments of the wheel, for example, sharing information without consent, suggesting talking to the abusive partner/family member, etc.

The group with the advocacy wheel should consider how the response of the health care professional can support, assist, and empower the victim/survivor to seek support. The group should give examples to complete a couple of segments of the wheel, for example, listening and giving validation, offering a referral, etc.

Each group should give feedback on a couple of segments each before presenting to the plenary the completed wheel. Each group should assign a representative, and the representative will present to the plenary the completed wheel (5 min each presentation).

One of the things they help to demonstrate is how important the words are that we use in our response to patients as they can either aid disclosure or unintentionally indicate collusion with the perpetrator. This means that we can all be part of the problem or part of the solution.

Add any other suggestion and encourage participants to a plenary discussion to finalize the wheels (10 min).

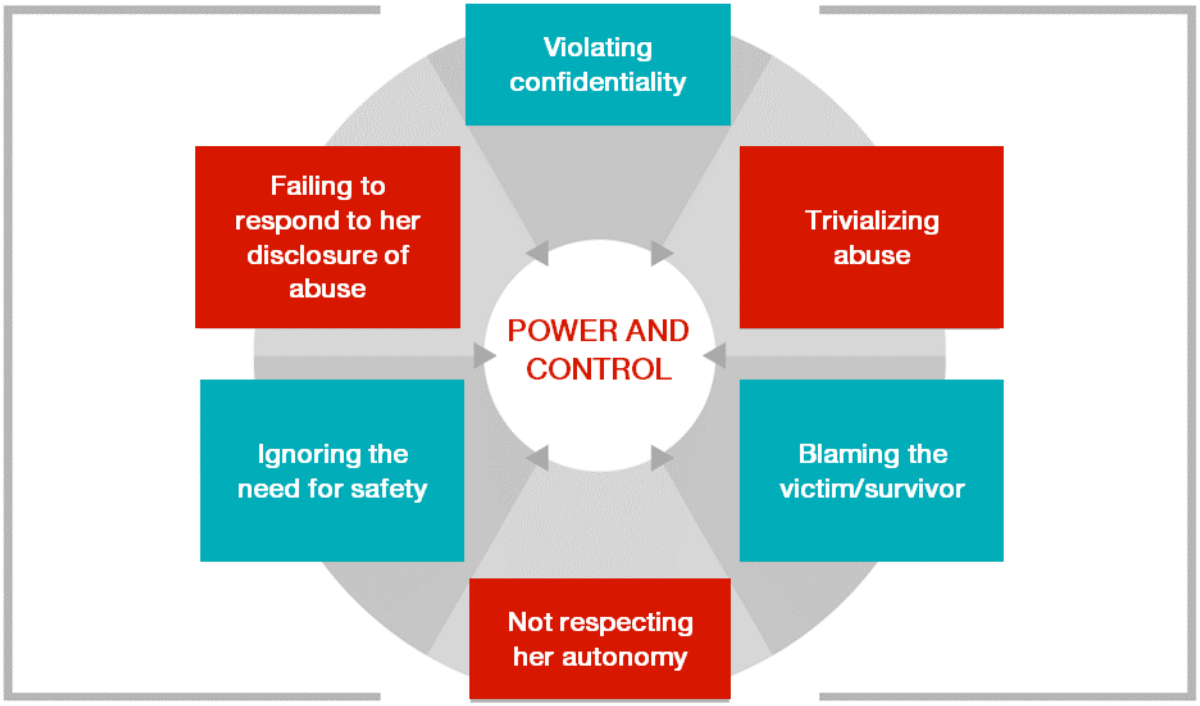
At the end of the exercise, you can handout the completed wheels as well.

[1] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015). RESPONSE MANUAL pages 46-48.

M1/S1/A5/H1

Power and control wheel [2]

For participants use, during the exercise.



[2] Adapted from the IRIS Workbook.

M1/S1/A5/H2

Advocacy wheel [3]

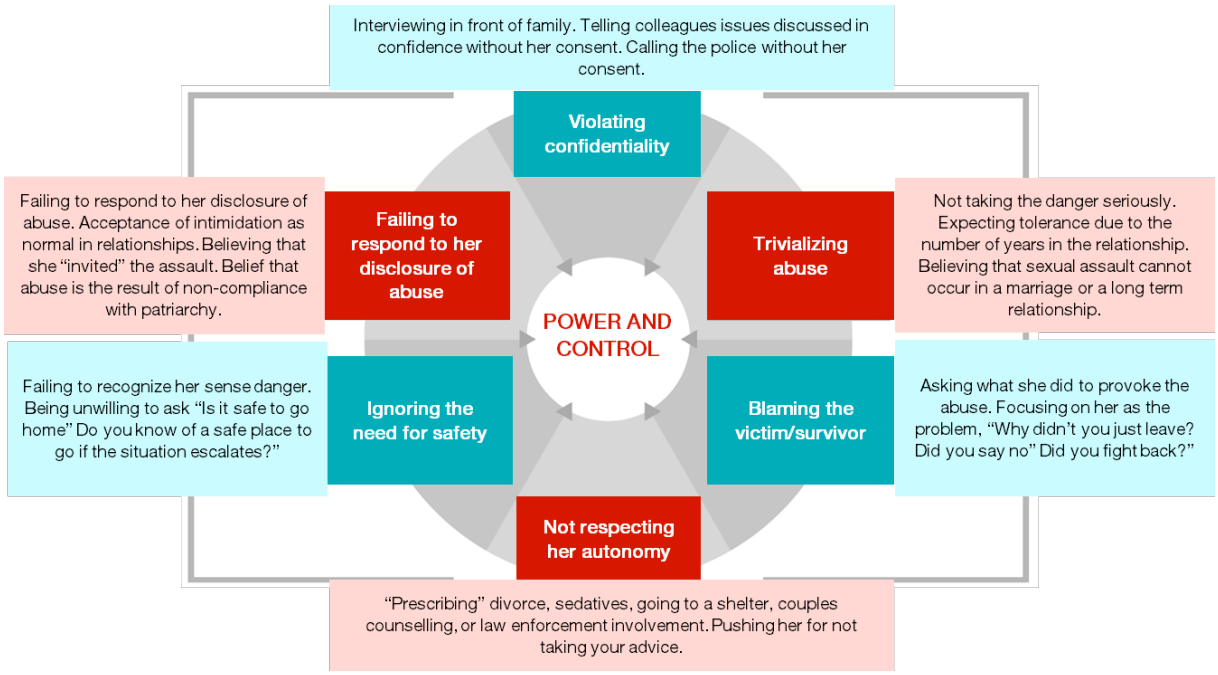
For participants use, during the exercise.

[3] Adapted from the IRIS Workbook.

M1/S1/A5/T1

Power and control wheel

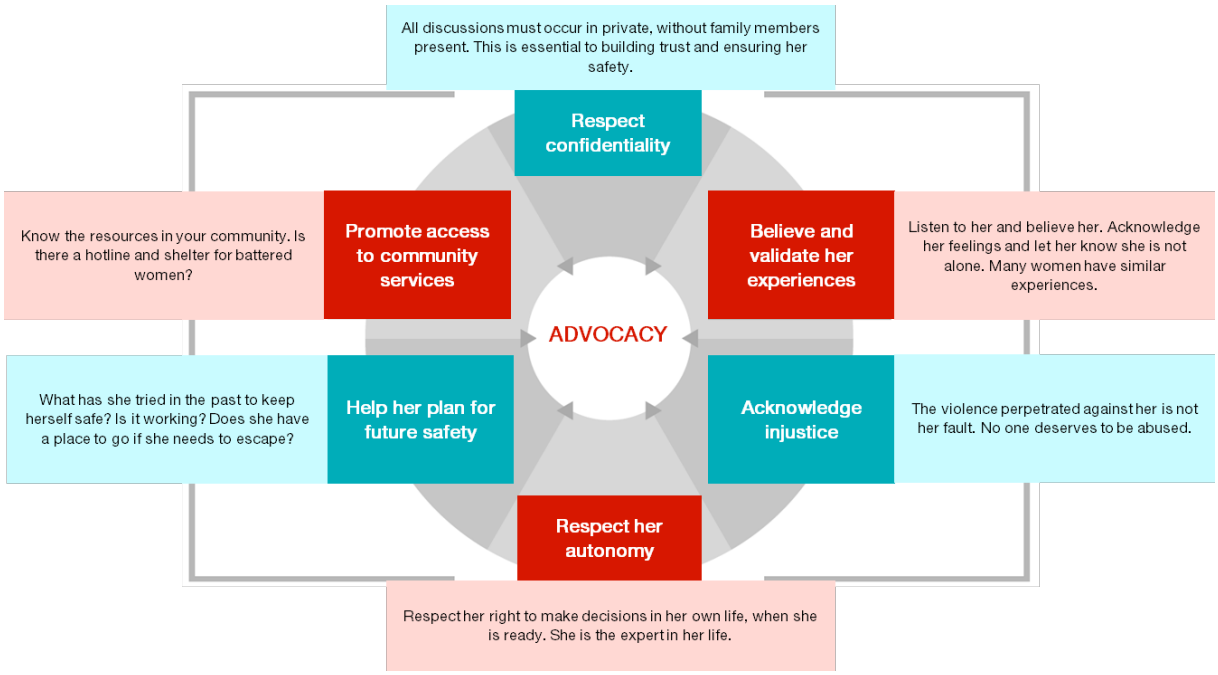
For trainer use, during the exercise.



M1/S1/A5/T2

Advocacy wheel

For trainer use, during the exercise.



M1/S1/A6/Presentation

SGBV as a health problem

5 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S1/A7/Presentation

Medical causes and impact of SGBV

10 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S1/A8/Group work

Problem tree

30 min.

Use the knowledge and examples discussed during the session to identify the problems women are confronted with in your country when it comes to reporting of SGBV cases.

Explain what a problem tree is.

A problem tree provides an overview of all the known causes and effects to an identified problem.

- To list and classify the problems to be addressed
- To examine and identify some of the causes
- To have a fresh & comprehensive understanding of the existing situation

Prepare the participants for the exercise.

Divide the participants in groups of 3-4 persons and handle to each group a flipchart sheet.

Ask each group to draw a big tree they could work with.

Explain how to construct a problem tree.

Ask the participants to list all problems that come to mind related to prevention of SGBV. Problems need to be carefully identified; they should be existing problems, not possible, imagined, or future ones. A problem is an existing negative situation, not the absence of a solution!

Ask the participants to construct their problem tree following the next three steps:

- Identify a 'Core Problem' (which will be written on the trunk of the tree). This process of negotiating the core problem may involve some trial and errors before settling on one.
- Determine which of the identified problems are 'causes' and write them on the roots of the tree
- Determine which of the identified problems are 'effects' and write them on the branches of the tree

Arrange in hierarchy both Causes and Effects, for example: how do the causes relate to each other - which leads to the other, etc. Participants can use arrows to link the causes and effects.

Ask the groups to present to plenary their problem trees.

Debrief on the result of the exercise.

The purpose of the exercise is to formulate a solution at the end. Once the participants settle on the core problem and identify the causes and effects, they can come up with a solution tree by reversing the negative statements that form the problem tree into positive ones.

Example: lack of knowledge will become increase knowledge.

Session 1.2. Guiding principles for providing women-centered care

Objectives

By the end of this training session, participants will be familiarized and have an increased understanding of the importance of using women-centered approach when dealing with gender-based violence.

Content covered

- Istanbul Convention
- Responsibility of health care professionals when discussing with victims/survivors of SGBV.

Learning activities, methods, and time

Activities	Method	Time (min)
Women-centered approach. The Istanbul Convention.	Presentation	10
Responsibilities of health care professionals	Presentation	10
Health care professionals' roles and responsibilities	Plenary work	20
	Total time	**40**

Learning outcomes

At the end of the session participants with be able to:

- Define women-centered approach
- Be familiarized with the Istanbul Convention

Additional reading

- The Istanbul Convention

M1/S2/A1/Presentation

Women-centered approach. The Istanbul Convention.

10 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S2/A2/Presentation

Responsibilities of health care professionals

10 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S2/A3/Plenary work

Health care professionals' roles and responsibilities

20 min.

During the presentation of the identified responsibilities of health care professionals engage the participants to add/discuss/give examples of situations in which they have facilitated disclosure of SGBV victims/survivors.

Break the participants in pairs.

Each pair will discuss about one situation in which they asked about SGBV and what they would do different using a women-centered approach (10 min).

Invite some pairs to share their ideas and encourage the participants to think and discuss about the resources they need (human, financial, time, training, etc.) to facilitate disclosure (10 min).

Session 1.3. Identifying SGBV survivors/patients addressing different health care services

Objectives

By the end of this training session, participants will be familiarized and have an increased understanding of the role of health care professionals in the identification of SGBV patients.

Content covered

- Identification of SGBV victims/survivors
- Screening
- Role of health care professionals
- Signs and symptoms of SGBV patients
- Challenges in addressing SGBV
- Mandatory reporting

Learning activities, methods, and time

Activities	Method	Time (min)
Identification of SGBV victims/survivors	Presentation	15
Clinical enquiry	Individual exercise	30
Signs and symptoms of SGBV patients	Presentation	20
Challenges in addressing SGBV, including mandatory reporting	Presentation	10
Mandatory reporting	Discussion	15
Haddon Matrix	Group work	30
	Total time	**120**

Learning outcomes

At the end of the session participants with be able to:

- Know the challenges in identifying SGBV
- Recognize different healthcare services and their role in the prevention and control of SGVB
- Demonstrate the ability to recognize different categories of SGBV victims/survivors
- Show sensitivity towards SGBV victims/survivors
- Accept sensitivity of mandatory reporting

Additional reading

Runyan CW. Using the Haddon matrix: introducing the third dimension. *Injury Prevention* 1998;4:302-307: https://injuryprevention.bmj.com/content/4/4/302

M1/S3/A1/Presentation

Identification of SGBV victims/survivors

15 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S3/A2/Individual work

Clinical Enquiry

30 min.

Print enough copies of the Clinical Enquiry handout (M1/S3/A2/H1) before the training workshop begins.

Explain the participants that this is an individual exercise.

Invite the participants to individually complete the exercise taking into consideration the recommendations below.

After the exercise is completed, invite participants to share their responses in the plenary and open the discussion. If they do not volunteer, invite 3-4 participants to share their responses.

M1/S3/A2/H1

Clinical Enquiry[4]

Please code these questions as red, yellow, or green.

🔴 Red means, “This is a terrible question. I would not use this with my patients.”

🟡 Yellow means, “Some parts of the question are OK and some of it needs changing.” Please suggest how you would change this question.

🟢 Green means, “This question is good, and I would use it with my patients.”

	🟢	🟡	🔴
The computer is asking me to ask you about domestic abuse. Is this happening to you?			
We know that 1 in 4 women experience domestic abuse in their lifetime. Does your husband or a family member hit, or kick you?			
How are things at home with your husband/partner/family? Has someone hurt you?			
We know that domestic abuse can be a problem for some people. Is this a problem for you?			
Sometimes people with depression/low self-esteem have experienced major life events that cause this and can explain why they feel so low. Living in an abusive relationship can cause this. Might that be happening to you?			
I’m sure this isn’t a problem for you...but I have to ask if you are experiencing domestic violence?			
We know women can present with these symptoms when they are being hurt by their husband. Is this happening to you?			

[4] Source: Blank K, Rosslhumer, M, “IMPLEMENT Training Manual on gender-based violence for health professionals”. (2015), p. 52

M1/S3/A3/Presentation

Signs and symptoms of SGBV patients

20 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S3/A4/Presentation

Challenges in addressing SGBV, including mandatory reporting

10 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M1/S3/A5/Plenary work

Mandatory reporting

15 min.

Explain participants that this is a plenary exercise.

Invite participants (2-3 volunteers) to discuss cases where mandatory reporting was required and think about how women-centered approach can improve their interaction with victims/survivors next time they will have to perform mandatory reporting.

Use the following questions to open discussion:

- Taking into consideration your work experience, can you identify some barriers you have encountered in performing mandatory reporting?
- Taking into consideration your work experience, what can you do to improve the rates of disclosure and reporting in your hospital/clinic?
- What type of support you consider health care professionals need to improve the rates of disclosure and reporting of SGBV?

This discussion is built to encourage participants to provide examples from their hospitals and share them with the group.

M1/S3/A6/Group work

Haddon Matrix

30 min.

Haddon Matrix is the most widely used framework in injury prevention to identify time phases of an event and influencing factors for each level. Primarily the Haddon Matrix was used to identify and map the causes and factors of road traffic crashes taking into consideration time: pre-event , before an event with potential for injury to happen (before the crash), during an event that can cause injury (during the crash), and after the event occurs (after the crash); and four different influencing factors: host (the person at risk for injury), the agent (the vehicle or vector – which can be another person) that impacts the host and lead to the production of injuries and environment – both social and physical – in which the injury event is happening. It is a widely used tool to support the planning and identifications of injury interventions and prevention strategies, taking into consideration the phases in time of the event. For our training we will use the Haddon Matrix to identify the factors contributing to the increased cases of SGBV victims/survivors and start thinking about prevention strategies where health care professionals can have an important role.

Print enough copies of the Haddon Matrix before the training workshop begins (M1/S3/A6/H1).

Divide the participants into groups of 3-4 people.

Explain to participants what Haddon Matrix is and what is their task.

The goal of the exercise is to fill in the 12 empty boxes where the two elements intersect with a risk factor or potential intervention strategy. There are multiple points one could intervene in preventing (pre-event) or reducing (event or post) injuries from an injury event. Encourage participants to have in mind interventions/strategies that address multiple levels, more than one “E,” (Education, Engineering, and Enforcement) and/or different boxes of the Haddon Matrix are most effective for increasing identification and referral of SGBV victims/survivors.

Allow time to participants to fill in the Haddon Matrix.

Once the matrix is completed, invite participants to a general discussion using the following questions [you don’t need to use all of them, you can use other questions that might have arisen during the work in groups]:

- Which of these factors are more likely to change?
- Will changes of these factors make a difference? If so, which ones?
- Where do you see your role in changing the identified factors? Where do you think you can make the most contribution in the identification and reporting process?

IMPORTANT!
There are no right or wrong answers. Don’t get stuck in which cell a factor belongs to. The different rows and columns help participants better understand where factors best fit but keep an opened mind as this exercise helps participants think broadly and identify some strategies to increase the level of involvement of health care professionals in the identification and referral of SGBV.

M1/S3/A6/H1

Haddon Matrix Blank Worksheet

	Host	Agent	Physical environment	Social environment (culture, attitudes)
Pre-event				
Event				
Post-event				

Module 2.
Essential health services addressing SGBV

Session 2.1: Essential health services

Objectives

By the end of this training session, participants will be familiarized with the essential steps for first line support and will have increased knowledge, attitudes and skills related to examination and care for SGBV patients.

Content covered

- First line support
- Care of injuries and urgent medical treatment
- Sexual assault examination and care
- Mental health assessment and care

Learning activities, methods, and time

Activities	Method	Time (min)
Current care for an SGBV case9	Plenary work	15
First line support	Presentation	15
Care of injuries and urgent medical treatment	Presentation	30
Sexual assault examination and care	Presentation	30
Mental health assessment and care	Presentation	30
	Total time	**120**

Learning outcomes

At the end of the session participants with be able to:

- List the essential health services
- Know the five steps of first-line support
- Explain how to conduct injury examination and following care
- Explain how to conduct sexual assault examination and following care
- Discuss communication strategies used with SGBV victims/survivors when offering treatment and care for sexual assault
- List the impact of SGBV on the mental health of victims/survivors
- Demonstrate the skills in providing first-line support
- Discuss communication strategies used with SGBV victims/survivors when communicating mental health
- Accept responsibility of the role of healthcare personnel in the treatment and care of SGBV victims/survivors

M2/S1/A1/Exercise

Current care for an SGBV case

15 min.

This is a group exercise to start the session and discussions [5]

In plenary, discuss the cases of the patients below.

Case 1

"You suffer with depression, and they just take it as a medical thing and not really like there's something behind it." (IRIS client – comment on clinician).

Case 2

"I had my shoulder broken by him…however my husband was with me so the GP gave me a piece of paper with a certain number where I can go and seek help and I was watching the reaction of my husband." (IRIS client – comment on clinician)

Guide the discussions starting from the following two questions:

- What are the key messages from patients about what they want?
- What do you think patients want and need?

Use the ideas to introduce the topic of "First Line Support".

[5] Adapted from: Blank K, Rosslhumer, M, "IMPLEMENT Training Manual on gender-based violence for health professionals". (2015), p. 48

M2/S1/A2/Presentation

First line support

15 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S1/A3/Presentation

Care of injuries and urgent medical treatment

30 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S1/A4/Presentation

Sexual assault examination and care

30 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S1/A5/Presentation

Mental health assessment and care

30 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

Session 2.2: Documenting SGBV

Objectives

By the end of this training session, participants will be familiarized with the correct steps for medico-legal documentation and recording and will demonstrate the ability to document and record injuries after a SGBV event.

Content covered

- Recording and classifying health consequences of SGBV,
- Collecting medico-legal evidence,
- Management of data (storage, analysis, sharing).

Learning activities, methods, and time

Activities	Method	Time (min)
Recording and classifying health consequences of SGBV	Presentation	30
Collecting medico-legal evidence	Presentation	15
Management of data (storage, analysis, sharing)	Presentation	15
Documentation form for cases of SGBV	Group work	30
	Total time	**90**

Learning outcomes

At the end of the session participants with be able to:

- Recognize and implement the correct steps of SGBV medico-legal documentation and recording
- Know the principles of data management
- Demonstrate the ability to document and record injuries after a SGBV event
- Understand the sensitivity of personal data recorded.

M2/S2/A1/Presentation

Recording and classifying health consequences of SGBV

30 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S2/A2/Presentation

Collecting medico-legal evidence

15 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S2/A3/Presentation

Management of data (storage, analysis, sharing)

15 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S2/A4/Group work

Documentation form for cases of SGBV

30 min.

Print enough copies of the documentation form before the training workshop begins.

Break the participants in pairs.

Each pair will receive a documentation form (M2/S2/A4/H1) and the following case study.

> After an evening of spent at her older sister's house, a 20-year-old woman was walking towards her parents' home. Only a few streets from her home, a man stopped her and asked for the time. She tried to evade him, but he turned violent, grabbing, and pushing her in a dark alley where he ripped off her clothes, grabbed her neck and hair and raped her while brutalizing different parts of her body. Afterwards, he stole her purse and ran away. The woman managed to arrive to the hospital approximately an hour later after the incident and you are the first medical person seeing the victim/survivor. What do you do?

Invite the participants to fill up the documentation form with necessary information, based on the learning drawn from the session's presentation (20 min).

Discuss in plenary on the participants' experience in working with the form, who easy or complicated was, if there were any items they did not understand.

M2/S2/A4/H1

Documentation form for cases of SGBV

Section 1: Information about healthcare facility	
Health facility: _____	Date: _____
Name of person who fills in the form: _____	Medical record number:_____
	☐ New case ☐ Recurrence
Type of referral:	☐ Spontaneous ☐ Ambulance ☐ Helicopter ☐ Police ☐ Other (specify): ____
Section 2: Information about the victim/survivor	
Name and surname:	
Phone number:	
Birthdate:	SSN:
Domicile:	☐ Rural ☐ Urban Address: _____
Nationality:	
Ethnicity:	
Marital status:	☐ Unmarried ☐ Consensual union ☐ Married ☐ Divorced ☐ Widow
Education level:	☐ Without education ☐ Primary school ☐ Secondary school ☐ Lyceum ☐ University ☐ Post-graduate education (master, doctoral)
Occupation:	☐ Unemployed ☐ Employed ☐ Freelancer ☐ Private company owner ☐ Agriculture ☐ Student ☐ Homemaker ☐ Retired
Employer/school:	_____ Monthly family income:
Number of children	_____ children, _____ under 10 years _____ between 10 and 18 years _____ over 18 years
Dependent persons/elderly	☐ Yes, ____ persons ☐ No
Psychiatric history	☐ No ☐ Yes, specify: _____
Criminal record	☐ No ☐ Yes, specify: _____
Section 3. Information about perpetrator	
Relationship with the victim/survivor:	☐ Husband ☐ Ex-husband ☐ Partner ☐ Child ☐ Parent ☐ Other (specify)
Name and surname:	Sex ☐ Female ☐ Male
Phone number:	
Birthdate:	SSN
Domicile:	☐ Rural ☐ Urban Address: _____
Nationality:	
Ethnicity:	
Marital status:	☐ Unmarried ☐ Consensual union ☐ Married ☐ Divorced ☐ Widow
Education level:	☐ Without education ☐ Primary school ☐ Secondary school ☐ Lyceum ☐ University ☐ Post-graduate education (master, doctoral)
Occupation:	☐ Unemployed ☐ Employed ☐ Freelancer ☐ Private company owner ☐ Agriculture ☐ Student ☐ Homemaker ☐ Retired
Employer/school:	Monthly family income:
History of SGVB	☐ No ☐ Yes
If yes, type of SGBV	☐ Physical ☐ Sexual ☐ Psychological (☐ Verbal ☐ Emotional) ☐ Neglect ☐ Economic ☐ Social
Psychiatric history	☐ No ☐ Yes, specify: _____
Criminal record	☐ No ☐ Yes, specify: _____
Substance consumption/abuse	☐ No ☐ Yes ☐ Don't know ☐ Alcohol occasionally ☐ Alcohol frequent ☐ Tobacco ☐ Tranquilizers ☐ Drugs ☐ Other (specify)

Section 4. Case management

Type of SGBV: ☐ Physical ☐ Sexual ☐ Psychological ☐ Neglect ☐ Economic ☐ Social

Location of SGBV incident: ☐ Domicile ☐ Public place ☐ Workplace ☐ Other (specify)

Tools used by perpetrator: ☐ Body parts ☐ Cutting objects ☐ Blunt objects ☐ Stinging objects ☐ Guns ☐ Poison/toxic substance

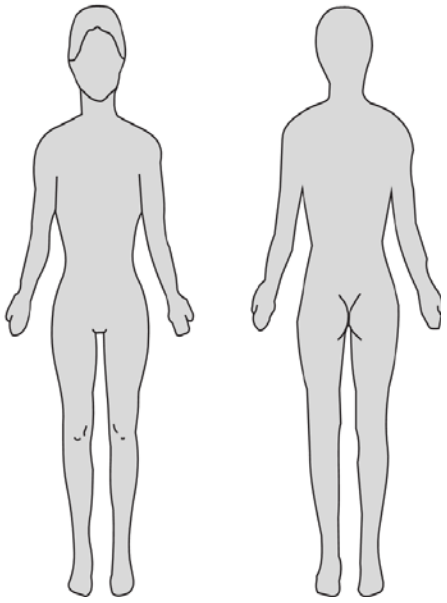
Institutions from which the victim/survivor requests assistance: ☐ Police ☐ Forensic Department ☐ Family doctor ☐ City Hall ☐ Child Rights Protection Departments ☐ NGOs ☐ Not sure/don't know

Intervention: ☐ Information ☐ Counselling ☐ Safety planning ☐ Referral ☐ Accompany

Institutions to which the case was referred: ☐ Police ☐ Forensic Department ☐ Family doctor ☐ City Hall ☐ Child Rights Protection Departments ☐ NGOs ☐ Other (specify)

INJURIES MAP

	Bruise	Scars	Cuts	Bleeding	Pain
Head					
Eyes					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulders					
Arms					
Hands					
Chest					
Back					
Abdomen					
Genitalia					
Thighs					
Calves					
Legs					



Vital functions:	BP	Respiratory rate	Temperature	O2 saturation	Glucose

Investigations: ☐ Lab ☐ Radiology ☐ Arms ☐ Legs ☐ Chest ☐ Head ☐ Spinal ☐ Pelvis ☐ Other (specify) ☐ CT cranium ☐ CT chest ☐ CT abdomen ☐ MRI

Procedures: ☐ O2 ☐ Vital functions monitoring ☐ Intubation ☐ Aspiration ☐ Suture ☐ Gastric lavage ☐ Thoracic drainage ☐ Naso-gastric drainage ☐ Bladder drainage ☐ Immobilisation (☐ Arms ☐ Legs ☐ Spinal)

Sexual assault examination and care ☐ Drugs to prevent STIs ☐ Drugs to prevent HIV ☐ Hepatitis B vaccination ☐ Emergency contraception pill ☐ IUDs ☐ Safe abortion

Diagnostic:

Therapeutic outcome: ☐ Transferred to another health facility ☐ Treated, home released ☐ Leaving ER without medical consent ☐ Death

Section 5. Medico-legal evidence (optional)

Informed consent obtained ☐ No ☐ Yes

Sample collected <72h from the incident ☐ No ☐ Yes, specimen label: _____

Photographs taken ☐ No ☐ Yes, specify label: _____

Session 2.3: Management of risk

Objectives

By the end of this training session, participants will be familiarized with the correct steps for risk-assessment and safety planning.

Content covered

- Understanding risk and carrying out a risk assessment
- Supporting the victim/survivor to develop a safety plan.

Learning activities, methods, and time

Activities	Method	Time (min)
Understanding risk and carrying out a risk assessment	Presentation	30
Supporting the victim/survivor to develop a safety plan	Presentation	30
Safety Planning	Role play	30
	Total time	**90**

Learning outcomes

At the end of the session participants with be able to:

- Understand the risk posed by SGBV and the role of risk assessment
- List the steps of a risk-assessment
- Know the minimum safety planning
- Demonstrate the ability to conduct a minimum risk assessment.

M2/S3/A1/Presentation

Understanding risk and carrying out a risk assessment

30 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S3/A2/Presentation

Supporting the victim/survivor to develop a safety plan

30 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S3/A3/Role play

Safety planning[6]

30 min.

The aim of the role play is to practice the safety planning in a case of GBV and communication with victims/survivors of SGBV, according to the principles discussed in training.

Introduce the role play. Inform the participants that the next exercise is a role play.

Before starting the role play, introduce the situation (Dilorom seeks medical help from a health center in her city) and encourage the participants for an open discussion.

Assign roles. The role play has three characters: Dilorom (a victim/survivor seeking help), a doctor/nurse working at the health center, and an observer.

Introduce to the participants the three characters and ask who wants to volunteer for the role play. The participants may have reservations about being involved in a role play or playing a character that they have been assigned. Respect the choices of the participants and use for the role play only the participants who offered themselves for this activity.

Prepare the role play. Handle the narrative to the participant playing Dilorom (M2/S3/A3/H1) and allow to read it for 1 minute.

- The doctor/nurse's task is to identify the risk factors and develop a minimal safety plan.
- The observer will follow the entire interaction between Dilorom and the doctor/nurse and will identify what was correctly done and what should be added or improved.

Act out the scenario. The three participants should use their imagination to put themselves inside the minds of the characters that they will represent. This involves trying to understand their perspectives, goals, motivations, and feelings when they enter the situation.

Maximum duration of the conversation between the doctor/nurse and the patient: 15 minutes.

Debrief the role play and provide feedback. It's important for all participants to discuss the role play activity once it's over. Invite each of the participants that played a character to share their experience so that the rest of participants can learn from the experience.

[6] Source: Blank K, Rosslhumer, M, "IMPLEMENT Training Manual on gender-based violence for health professionals". (2015), p. 52

Questions for the person playing the victim/survivor:

- How did you feel in your role?
- Was the behavior of the doctor/nurse useful?
- What could the doctor/nurse have done differently?

Questions for the person playing the health care professional:

- How did you feel in your role?
- What did you handle well?
- What was the most difficult for you?
- What could you have done differently?
- What do you need to do in your work practice to support a patient in safety planning?

Ask the observer to share his/her feedback and observations, then open the discussion to the group.

Invite all the participants to share their thoughts, what they have observed and learned.

M2/S3/A3/H1

Dilorom role

Dilorom seeks medical help from a health center in her city because of chronic stomach pain and sleeping problems. The doctor observes several bruises on her arms and neck. Dilorom reports that her husband repeatedly beats her and sometimes also the children. Several times, he forced her to have sexual intercourse. He also verbally abuses her and threatens to kill her if she leaves him. Dilorom wants to leave but she is afraid of what he would do if she does leave him. Together with her husband and children, she lives with her in-laws. From her husband's parents, she cannot expect any help – they regularly insult her and blame her for her husband's violent behaviour.

Dilorom asks the doctor what she could do for her safety.

Session 2.4: Providing health support to vulnerable group experiencing SGBV

Objectives

By the end of this training session, participants will be familiarized and have an increased understanding of particularities in interacting with persons with different disabilities victims/survivors of violence.

Content covered

- Guidelines for service providers and support staff working with women and young persons with various disabilities
- Healthcare to elderly experiencing SGBV.

Learning activities, methods, and time

Activities	Method	Time (min)
Own beliefs and assumptions relating to SGBV and vulnerable groups	Quiz	15
Guidelines for service providers and support staff working with women and young persons with various disabilities	Presentation	30
Healthcare to elderly experiencing SGBV	Presentation	15
Reflect change in knowledge and attitudes	Group work	30
	Total time	**90**

Learning outcomes

At the end of the session participants with be able to:

- Understand the particularities in interacting with persons with different disabilities victims/survivors of violence
- Explain the differences in offering support for vulnerable victims/survivors of SGBV
- Demonstrate openness to offer support for vulnerable victims/survivors of SGBV.

M2/S4/A1/Quiz

Own beliefs and assumptions relating to SGBV and vulnerable groups[7]

15 min.

Use the following statements and ask the participants reply if they consider them "true" or "false". After each statement and participants' feedback/opinions, give the response and open the discussion. This exercise is opening the presentation of the session.

Some disabilities may be hidden or difficult to see.

True – Some disabilities, such as mental and intellectual disabilities, are not visible, but people with these types of disabilities may be stigmatized in communities and experience severe discrimination.

Persons with disabilities are not vulnerable to domestic violence.

False – Persons with disabilities are vulnerable to all forms of GBV. They may have less power in relationships and weaker social networks, making them especially vulnerable to GBV

SGBV victims/survivors with disabilities should go to separate, more specialized services designed for persons with disabilities.

False – Services designed for GBV victims/survivors should be accessible to ALL victims/survivors, and their staff should have the right skills and capacities to respond to the needs of all GBV victims/survivors, including those with disabilities

Women with disabilities experience discrimination based on both gender and disability.

True – For women and girls with disabilities, their gender and disability make them especially vulnerable and at increased risk of violence. They may be isolated in their homes, discriminated against by the community, unable to access services or protect themselves from violence. Women with disabilities are also often expected by their families, husbands, and society to undertake the many duties and responsibilities, as well as access services, in the same ways as other women without the support or adaptations they need. They also experience extreme forms of discrimination when families, husbands and societies do not understand or seek to recognize their situation or their abilities. They may become alienated from their families and partners, unable to interact or socialize with friends or family, or be abandoned — which can in turn lead to greater stigma, rejection, and violence in the community

Girls with intellectual disabilities don't need knowledge and awareness about GBV.

False – Girls with intellectual disabilities are especially vulnerable to GBV, in part because they do not receive the same education or have the same peer support as other girls. They also have a right to know about issues and services available to them even though the information may need to be adapted to their cognitive abilities

There are things that I can do to prevent SGBV against women and girls with disabilities and support victims/survivors with disabilities

True – There are many things we can do to remove barriers and promote access and participation of persons with disabilities. These may be simple or sophisticated interventions that help to reduce the risks that women and girls with disabilities face.

[7] Statements adapted from WRC. Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings (2015). p 25-26.

M2/S4/A2/Presentation

Guidelines for service providers and support staff working with women and young persons with various disabilities

30 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S4/A3/Presentation

Healthcare to elderly experiencing SGBV

15 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S4/A4/Group work

Reflect change in knowledge and attitudes exercise[8]

30 min.

Ask participants to divide into three groups.

Each group will have to discuss on the following assigned topics:

- **Group 1:** How does SGBV experienced by women and girls look like? How are you approaching it as a medical professional?
- **Group 2:** What does SGBV experienced by women with disabilities look like? How are you approaching it as a medical professional?
- **Group 3:** What does SGBV experienced by elder women look like? How are you approaching it as a medical professional?

Display on the screen or write on the flipchart the three tasks, to be visible to the three groups all over the exercise.

Each group will write words or ideas on cards or sticky notes that reflect the SGBV experienced by each of these groups and possible approaches to them from a medical standpoint.

Ask each group to present these ideas in plenary and invite all participants to discuss the common features and differences between these three vulnerable groups that might experience SGBV.

[8] Exercise adapted from WRC. Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings (2015). p 36-37.

Session 2.5: Communication skills for health care providers

Objectives

By the end of this training session, participants will improve their communication skills with SGBV victims/survivors.

Content covered

Adapting principles of Motivational Interviewing to facilitate patient communication.

Learning activities, methods, and time

Activities	Method	Time (min)
Adapting principles of motivational interviewing to facilitate patient communication	Presentation	40
Using motivational interviewing when communicating with the patients – case study	Group work	50
	Total time	**90**

Learning outcomes

At the end of the session participants with be able to:

- Discuss the active listening as key communication skill
- Demonstrate communication skills with victims/survivors of SGBV.

M2/S5/A1/Presentation

Adapting principles of motivational interviewing to facilitate patient communication

40 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M2/S5/A2/Group work

Using motivational interviewing when communicating with the patients

50 min.

Print enough copies of the material “Using motivational interviewing when communicating with the patients” (M2/S5/A2/H1) before the training workshop begins.

Divide the participants in pairs. Make sure that the pairs members are not the same as for the previous exercises.

The two participants in each pair will by assigned to plays the role of Aimee and the health visitor.

Ask the pairs to play by reading the material “Using motivational interviewing when communicating with the patients” (M2/S5/A2/H1) which is a dialogue between Aimee and her health provider (midwife/gynecologist/health visitor) (30 min).

The participants playing the role of Aimee should highlight the points of good practice demonstrated by the health providers, considering the language used, the way the health providers asked questions and how they managed and guided the discussion (20 min).

M2/S5/A2/H1

Using motivational interviewing when communicating with patients [9]

Health provider: Hello Aimee. Thanks for coming to the consultation. How are you feeling today?

Aimee: Hello! I'm feeling ok.

Health provider: That's good to hear. It seems that things are going well for you.

Aimee: Yes, thank you!

Health provider: It is very important that all patients accessing our services have the opportunity to talk about their experience of domestic violence because domestic violence is very common and it can get worse during pregnancy. So, would it be ok for you if we focus the conversation a little on domestic violence? We respect the confidentiality of what you tell us at all times and the only exception to that is if you choose to tell us that a child is being hurt or anyone's life is at risk.

Aimee: Yes, it's ok.

Health provider: Would it be ok for you to talk about your feelings of fear or about experiencing violence from anyone close to you?

Aimee: Well, I think Mark has been under a lot of strain at work recently but it is getting to be a bit much.

Health provider: It sounds as though you're feeling under strain too. What has his behaviour been like at home?

Aimee: Well, I thought we'd sorted it out. After Sam was born Mark started to get aggressive and he hit me a few times. It hasn't happened for nearly a year and I honestly thought he wasn't going to get like that again. But last week, he got furious because I'd been out with a friend all day and I hadn't got the food ready. He punched my stomach. I was terrified.

Health provider: You went through such a difficult situation last week. There was no way you could predict that, as nothing had happened for over a year. He took you by surprise. That is so frightening. Would you tell me what happened after that?

Aimee: He left and I started to wonder if I should go to stay with my mum. I was going over later to pick up Samantha anyway and I was afraid of what he might do next. But I didn't stay and when he got back he was very apologetic. He's been a lot better since then as if he's got something out of his system. Nothing bad seemed to happen so I left it.

Health provider: Although you don't approve of his behaviour as you know it's dangerous for you and for Samantha, you decided not to leave him. The fact that he was so apologetic made you find excuses for him and leave things as they are. And what are you feeling about it now?

Aimee: I'm just so confused. I kept pretending it wasn't happening but now I'm wondering what I'm doing wrong to provoke him.

Health provider: You're wondering if it's your fault but you're really not to blame. Nobody deserves to be hit or to have to live in fear.

Aimee: But I really love him and we used to get on so well before. I wish it would be like that still.

[9] Source: Johnson Medina, Dulf Diana, Sidor Alexandra. RESPONSE Training Manual for Reporting of Gender-Based Violence in Women's Health Services. Project RESPONSE, 2017.p.53-56.

Health provider: You're feeling a strong conflict inside. On the one hand you feel frightened and have wanted to leave at times, and on the other, you want to stay and for things to go back to how they were before.

Aimee: I wonder if things can ever be the same as before.

Health provider: You would do anything to make things as before, but you know that accepting his behaviour is not an option in the long term. What would you like to do about this situation?

Aimee: (Silence)

Health provider: Would you like me to give you some information about what help is available to you?

Aimee: Yes, it might be good to know. I guess so.

Health provider: Well, sometimes it can help to talk about how you're feeling and we have a counsellor you can see who can spend more time with you. You can work with the counsellor to solve confusing feelings and the counsellor can support you, whatever you decide to do. Then if your partner gets violent again there are several options. You can always call the police to help you in that situation because you know it's illegal for him to hit you.

Aimee: I don't think I could ever do that to him.

Health provider: It is a difficult decision to do that and hopefully you will never have to do it. If you are still interested in other support services, there is also the local specialist domestic abuse service if you want to speak to someone on the phone at any time, or if you ever need to leave in a hurry and you need somewhere to stay. You can contact them even if you aren't thinking of leaving straight away, just to be in touch for them to support you. There are some numbers here on this leaflet. Would it be safe for you to take a leaflet or would you rather write the numbers down?

Aimee: I'll write them down in code as I don't want Mark to know I've spoken about this.

Health provider: You feel more comfortable, at this point, to write them down in code. Sometimes it's good to have things ready too, in case you ever need to leave in a hurry, things like important documents, medicines, toys for Samantha etc.

Aimee: Yes, that sounds like a good idea.

Health provider: Also Aimee, would it be ok for you if we talk a little about Samantha?

Aimee: Yes, it's ok.

Health provider: Do you think she may be at risk of harm from Mark? Was she ever present when he hit you?

Aimee: No luckily, she wasn't around and didn't see what happened. I'm pretty sure that he wouldn't harm her. You know, I think I would like to see the counsellor as I can't believe this is happening to me.

Health provider: We know that even when a child isn't in the same room as where the violence occurs that they may well be affected so I will ask you about this again when we next meet. Would you like to use the phone to make an appointment? Aimee, would it be ok if I record what you've told me in your case notes?

Aimee: I don't want anyone else to know about it. I feel too ashamed. I don't want you to record it.

Health provider: You don't want people to know now but it could be important for you in the future to have a record especially if you ever decide to take legal action or need to apply for housing. And your notes remain confidential within this department.

Aimee: Oh I see, well I suppose if you're sure that no-one will find out and if it could help me, then maybe you should.

Health provider: This happens to a lot of women and it's not their fault. The important thing is that you get the support you need. Whenever you need, call me or come and see me at any time.

Module 3.
Multi-sectoral coordinated response to SGBV

Session 3.1: Referral system

Objectives

By the end of this training session, participants will be familiar and have an increased understanding of pathways for referral and reporting for SGBV victims/survivors.

Content covered

- Referral process and pathway
- Referral network
- Services provided by other key sectors.

Learning activities, methods, and time

Activities	Method	Time (min)
Referral process and pathway	Presentation	20
Referral network	Presentation	20
Services provided by other key sectors	Presentation	20
When is it safe to ask patients about GBV?	Individual exercise	30
	Total time	**90**

Learning outcomes

At the end of the session participants with be able to:

- Know the process of referral
- Identify pathways for reporting and referral taking into consideration best practices and national recommendations and laws
- Understand the essential services provided by other key sectors (social, police)
- Demonstrate referral skills for victims/survivors of SGBV
- Illustrate the link of healthcare facilities with the other services provided to SGBV victims/survivors.

Additional reading

- Johnson Medina, Dulf Diana, Sidor Alexandra. *RESPONSE Training Manual for Reporting of Gender-Based Violence in Women's Health Services*; Project RESPONSE, 2017. Fundamental reference tool for health care professionals pages 62-65. Available online: http://gbv-response.eu/wp-content/uploads/2017/03/00_manual_response-english_web.pdf

M3/S1/A1/Presentation

Referral process and pathway

20 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M3/S1/A2/Presentation

Referral network

20 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M3/S1/A3/Presentation

Services provided by other key sectors

20 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M3/S1/A4/Individual work

When is it safe to ask patients about GBV? [10]

30 min.

Print enough copies of the case study (M3/S1/A4/H1) and scheme (M3/S1/A4/H2) before the training workshop begins.

Inform participants that this is an individual exercise.

Offer each participant one copy of the case study and one copy of the scheme.

Following the scheme, each participant has to assess if it safe to ask about violence and to formulate questions about inquiring for GBV and offer a referral (10-15 min).

In the plenary, discuss their responses and best practices, based on what they identified (15-20 min).

[10] Johnson Medina, Dulf Diana, Sidor Alexandra. RESPONSE Training Manual for Reporting of Gender-Based Violence in Women's Health Services. Project RESPONSE, 2017.p.62-63.

M3/S1/A4/H1

When is it safe to ask patients about GBV?

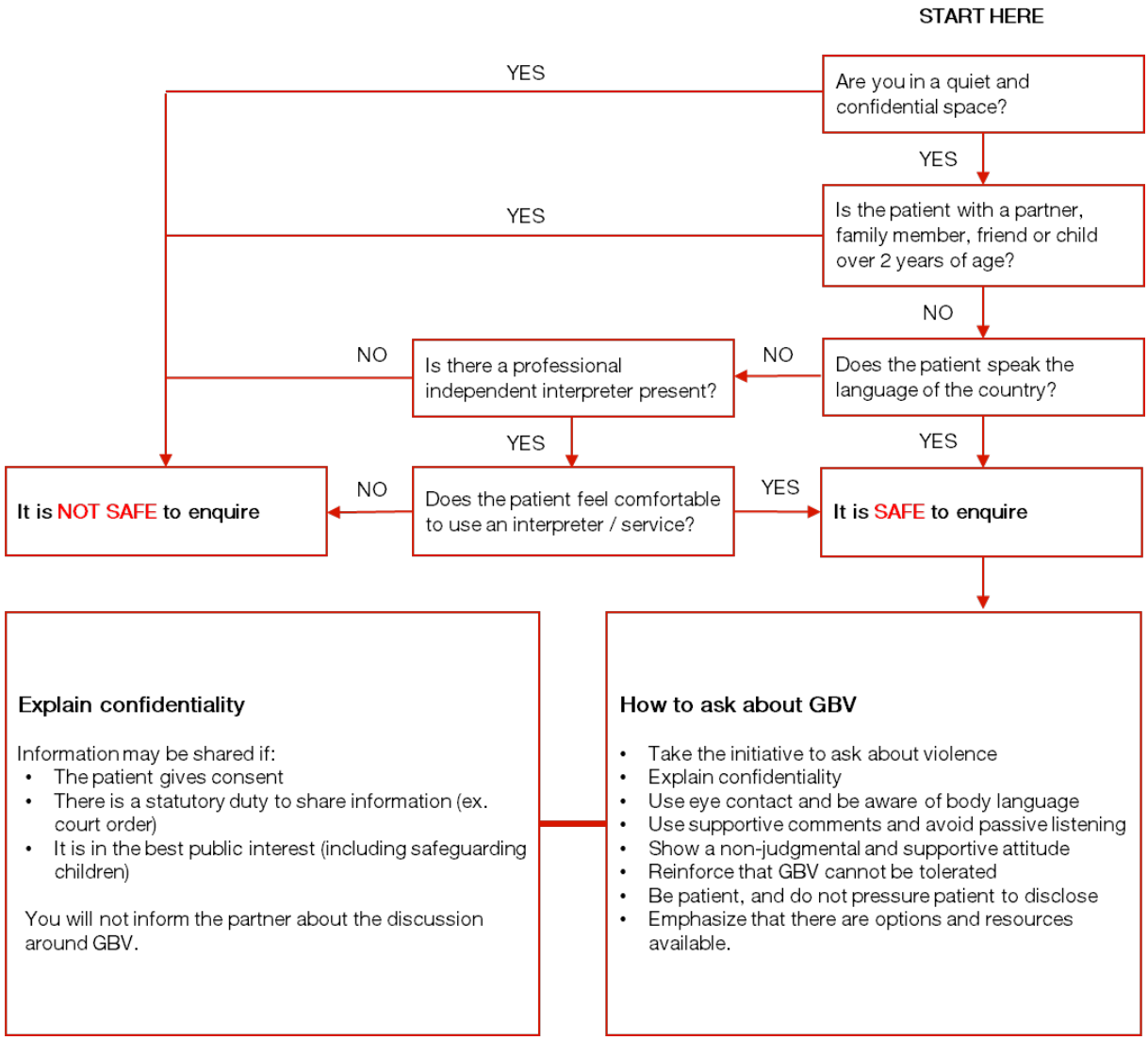
Alishia is a 35-year-old Asian woman. She has been married to Karim for 12 years. They have three children, aged ten, six, and two. Alisha was a secretary but has not worked since her first child was born. Karim is a computer programmer. Alisha has experienced abuse from Karim throughout their marriage. He is a domineering man and likes to oversee family matters. As the sole breadwinner, he has always controlled the family finances, restricting the amount of money available to Alisha for household shopping and items for the children. Alisha has always thought she would like to return to work, but she now lacks confidence in her skills. This has been aggravated by Karim's negative attitude towards her, saying that no one would employ her, she is useless, and that it is anyway her job to stay at home and look after the house and the children. Karim can be very moody, and unpredictable in his behavior towards Alisha. She constantly feels anxious about pleasing him and feels that she is 'walking on eggshells' all the time. Karim is always criticizing Alisha and does not like her to go out. other than to take the children to and from school. Karim is very sexually demanding. Alisha comes alone to the hospital for a regular check-up, and you notice bruises on her body that might indicate violence.

Your task:

- Assess if it safe to ask about violence
- Formulate questions about inquiring for GBV
- Offer a referral.

M3/S1/A4/H2

When is safe to ask patients about SGBV?



Session 3.2. Multi-sectoral response to SGBV

Objectives

By the end of this training session, participants will be able to:

- Identify all six functions of the multi-sectorial response to SGBV.
- Define how a case management is done
- Define who are the stakeholders involved in a case management process.

Content covered

- Functions/guiding principles of multi-sectorial response to SGBV
- Multi-sectorial coordination
- Developing cooperation.

Learning activities, methods, and time

Activities	Method	Time (min)
Concept Map	Group work	30
Principles of multi-sectorial response to SGBV	Presentation	10
Stakeholders' assessment	Discussion and exercise	20
Multi-sectorial coordination	Presentation	20
Developing cooperation	Presentation	20
	Total time	**100**

Learning outcomes

At the end of the training session the participants will have a better:

- Understanding of the six functions of multi-sectoral response to SGBV.
- Understanding of the process of coordinated case management.
- Identify pathways for reporting and referral taking into consideration best practices and national recommendations and laws.

Additional reading

UNFPA EECA RO, EEIRH (2015). Towards a Multi-sectoral Response to Gender-Based Violence. Mapping the Current Situation in the Eastern Europe and Central Asia Region. Available online: https://femroadmap.eu/UNFPA_EECA_RO_Survey_report_on_Multi-sectoral_Response_to_GBV.pdf
Johnson Medina, Dulf Diana, Sidor Alexandra. *RESPONSE Training Manual for Reporting of Gender-Based Violence in Women's Health Services*; Project RESPONSE, 2017. RESPONSE Project Framework pages 37-39. Available online: http://gbv-response.eu/wp-content/uploads/2017/03/00_manual_response-english_web.pdf.

M3/S2/A1/Group work

Concept Map

20 min.

A concept map is a visual organizer which will help training participants to better understand a new concept, in our case, the concept map will be used to understand the membership and roles of a multi-sectorial group with the goal for prevention and control of sexual and gender-based violence.

The purpose of the exercise is to engage participants to draw and acknowledge their own understanding of what a multi-sectorial response group stands for. The exercise can be performed before or after the sessions, depending on your perspective as trainer. Below are offered two scenarios, depending on the chosen moment by you.

If used before the lecture

Split training participants in small groups of 3-5 members.

Each group will receive a copy of the example of Concept map (M3/S2/A1/H1) and a blank sheet of paper in which you invite participants to draft their vision about who are the members of a multi-sectorial response group and how they are connected.

Provide participants with the following rules:

- In the middle of your paper, include the subject of the session (multi-sectorial response).
- Draw branches that point away from the center. Each branch symbolizes one stakeholder that should be a member of the multi-sectorial response group.
- From each branch more ideas can branch off. There is no limit to the number of hierarchical levels in a map, here invite participants to consider the different primary stakeholders and secondary stakeholders.

Once the concept maps are drawn, ask each group to assign a speaker and present their map. Make referral to the maps during your lecture; and if time allows, ask participants to adjust their map at the end of the lecture, based on the new learnings.

If used after the lecture

Split training participants in groups of 3-5 members.

Each group will receive a blank sheet of paper in which you invite participants to display the information they have just heard, visually.

Provide participants with the following rules:

- In the middle of your paper, include the subject of the session (multi-sectorial response).
- Draw branches that point away from the center. Each branch symbolizes one thought or idea related to the subject, which is multi-sectorial response. Use meaningful keywords to write these ideas onto the branches. You could focus on the structure of a multi-sectorial response, or the membership.
- From each branch more ideas can branch off. There is no limit to the number of hierarchical levels in a map.

Display the task on screen or flipchart all over the duration of the exercise, to be visible to all groups.

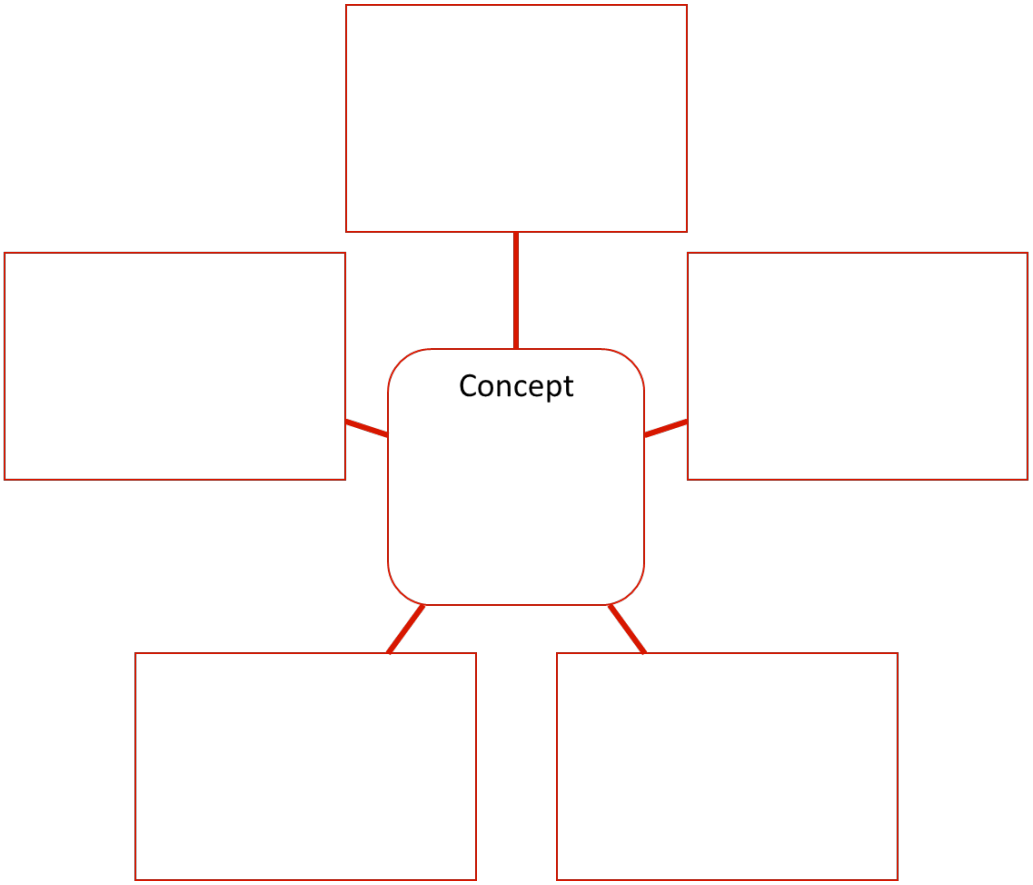
Once the concept maps are drawn, ask each group to assign a speaker and present their map.

Invite each group to present their concept map and invite the rest of participants to offer their thoughts and feedback.

Conclude the exercise by highlighting the common points between the concept maps, adding what is missing.

M3/S2/A1/H1

Concept map



M3/S2/A2/Presentation

Principles of multi-sectorial response to SGBV

10 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M3/S2/A3/Group work

Stakeholders' assessment

20 min.

The purpose of the exercise is to open a discussion regarding the need to represent all affected parties in a multi-sectorial response to SGBV group, even if their engagement might be lower.

Divide participants as they were divided for the Concept Map exercise.

Use the same teams as in the Concept Map Exercise.

Each group will receive a copy of the example of Stakeholders table (M3/S2/A3/H1)

Invite participants to group the identified members of the multi-sectorial group in Concept Map exercise into primary, secondary, and key stakeholders.

Stakeholders are people/institutions interested in SGBV response or directly affected by SGBV response. For a multi-sectorial response to SGBV to work, it is important to identify the stakeholders taking into consideration all affected parties.

Typically, stakeholders can be organized into three categories:

Primary stakeholders:

- Those served or affected by SGBV response (beneficiaries or targets)

Secondary stakeholders:

- Those directly involved with or responsible for beneficiaries of the SGBV response
- Those whose jobs or lives might be affected by the process or results of the SGBV response

Key stakeholders:

- Government officials and policy makers
- Those who can influence others
- Those with an interest in the outcome of an effort

Complete the stakeholders table in groups (10 min).

Once the stakeholders were identified and divided into groups, invite participants to a plenary discussion to identify the stakeholder with the highest interest for multi-sectorial response to SGBV and the stakeholder with the lowest interest for the multi-sectorial response of SGBV. Encourage participants to provide with arguments for their decision (10 min).

M3/S2/A3/H1

Stakeholders' assessment

Primary stakeholders	Secondary stakeholders	Key stakeholders

M3/S2/A4/Presentation

Multi-sectorial coordination

20 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

M3/S2/A5/Presentation

Developing cooperation

20 min.

Distribute to the trainees the handout of the presentation.

Give the presentation using the attached PowerPoint file and the speaker notes.

Closure

Objectives

Measure changes immediate after the training, receive feedback from participants and discuss possible questions from their side.

Methods and time

Activity	Method	Time (min)
Post-test	Plenary	15
Training evaluation and feedback	Plenary	15
Certificate award and closure of the training	Plenary	15
	Total time	**45**

END/A1

Post-test

15 min.

Print enough copies of the post-test before the last day of the training workshop begins.

Remind the participants that a post-test will be applied to understand their level of knowledge gained during the training workshop, compared to the level assessed before starting the training.

Remind the participants that there is no need to put their names on the test sheet as this exercise is not an individual but group knowledge evaluation. If it was decided to mark the pre-test sheets, ask the participants to use the same sign to mark the post-test as well. In this way, their confidentiality will be protected.

Handle each participant one copy the post-test (END/A1/H1).

Ask the participants to take 10 minutes to write down their answers to the questions.

Collect the post-tests and make sure all the tests were marked with a sing (if decided so).

Answer to all questions that might arise at this point.

END/A1/H1

Post-test

It is important to collect feedback and comments from participants of this training. By telling us what you think, we can make sure that the training we offer is suited to your needs and requirements. The information you give is confidential and you do not have to put your name on the form.

1. What is your job title? Please circle.

- Doctor
- Nurse
- Midwife
- Social Worker
- Psychologist
- Other, please specify_____

2. Have you had previous training on gender-based violence (physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life)?

- No
- I don't know
- Yes. Estimated total number of hours ____

3. How prepared you feel to….

Mark the number which best describes how prepared you feel

	1 Not prepared	2 Slightly	3 Moderately	4 Fairly well	5 Well prepared
Ask questions to promote disclosure of sexual and gender-based violence with your patients					
Ask questions to promote disclosure of sexual and gender-based violence with your patients					
Appropriately respond to disclosures about sexual and gender-based violence in your patients					
Identify signs and symptoms associated with sexual and gender-based violence based on patient history and physical examination					
Perform a risk assessment on a patient					
Document violence history and physical examination findings in patient's record					
Make appropriate referral for a patient					

4. What are the main forms of SGBV?

- Sexual
- Physical
- Psychological
- Social
- Denial of resources/access to services
- Educational

5. Which are the four Guiding Principles for engaging with victims/survivors of SGBV?

- Show respect
- Work together
- Maintain confidentiality
- Ensure the safety of the victim/survivor
- Refer all victims/survivors
- Non-discrimination

6. What services do victims/survivors of sexual violence and gender-based violence require? Choose only one answer.

- Health care
- Psychosocial support
- Security
- Legal aid
- All of the above
- None of the above

7. Persons with disabilities are not vulnerable to domestic violence:

- True
- False

8. SGBV victims/survivors with disabilities should go to separate, more specialized services designed for persons with disabilities.

- True
- False

9. What type of medical care should be offered for SGBV victims/survivors. Choose the correct answers

- Physical assessment
- Financial assessment
- Sexual assault examination
- Living conditions assessment
- Mental health assessment

10. How many new diagnoses (picked up an acute case, uncovered ongoing abuse, or had a female patient disclose a past history) of gender-based violence would you estimate you have made in the last 6 months?

Number_____

11. Which of the following actions have you taken when you identified gender-based violence in a patient in the last 6 months? (Mark all that apply)

	Always	Mostly	Sometime	Almost never	Never
Referral to a social worker					
Referral to violence prevention services					
Referral to a shelter					
Referral to the police					
Referral to the court					

12. Any comments to share:

_____
_____
_____
_____
_____
_____
_____
_____

Thank you for completing this form!

END/A1/T1

Post-test correct answers [11]

It is important to collect feedback and comments from participants of this training. By telling us what you think, we can make sure that the training we offer is suited to your needs and requirements. The information you give is confidential and you do not have to put your name on the form.

1. What is your job title? Please circle.

- Doctor
- Nurse
- Midwife
- Social Worker
- Psychologist
- Other, please specify_____

2. Have you had previous training on gender-based violence (physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life)?

- No
- Don't know
- Yes. Estimated total number of hours ____

3. How prepared you feel to….

Mark the number which best describes how prepared you feel

	1 Not prepared	2 Slightly	3 Moderately	4 Fairly well	5 Well prepared
Ask questions to promote disclosure of sexual and gender-based violence with your patients					
Ask questions to promote disclosure of sexual and gender-based violence with your patients					
Appropriately respond to disclosures about sexual and gender-based violence in your patients					
Identify signs and symptoms associated with sexual and gender-based violence based on patient history and physical examination					
Perform a risk assessment on a patient					
Document violence history and physical examination findings in patient's record					
Make appropriate referral for a patient					

[11] Source: Johnson Medina, Dulf Diana, Sidor Alexandra. RESPONSE Training Manual for Reporting of Gender-Based Violence in Women's Health Services. Project RESPONSE, 2017.p.44-45. Available here.

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5. Which are the four Guiding Principles for engaging with victims/survivors of SGBV?

- Show respect
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- Refer all victims/survivors
- Non-discrimination

6. What services do victims/survivors of sexual violence and gender-based violence require? Choose only one answer.

- Health care
- Psychosocial support
- Security
- Legal aid
- All of the above
- None of the above

7. Persons with disabilities are not vulnerable to domestic violence:

- True
- False

False - Persons with disabilities are vulnerable to all forms of GBV. They may have less power in relationships, as well as weaker social networks, making them especially vulnerable to GBV. Women and girls with disabilities in particular face structural and systematic gender inequalities, reinforcing abuse of power between men and women as social groups.

8. SGBV victims/survivors with disabilities should go to separate, more specialized services designed for persons with disabilities.

- True
- False

False – Services designed for GBV victims/survivors should be accessible to ALL victims/survivors. These services and their staff should have the right skills and capacities to respond to the unique needs of GBV victims/survivors, including those with disabilities.

9. What type of medical care should be offered for SGBV victims/survivors. Choose the correct answers

- Physical assessment
- Financial assessment
- Sexual assault examination
- Living conditions assessment
- Mental health assessment

10. How many new diagnoses (picked up an acute case, uncovered ongoing abuse, or had a female patient disclose a past history) of gender-based violence would you estimate you have made in the last 6 months?

Number_____

11. Which of the following actions have you taken when you identified gender-based violence in a patient in the last 6 months? (Mark all that apply)

	Always	Mostly	Sometime	Almost never	Never
Referral to a social worker					
Referral to violence prevention services					
Referral to a shelter					
Referral to the police					
Referral to the court					

12. Any comments to share:

_____
_____
_____
_____
_____
_____
_____
_____

Thank you for completing this form!

END/A2

Training evaluation and feedback

15 min.

Explain the participants the importance of the training evaluation and feedback.

Remind the participants that the training evaluation and feedback is anonymous, they can add their name only if they wish.

Handle each participant one copy the Training evaluation form (END/A2/H1).

Allow time to fill in the evaluation form (7-10 min).

Collect the evaluation form.

Give the floor to participants who want to offer their reflections on the entire training workshop.

END/A2/H1

Training evaluation form

1. How do you evaluate the training overall, on a scale of 1 to 10? _____

(1 = not at all satisfied 10 = very satisfied)

2. Please assess the following aspects of the training

	Yes, very much	Somewhat yes	No, rather not	Not at all
The training was well structured.				
There was appropriate time allocated to each module.				
Time for discussion was sufficient				
The handouts and materials were useful.				
The training was relevant.				
The training will benefit my work.				
I would recommend the training to others.				

3. How do you assess the performance of the trainers?

	Yes, very much	Somewhat yes	No, rather not	Not at all
I found the trainers to be knowledgeable.				
I found the trainers ensured good interaction and exchange with and among participants.				
I found the trainers had good presentation skills.				
I would recommend the trainers for similar trainings.				

4. How do you assess the overall organization/logistics of the training?

	Excellent	Good	Not so good	Poor
Training facilities				
Coffee breaks, lunches				
Location of the training				

Any comments or suggestions for improving the training?

_____
_____
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_____
_____

Thank you very much for supporting this evaluation!

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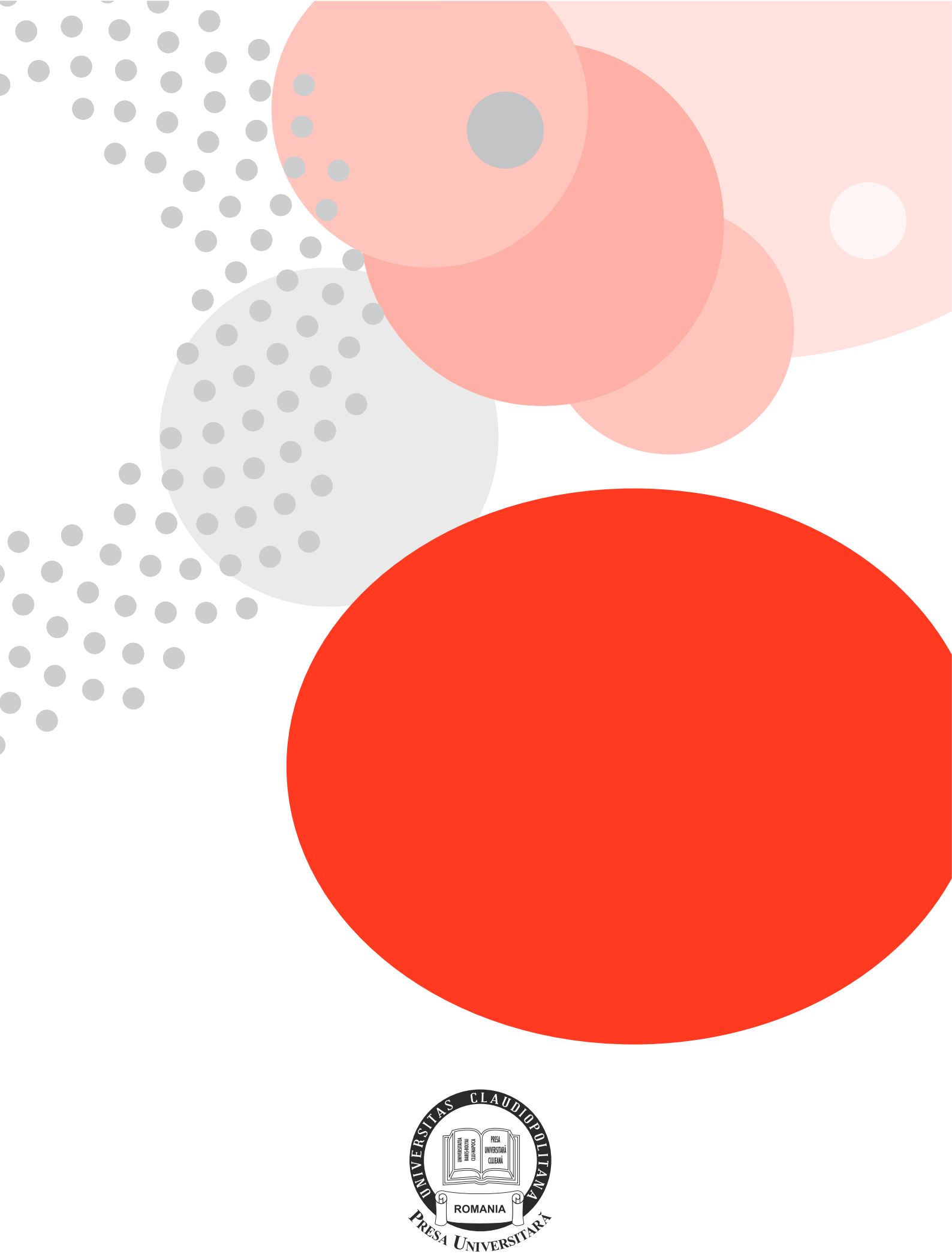

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