



MINISTRY OF HEALTH

Management of Intimate Partner Violence in Health Care Settings: A Training Manual for Health Care Providers



Division of Reproductive and Maternal Health

June 2021

REPUBLIC OF KENYA



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FOREWORD

Intimate partner violence (IPV) is any behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. IPV can have devastating and life-long effects on cognitive, psychological, physical and reproductive health, social wellbeing and violates human rights of the survivor.

The 2013 WHO 'Prevalence and health effects of intimate partner violence and non-partner sexual violence' study estimated that IPV is widespread in all countries studied. The findings showed that almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner and as many as 38% of all murders of women are committed by intimate partners.

In Kenya, about 2 in 5 (39%) women aged 15 to 49 years and about 1 in 10 (11%) men reported having experienced either sexual or physical IPV at some point in their lives (KDHS 2014). Notable progress has been made in Kenya in establishing legal and policy frameworks to address IPV under the umbrella of domestic violence. These include The Protection Against Domestic Violence Act 2015 and The National Policy for Prevention and Response to Gender Based Violence 2014.

Many individuals will have contact with health services several times during their lives. Amongst them are survivors of violence who may never directly report their experience of violence to health care providers as they seek out these health services. In health care settings where providers are well trained, caring and sensitive, most survivors respond positively to being asked about their exposure to violence. Health care providers are therefore in a unique position to identify survivors and offer them appropriate management and referrals.

In this regard, the World Health organization (WHO) developed clinical guidelines that aim to provide evidence-based guidance to healthcare providers on the identification and appropriate response to IPV and sexual violence. Based on this guidance, the Ministry of Health (MOH) has developed a comprehensive training manual to empower health care providers with the necessary knowledge and skills in order to ensure an appropriate health sector response to intimate partner violence.

This manual addresses emerging issues including Reproductive Coercion (RC) and aims to equip health care providers and Health Management Teams with knowledge, skills and positive attitudes necessary for the provision of integrated, comprehensive quality care to address the management of survivors in order to ensure appropriate health sector response to IPV. The manual recognizes that to effectively address IPV, an integrated, comprehensive, multi-sectoral approach is key. Additionally, the manual recognizes the need to have strong coordinated referral and linkage interventions involving actors and actions that address IPV prevention, response, recovery and mitigation.

Dr. Patrick Amoth, EBS

Ag. Director General for Health
Ministry of Health

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Dr. Stephen Kaliti

Head, Division of Reproductive and Maternal Health
MINISTRY OF HEALTH

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ECp	Emergency Contraceptive Pill
FHOK	Family Health Options Kenya
FP	Family Planning
GBV	Gender Based Violence
HITS	Hurts, Insults, Threatens and Screams
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
KDHS	Kenya Demographic and Health Survey
MCH	Maternal and Child Health
MOH	Ministry of Health
PEP	Post Exposure Prophylaxis
PRC	Post Rape Care
RC	Reproductive Coercion
SGBV	Sexual and Gender Based Violence
SOPs	Standard Operating Procedures
SSA	Sub-Saharan Africa
SV	Sexual Violence
SVRI	Sexual Violence Research Initiative
VAW	Violence against Women
VAC	Violence against Children
VAWG	Violence against Women and Girls
WHO	World Health Organization

DEFINITION OF KEY TERMS

Case-finding: Also known as clinical enquiry, is asking women presenting in health care settings about intimate partner violence (IPV) based on clinical conditions, the history and (if appropriate) examination of the patient.

First-line Support: Refers to the minimum level (primarily psychological) support and validation of their experience that should be received by all women who disclose violence to a healthcare provider. It shares many elements with what is being called 'psychological first aid' in the context of emergency situations involving traumatic experiences.

Forensic Examination: Medical examination conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion. 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.

Referral System: A comprehensive institutional framework that connects various entities with well-defined mandates, responsibilities, and powers into a network of cooperation, with the overall aim of ensuring the protection and assistance of survivors of IPV, to aid in their full recovery and empowerment, the prevention of IPV, and the prosecution of perpetrators.

Reproductive Coercion (RC): It is a form of domestic violence where behaviour concerning reproductive health is used to maintain power, control and domination within a relationship. (*American college of obstetricians and gynaecologists*).

Universal Screening: This is asking all clients who present at the health facility about violence. WHO does not recommend universal screening for violence of clients attending health care.

Intimate partner: This is the former or current husband or wife or boyfriend or girlfriend or lover

Intimate Partner Violence (IPV): Behaviour by either a current or former intimate partner that causes physical, sexual, psychological or economic harm, including acts of physical aggression, verbal abuse, sexual coercion, reproductive coercion, and other controlling behaviours.

Gender-based Violence (GBV): This is violence directed at an individual based on his or her biological sex, gender identity or expression, perceptions or adherence to socially defined norms of masculinity and femininity.

Violence against Women (VAW): All acts of gender-based violence that result in, or are likely to result in, 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.

Domestic Violence and Abuse (DVA): Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between intimate partners, family or household members. This can encompass, but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional. It also includes 'honor-based' violence, child marriage, female genital mutilation, forced wife inheritance, interference from in-laws, forced marriage, sexual violence within marriage, virginity testing and widow cleansing.

Community Health Volunteer: This is a member of the community nominated by their communities to improve the community's health and wellbeing and to facilitate the referrals of individuals as need be.

Community Health Assistant /Community Health Extension Worker: This is a formal employee of the County Government forming the link between the community and the local health facility.

Survivor-Centred Approach: A survivor centred approach puts the needs, wishes and opinions of the survivors at the centre of their care. Everything begins with the experiences of the survivor. These experiences determine the needs, which determine the services required.

Psychosocial Support: Is the process of facilitating resilience within individuals, families and communities through enabling them to bounce back from the impact of crises and helping them to deal with such events in the future. By respecting the independence, dignity and coping mechanisms of individuals and communities, psychosocial support promotes the restoration of social cohesion and infrastructure.

Informed Consent: Where the service provider has disclosed all relevant information including the purpose, benefits and potential risks for the proposed course of action to the individual, so that the individual can then arrive at a choice as to whether or not to proceed.

Assent: Agreement by a minor or any person not competent to give legally valid informed consent e.g., a child or cognitively impaired person, to participate in a procedure or treatment.

INTRODUCTION

Intimate partner violence (IPV) defines any physical, emotional, sexual, economic abuse or controlling behaviours by an intimate partner. IPV can have devastating and life-long effects on a woman's cognitive, psychological, physical and reproductive health. The 2005 World Health Organisation (WHO) Multi-country Study on Women's Health and Domestic Violence against Women found that IPV was widespread in all countries with up to 61% of women reporting having ever experienced physical violence by a partner and 59% having experienced sexual violence by a partner at some point in their lives.¹ The KDHS 2014 stated almost 2 in 5 women (39%) aged 15 to 49 years and about 1 in 10 men (11%) reported having experienced either sexual or physical IPV at some point in their lives.²

Kenya is among the countries that have ratified international conventions and declarations on Sexual and Gender Based Violence. The Bill of Rights in the Kenyan constitution, chapter 4 guarantees human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalized. In line with this, Kenya developed The National Policy for Prevention and Response to Gender Based Violence³, which seeks to coordinate the multi-sectoral response to domestic violence in Kenya. Additionally, guidelines on the management of sexual and gender based violence are in place⁴.

IPV is of growing public concern, and health providers are usually the first point of professional contact for survivors of IPV. Nonetheless, health providers are often hampered by inadequate skills and knowledge. Building the capacity of health professionals to detect and manage cases of IPV is paramount to ensure the best physical and emotional outcomes for the survivor. The WHO has developed clinical and policy guidelines⁵ that aim to provide evidence based guidance to healthcare providers on the appropriate response to IPV and sexual violence against women. Kenya has now developed curricula based on this guidance for health service providers in order to ensure an appropriate health sector response to intimate partner violence.

1. 2005 WHO Multi-Country Study on Women's Health and Domestic Violence against Women Strengthening Gender Based Violence and HIV Response in Sub-Saharan Africa (LVCT/WHO/SVRI)
2. Kenya Demographic and Health Survey 2014
3. The National Policy for Prevention and Response to Gender Based Violence 2014
4. Ministry of Health National Guidelines on Management of Sexual Violence in Kenya 2014
5. WHO clinical and policy guidelines: Responding to intimate partner violence and sexual violence against women 2013
6. WHO clinical and policy guidelines: Responding to intimate partner violence and sexual violence against women 2013

Course Description

This training is designed to build capacity of the health service provider to effectively and comprehensively manage cases of intimate partner violence. This course comprises 8 modules covering all aspects of the management of intimate partner violence from screening to reporting and referral. The content is guided by the WHO clinical and policy guidelines on intimate partner and sexual violence and adapted to the Kenyan context using local data and studies on intimate partner violence.

Course Duration

The course duration is 3 days.

Goal

The goal of this course is to develop the capacity of health service providers to identify and manage survivors of intimate partner violence in health care settings in Kenya.

Course Objectives

1. To understand intimate partner violence including its prevalence, forms of IPV, causes and risk factors, myths, misconceptions and attitudes about IPV, the cycle of violence and the impact of IPV in our settings
2. To understand the core ethical guiding principles of safety, respect, privacy and confidentiality, autonomy and non-discrimination in the IPV response
3. To equip providers with skills in screening and identification of IPV survivors
4. To equip providers with skills in clinical care for IPV survivors including first-line support, mental health assessment and psychological support and counselling
5. To understand IPV coordination, referrals and linkages at facility, community and other service delivery levels
6. To understand the special considerations of IPV in special situations and populations such as adolescents, men, women with disabilities and humanitarian situations
7. To understand the monitoring and evaluation components of IPV including data collection, IPV Indicators and data tools.

Course Modules

There are 8 course modules as outlined below:

- Module 1: Introduction to Intimate Partner Violence
- Module 2: Guiding Principles in IPV Response
- Module 3: Identification of Intimate Partner Violence
- Module 4: First Line Support for IPV Survivors
- Module 5: Psychological Support and Counselling
- Module 6: Coordination, Referrals and Linkages
- Module 7: IPV in Special Situations
- Module 8: Record Keeping, Documentation, Monitoring and Evaluation

Training Methodology and Materials

The course delivery incorporates classroom-based lecture that will intersperse with plenary and group facilitated discussions, brain-storming sessions, scenarios and case-studies, video clips and power point slides. Emphasis will also be placed on practical sessions as well as scenario-based/role-playing training.

The course will utilize participants and facilitator's manuals, audio-visual equipment, flip-charts, markers, case-studies, videos, role-play guides, data tools, registers and job-aids.

Target Audience

This course targets any health service providers including, but not limited to; doctors, nurses, clinical officers, counsellors, psychologists, (medical) social workers, health facility managers and policy makers at all levels of government. Health service providers will need to have undergone the Ministry of Health Training On Management Of Sexual Violence in order to gain most from the content contained in this training curriculum.

Evaluation and Certification

The participants' knowledge and efficacy will be evaluated using a pre and post-test. Certification will be determined by 80% pass on the post-test and attendance of all the sessions.

IPV Training Program

TIME	DAY 1	DAY 2	DAY 3
8:00 - 10:30am	<ul style="list-style-type: none">• Registration & introduction• Climate setting• Expectations• Group norms• Course objectives• Logistics• Pre-test	MODULE 3: IDENTIFICATION OF INTIMATE PARTNER VIOLENCE <ul style="list-style-type: none">• Rationale & approaches in the identification of IPV cases• How to enquire about IPV	MODULE 6: COORDINATION, REFERRALS, LINKAGES <ul style="list-style-type: none">• Referral process for an IPV clients• Appropriate support services and referral mechanisms
10:30 - 11:00am	Tea Break		

11:30am - 1:00pm	MODULE 1: INTRODUCTION TO INTIMATE PARTNER VIOLENCE <ul style="list-style-type: none"> • Definitions, situation analysis & forms of IPV • Understanding the cycle of violence, risk factors and impact • Self-awareness and community perceptions on IPV 	MODULE 4: First line support, risk assessment and safety planning for IPV survivors MODULE 5: PSYCHOSOCIAL SUPPORT AND COUNSELLING <ul style="list-style-type: none"> • Introduction to counselling • Psychosocial support 	MODULE 7: Intimate partner violence in special situations MODULE 8: Record keeping, documentation, monitoring and evaluation
1:00 - 2:00pm	Lunch Break		
2:00pm - 4:30pm	MODULE 2: GUIDING PRINCIPLES IN IPV RESPONSE <ul style="list-style-type: none"> • Client-centered approach & the guiding principles • Barriers in addressing IPV 	<ul style="list-style-type: none"> • Individual counselling • Group counselling • Care for care giver 	Post test Course Evaluation Closure
4:30 - 5:00pm	Tea Break		



Facilitator's instructions

1. Welcome and thank participants for making the time to attend the session
2. Use an introductory activity such as the "toilet paper" activity outlined below or any other activity applicable to your setting to break the ice and set the stage for learning
3. Familiarize participants with the venue including the washrooms, dining rooms etc
4. Put up a flipchart on the wall with "parking lot" headline that will be utilized to park any issues/questions that will be handled later on in the training.



Introduction activity: Toilet paper

The following is an introductory activity that can be used:

- To give participants a chance to get to know one another
- To give the facilitator a sense of who the participants are
- To foster an open, relaxed, non-threatening environment for the training session.

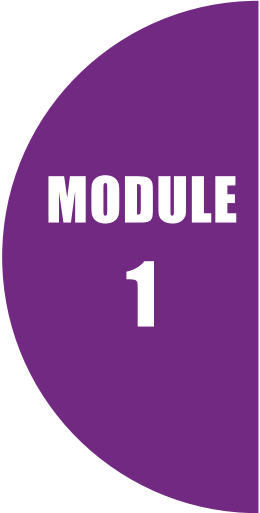
Pass a roll of toilet paper and tell the participants to take as much toilet paper as they think they will need as it is passed around the room (no further explanation at this point). When the toilet paper is finished being passed around the room, say: Now that we all have our toilet paper, please separate the toilet paper into each individual square like this (demonstrate to the group). For each sheet, please tell us something about you. Let's go around the room and share, and please include the following information:

- Name
- The facility where you work
- How many years you have worked as a healthcare provider
- Area/ Department in which you work
- For each remaining squares they should share something about themselves (e.g. family, hobbies, interests etc.)



Facilitator's instructions

1. Agree on group norms (ground rules) for the training with the participants and list them on a flipchart. Possible norms include:
 - Participate actively.
 - Respect each other's opinions and experiences.
 - Punctuality - Be on time for all activities.
 - Responsible use of phones and other gadgets (tablets, laptops etc): either turn off, put on silent mode or not use them during the training sessions.
 - Confidentiality – how to deal with sensitive materials/information
 - Active participation
2. Post them in a visible spot in the room for reference as needed throughout the training.
3. Share the slide on goal and objective of the training
4. Share the training timetable with the participants
5. Emphasize to participants that this is a 'training and learning' session – a two-way, interactive process through which the facilitator and the participants learn from one another.



**MODULE
1**

**INTRODUCTION
TO INTIMATE
PARTNER
VIOLENCE**

Introduction

IPV encompasses a wide range of acts, including physical, sexual, verbal, psychological and economic violence and other controlling behaviours. It is therefore important for health professionals to understand and recognize the full range of acts that may constitute IPV.

Purpose of the Module

This module provides a background on intimate partner violence (IPV) including the types of IPV; the factors and vulnerabilities leading to it the general myths and misconceptions on IPV; health care providers attitudes to IPV and the impact of IPV on women's and children's health and wellbeing.

Learning Outcomes

By the end of this module, the participant should be able to:

1. Define IPV and related terms
2. Describe the global and Kenya prevalence of IPV
3. Describe the types of IPV
4. Explain the causes, contributing factors, risks and impact of IPV
5. Describe the dynamics of IPV and the cycle of violence
6. Explore the attitudes of communities and health care providers on IPV, and common myths and misconceptions

Session Plan

TIME	UNIT	LEARNING OUTCOME	TEACHING METHODOLOGY	TEACHING AIDS/ MATERIALS
20 mins	Definition of IPV and related terms	Define IPV and related terms	Brainstorm Facilitated discussion	Laptop LCD projector Facilitator's guide Participant's manual Power-point slides Flip charts Markers
20 mins	Global and Kenya prevalence of IPV	Describe the global and Kenya prevalence of IPV	Illustrated lecture	
35 mins	Types of Intimate Partner Violence	Describe the types of IPV	Brainstorming Facilitated discussion	

60 mins	Understanding the cycle of IPV, Causes, contributing factors, risks and impact of IPV	<p>Explain the causes, contributing factors, risks and impact of IPV</p> <p>Describe the dynamics of IPV and the cycle of violence</p>	<p>Group Discussion</p> <p>Brainstorming</p>	
45 mins	Attitudes of communities and health care providers on IPV, and common myths and misconceptions	Explore the attitudes of communities and health care providers on IPV, and common myths and misconceptions	<p>Group activity</p> <p>Debate</p>	

UNIT 1 DEFINITION OF INTIMATE PARTNER VIOLENCE AND RELATED TERMS 20mins

Unit Objective

To define intimate partner violence and other related terms.

Terms

Intimate partner

This is the former or current husband or wife or boyfriend or girlfriend or lover.

Intimate Partner Violence (IPV)

Behaviour by either a current or former intimate partner that causes physical, sexual, psychological or economic harm, including acts of physical aggression, verbal abuse, sexual coercion, reproductive coercion, and other controlling behaviours.

Gender Based Violence (GBV)

Gender-based violence (GBV) is violence directed at an individual based on his or her biological sex, gender identity or expression, perceptions or adherence to socially defined norms of masculinity and femininity.

Domestic Violence and Abuse (DVA)

Any incident or pattern of incidents of controlling, coercive or threatening behavior, violence or abuse between intimate partners, family members. This can encompass, but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional. It also includes 'honour-based' violence, child marriage, female genital mutilation, forced wife inheritance, interference from in-laws, forced marriage, sexual violence within marriage, virginity testing and widow cleansing.

Violence against Women (VAW)

All acts of gender-based violence that result in, or are likely to result in, 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.

Reproductive Coercion (RC)

It is a form of domestic violence where behaviour concerning reproductive health is used to maintain power, control and domination within a relationship.

UNIT 2 SITUATIONAL ANALYSIS OF INTIMATE PARTNER VIOLENCE

20 mins

Unit Objective

To describe the prevalence of IPV globally and in Kenya.



Facilitator's instructions

1. Introduce the unit and unit objective
2. Begin by seeking opinions on how prevalent the participants think IPV is in Kenya
3. Using the PowerPoint presentation to present the statistics globally and in Kenya
4. The global statistics are primarily derived from the 2013 WHO Global and regional estimates of violence against women and the 2005 WHO multi-country study. The Kenyan statistics are primarily derived from the Kenya Demographic and Health Survey 2014.
5. Summarize the unit

Global and Kenya Prevalence of IPV

Intimate partner violence (IPV) is one of the most common forms of violence and occurs in all settings and among all socioeconomic, religious and cultural groups. The overwhelming global burden of IPV is borne by women. Although women can be violent in relationships with men, the most common perpetrators of violence against women are male intimate partners or ex-partners. By contrast, men are far more likely to experience violent acts by strangers or acquaintances than by someone close to them. The 2013 WHO Global and regional estimates of violence against women; estimated that IPV is widespread in all countries studied. The findings showed that

- almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner
- as many as 38% of all murders of women are committed by intimate partners

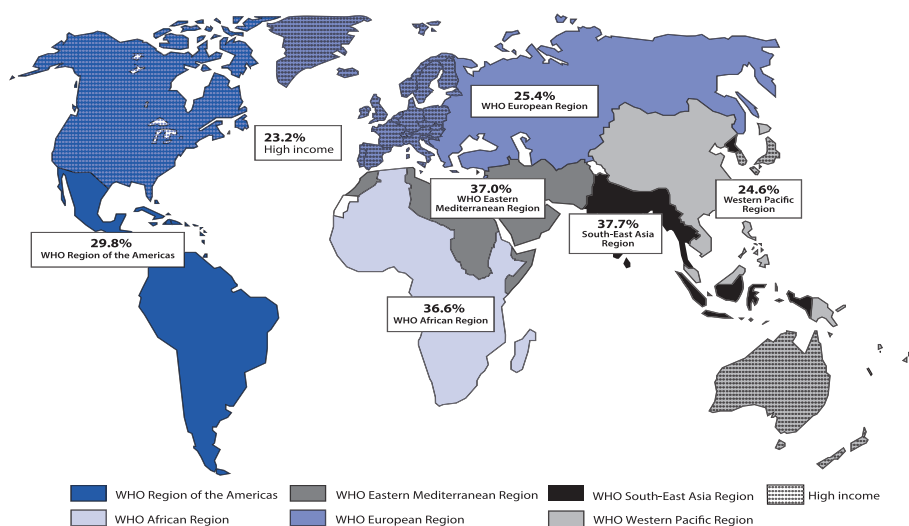


Figure 1: Global map showing regional prevalence rates of intimate partner violence

The 2014 Kenya Demographic and Health Survey reports that in Kenya,

- About 4 in 10 (41%) of women reported having experienced either sexual or physical violence from an intimate partner at some point in their lives.
 - 14% of women have ever experienced sexual violence committed by a spouse or partner,
 - 38% of women have ever experienced physical violence by an intimate partner
- About 1 in 10 (10.9%) of men reported having ever experienced some form of intimate partner violence.

Key Messages

- IPV is a significant public health problem globally and in Kenya
- IPV is a fundamental violation of human rights, and a contributor to gender inequality and discrimination globally.
- IPV occurs in all settings and among all socioeconomic, religious and cultural groups.

Unit Objective

To discuss the types of IPV and to provide examples of each type of IPV.

Physical violence

Physical force that results in bodily injury, pain, or impairment. The severity of injury ranges from minimal tissue damage and broken bones, to permanent injury and death. Acts of physical violence 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, using weapons (knives, guns)
- Denying food, warmth or sleep or medical care
- Keeping someone locked up or locked out of the house
- Holding a person to keep them from leaving
- Abandoning someone in a dangerous place
- Harmful traditional practices forced on an intimate partner

Sexual violence

Sexual violence is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances against a person's sexuality using coercion, threats of harm or physical force.

These include but are not limited to:

- Rape: using force, threats or intimidation to make someone perform sexual acts; having sex with a person who doesn't want to have sex; forcing sex after beating a person; forcing sex when someone is sick or when it is a danger to their health; forcing a person to have sex in front of others.
- Forced exposure to pornography
- Reproductive coercion: Pregnancy coercion, contraceptive sabotage, pressure not use contraceptives, forced contraceptive, pregnancy termination coercion.
- Sexual degradation, including: using abusive insults; sexual criticism; making demeaning gender based comments
- Forced sadomasochistic practices
- Insisting on unwanted and uncomfortable touching
- Forcing a person to strip
- Having affairs with other people after agreeing to a monogamous relationship
- Publicly showing sexual interest in other people
- Withholding sex and physical affection.

Psychological violence (emotional violence)

An action or set of actions that directly impair an intimate partner's psychological integrity. Acts of psychological violence include:

- Threats of violence and harm against a partner or somebody close to them, through words or actions (ex. through stalking or displaying weapons)
- Humiliating and insulting comments
- Isolation and restrictions on communication

- Use of children by a violent intimate partner to control or hurt. These acts constitute both, violence against children, as well as IPV
- Denial: Saying the abuse doesn't happen; saying the abused caused the abusive behaviour; being publicly gentle and patient or charming, but privately violent and abusive
- Manipulating a person with lies and contradictions

Economic/Financial violence

Used to deny and control a partner's access to resources, including time, money, transportation, food, or clothing. Acts of economic violence include:

- Prohibiting a partner from working
- Excluding her from financial decision-making in the family
- Withholding money or financial information
- Refusing to pay bills or maintenance for the partner and/or the children
- Destroying partners' things or jointly owned assets

Key message

IPV encompasses a wide range of acts, including:

- physical
- sexual
- verbal
- psychological
- economic / financial violence and other controlling behaviours

UNIT 4 UNDERSTANDING THE CYCLE OF VIOLENCE, RISK FACTORS AND IMPACT OF IPV 1 HOUR

Unit Objectives

1. Describe the risk factors of IPV
2. Describe the power and control wheel
3. Explain the cycle of violence
4. Discuss the impact of IPV

Risk Factors of Intimate Partner Violence

The most widely used model for understanding violence is the ecological model, which proposes that violence is a result of factors operating at four levels: individual, relationship, community and societal. Most studies have researched women as the majority survivors of IPV and men as the primary perpetrators. It is also important to note that, at the individual level, some factors are associated with perpetration, some with victimization and some with both.

Risk Factors for Violence based on the Ecological model			
Societal Broad factors that reduce inhibitions against violence	Community neighbourhood, schools and workplaces	Relationship With family, intimate partners and friends	Individual Personal factors that influence individual behavior
<ul style="list-style-type: none"> • Poverty • Economic, social and gender inequalities • Poor social security • Masculinity linked to aggression & dominance • Weak legal and criminal justice system • Perpetrators not prosecuted • No legal rights for victims • Social and cultural norms support violence • Small fire arms • Conflict or post-conflict • Internal displacement and refugee camps 	<ul style="list-style-type: none"> • High unemployment • High population density • Social isolation of females & family • Lack of information • Inadequate victim care • School & workplaces not addressing GBV • Weak community sanctions against GBV • Poor safety in public spaces • Challenging traditional gender roles • Blaming the victim • Violating of victim confidentiality 	<ul style="list-style-type: none"> • Family dysfunction • Inter-generational Violence • Poor parenting practices • Parental conflict involving violence • Association with friends who engage in violent or delinquent behaviour • Low socio-economic status socio-economic stress • Friction over women's empowerment • Family honor more important than female health and safety 	<ul style="list-style-type: none"> • Gender, age and education • A family history of violence • Witnessing GBV • Victim of child abuse or neglect • Lack of sufficient livelihood and personal income • Unemployment • Mental health and behavioral problems • Alcohol and substance abuse • Prostitution • Refugee Internally displaced • Disabilities • Small fire arms ownership

Individual factors

Some of the most consistent factors associated with increased likelihood of committing violence and experiencing violence.

Committing Violence	Experiencing Violence
<ul style="list-style-type: none">• Age• Level of education• Learned behaviors e.g. Witnessing or experiencing violence as a child• Personality disorders (Narcissist, Borderline, Antisocial)• Acceptance of violence (e.g. Feeling it is acceptable for a man to beat his partner)• Past history of abusing partners• Harmful use of alcohol and drugs	<ul style="list-style-type: none">• Level of education• Exposure to violence• Sexual abuse during childhood• Acceptance of violence• Marginalized populations e.g. Person with disability, Orphans and Vulnerable Children, Gender and sexual minority

Relationship factors associated with increased risk of IPV include:

- Relationship conflicts
- Dissatisfaction in the relationship
- Partner dominance
- Economic stress
- Multiple partners
- Disparity in education

Community and societal factors associated with increased risk of IPV include:

- Gender-inequitable social norms (especially those that link notions of manhood to dominance and aggression)
- Poverty
- Low social and economic status of women
- Weak legal sanctions against IPV within marriage
- Inadequate implementation of laws and policies; impunity
- Acceptance of violence as a way to resolve conflict

The Dynamics of Intimate Partner Violence- The Power and Control Wheel

Power is the ability to influence your own or others' experiences.

Control is the power to influence or direct people's behaviour or the course of events.

Power can be positive or negative. It can be used to do right or to do wrong. One of the most common yet destructive forms of power in our communities is the negative use of power that leads to violence against women

Positive Forms of Power

- **Power Within** is the positive feeling we experience when we love and accept ourselves, believe we are valuable, and feel deserving of all our human rights. Power within is the foundation for all other positive forms of power.
- **Power To** is when we take action to positively influence our own and others' lives.
- **Power With** is when we join others without bias or discrimination to positively improve our own and others' lives.

Negative Power

Power Over is when our words or actions make it difficult, frightening or even dangerous for others to use their own power. The resulting imbalance of power often leads to violence in its many forms – physical, sexual, emotional or economic.

Violence is rooted in gender inequality where unequal power relationships create disparities in opportunities and outcomes. Due to gender discrimination and lower socio-economic status, women and girls have fewer options and fewer resources at their disposal to avoid or escape abusive situations, to seek reparations or justice, or otherwise reassert their power and independence.

Power and Control Wheel

The Power and Control Wheel offers a framework for understanding the manifestations and mechanisms of power and control in an intimate relationship. The wheel consists of eight spokes that summarize the patterns of behaviors used by an individual to intentionally control or dominate an intimate partner.

Additionally, they use intimidation, emotional abuse, isolation, minimizing, denying, blaming, using children, male privilege, economic abuse, coercion and threats. These actions serve to exercise 'power and control' – these words are in the center of the wheel. The rim of the wheel is made of physical and sexual violence – that holds it all together

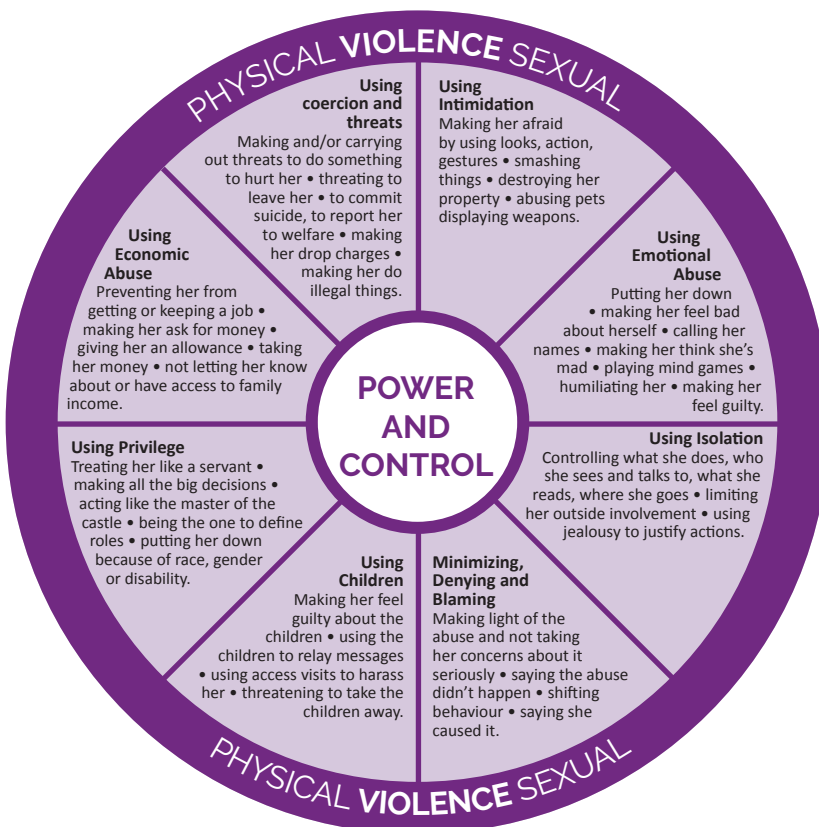


Figure 2: The power and control wheel

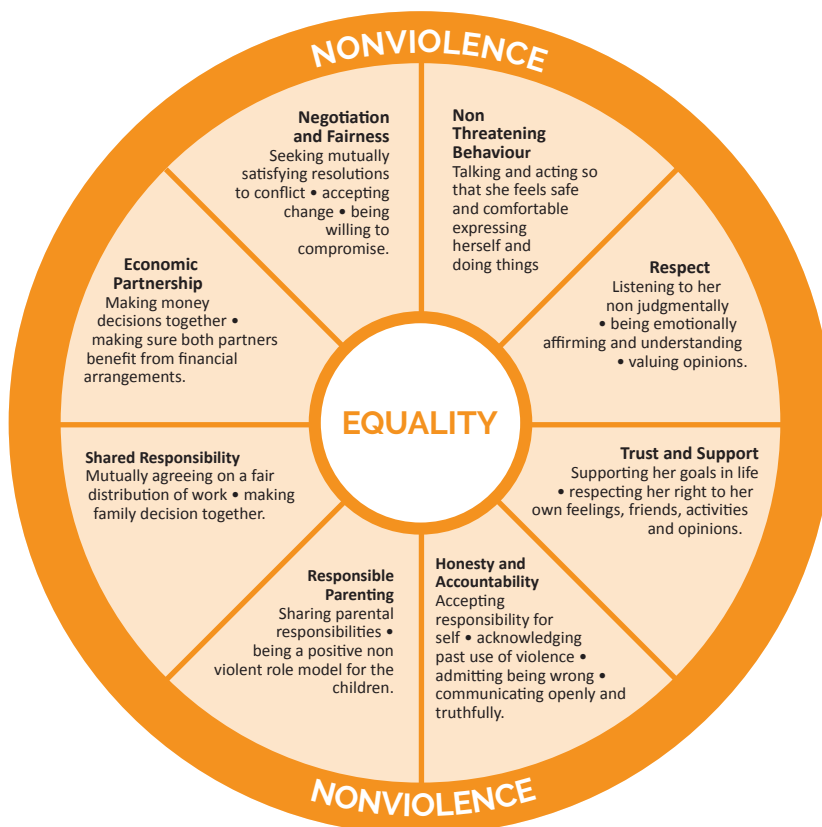


Figure 3: Non-violence equality wheel

The Cycle of Intimate Partner Violence

This model is helpful in understanding how someone can become caught up in a potentially never-ending life of violence. Essentially, abusive relationships involve a build-up of tension between partners, a violent explosion that releases the tension and things, a making up or honeymoon phase and a temporary return to peaceful interaction.

This cycle will continue and violence will become more frequent as the relationship progresses, unless the abuser makes changes to his behaviour (which is unlikely to happen without professional help). The lengths of the cycle and of the four phases will vary from couple to couple. The following is a more detailed description of the phases of an abusive relationship.

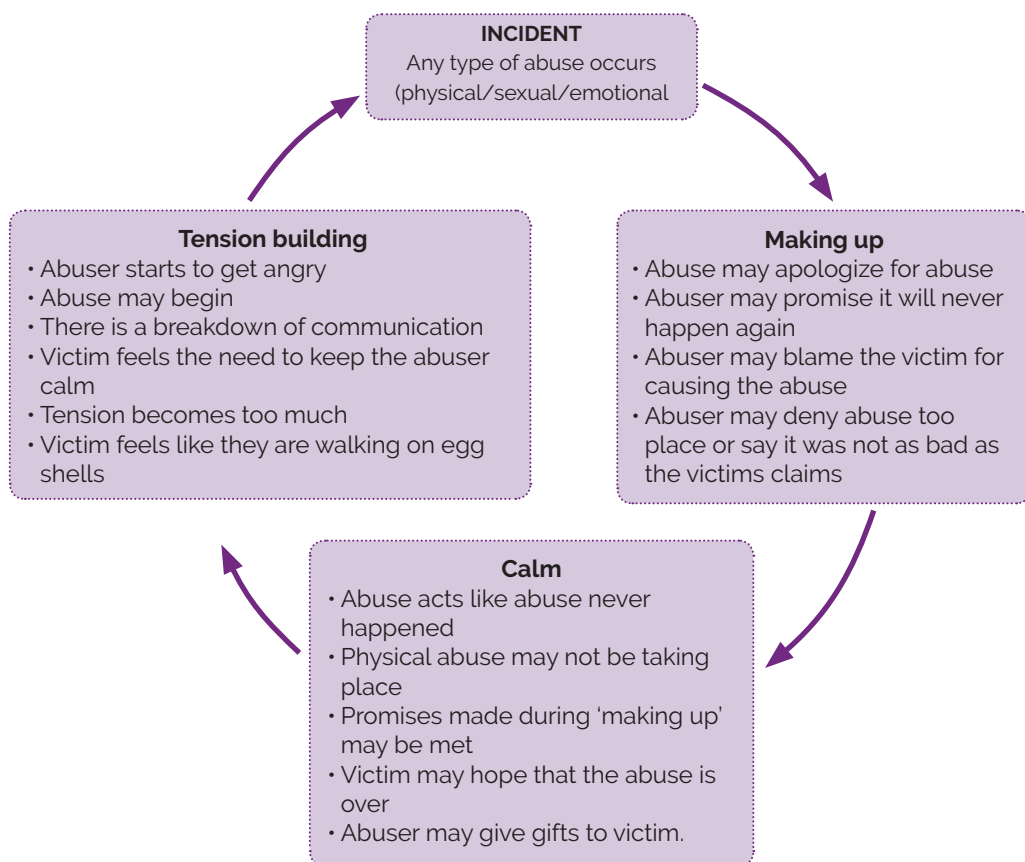


Figure 4: The Cycle of Violence

The Impact of Intimate Partner Violence

On survivor

IPV affects a person's physical and mental health through direct pathways, such as injury, and indirect pathways, such as chronic health problems that arise from prolonged stress. A history of experiencing violence is therefore a risk factor for many diseases and conditions.

IPV can impact all aspects of health – physical, sexual, and reproductive, mental and behavioural health. Health consequences of IPV can be both immediate and acute, as well as long-lasting and chronic; negative health consequences may persist long after the violence has stopped. They include the following:

- **Physical Harm** – Injuries, functional impairments, permanent disabilities
- **Risky Health Behaviors** – Alcohol and drug use, smoking, sexual risk-taking, self-injuring behavior
- **Psychosomatic symptoms** – Chronic pain syndrome, irritable bowel syndrome, gastrointestinal disorders, urinary tract infections, respiratory disorders

- **Reproductive Health Consequences** – Pelvic inflammatory disease, sexually transmitted infections /HIV, unintended pregnancy, miscarriage/abortion, unsafe abortion, pregnancy complications, low birth weight,
- **Psychological Consequences** – Post Traumatic Stress Disorder, depression, anxiety, fears, sleeping disorders, eating disorders, suicidal thoughts, low/lack of sexual drive, and low self-esteem
- **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 age 15 to 44 in developing countries
- **Death** – fatal outcomes as immediate result of a partner 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)

Other impacts may include:

- **Negative social outcomes-** separation, divorce, dysfunctional families, stigma and discrimination
- **Economic** -Economic violence includes denying access to and control over basic resources (UN General Assembly, 2006). It causes, or attempts to cause, an individual to become financially dependent on another person by obstructing their access to or control over resources and/or independent economic activity.

Economic violence may include:

- Preventing access to money
- Stopping someone from getting or keeping a job
- Making major financial decisions without consultation
- Controlling all access to money earned, while leaving the victim to pay all household bills
- Undermining a partner's attempts to improve education, training or employment
- Withholding food, clothes, medications and health care or shelter

On children

The impact of IPV on children is harmful. Children who are exposed to violent behaviour are more likely to grow up to be perpetrators or victims themselves. Children who witness violence grow up in an atmosphere of fear, exercise of power, helplessness and insecurity and stress.

Additionally, children exposed may suffer consequences including; sexual violence (defilement, incest), teenage pregnancy, drug and substance abuse, becoming street children, crime, school dropout, mental health disorders, domestic violence by enduring similar violence. The likelihood of children suffering life-long consequences of childhood domestic violence are high: boys are more likely to grow up to be perpetrators, while girls are more likely to suffer violence. It is essential that children are given help and support in dealing with their experiences of violence.

Children exposed to IPV may present with the following:

- Sleeping and eating disorders
- Bed-wetting
- Speech disorders
- Withdrawal
- Behavioural disorders
- Aggression
- Depression
- Difficulties at school
- Psychosomatic disorders
- Self-harm
- Suicidal thoughts or acts

On workplace

- Low productivity
- Absence from work
- Employee turnover

On Society

- Increased national expenditure in healthcare
- Decreased productivity
- Decrease in potential revenue
- Legal fee and cost of managing violence

Key Messages

- Intimate partner violence is a result of factors operating at four levels: **individual, relationship, community** and **societal**.
- The dynamics of IPV are better captured in the **Power and Control Wheel** which offers a framework for understanding the manifestations and mechanisms of power and control in an intimate relationship.
- The impact of IPV affects a person's physical and mental health through **direct** pathways, such as injury, and **indirect** pathways, such as chronic health problems that arise from prolonged stress.

Unit Objectives

1. Explore individual attitudes and the societal/community perceptions on IPV
2. Discuss how the perceptions may affect the care given to IPV survivors

**Activity: Voting with your feet (30 Minutes)**

- Find a space where participants can easily move around.
- Ask the participants to stand in the middle in a straight line
- Label/Designate one side of the space as “**Agree**” “**Disagree.**” and “**Neutral**”
- Read one of the statements listed in the **Handout - vote with your feet (Anne I: Facilitator Handout: Attitudes towards IPV Vote with Your Feet Activity)** out loud.
- Ask participants to respond by moving closest to the sign/side - either agree, disagree or neutral depending on whether they agree or disagree with the statement.
- Ask the participants to choose where they stand based on how strongly they agree or disagree with the statement.
- After each statement, facilitate a discussion about why people chose the response they did. This will help dig deeper into their underlying belief systems.
- Allow some time for debate between people of differing view points by asking each side to explain their view to the other side
- After a short debate, ask people if they would like to change their position.
- Repeat this by reading a 4-5 more statements, depending on how much time is available.
- Allow each person to express his or her thoughts without making a judgment about who is right or wrong. These are complicated, emotional issues, and some participants may react strongly to the statement and others' views. Remember, everyone brings his or her own personal perspective to this exercise.

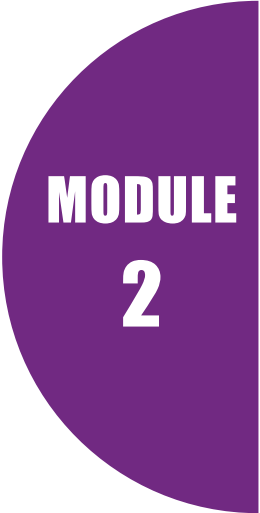
Take away messages

- The purpose of the exercise was to reflect on our personal beliefs about IPV to see how our perceptions and beliefs might affect the care that we as health care providers offer to survivors.
- All of us hold attitudes and beliefs that reflect the norms and values of the societies we live in.
- Our attitudes may also be in conflict with those of others.
- It is important to respect others' beliefs and attitudes about acceptability of violence, but to also challenge those attitudes and values or beliefs that can be harmful to others.

- It is important to challenge our own values and beliefs and reflect if they can harm others or affect how we treat survivors.
- Survivors of IPV are often acutely aware of their surroundings and can sense when someone has a negative opinion about them because of their beliefs.
- It is important to respect the reproductive rights of women

Key Messages

- Personal/societal/religious Values and attitude can affect the ability to offer effective services to IPV survivors, it is therefore important not to be judgemental or biased when attending IPV survivors.



**MODULE
2**

**GUIDING
PRINCIPLES IN
IPV RESPONSE**

Introduction

Guiding principles are values that guide the provision of health care services to IPV survivors. This entails upholding survivors' rights and addressing their needs and wishes. Guiding principles aim to create a supportive environment in which the IPV survivor is treated with dignity and respect. This module covers the guiding principles on provision of IPV services including violence disclosure, identification of survivor and health care provider barriers on access to care and appropriate mitigation measures.

Purpose of the module

This module is intended to introduce the principles that guide the provision of IPV services and the concept of survivor-centred care. Its aim is to teach the appropriate approach when enquiring and providing services to IPV survivors, in addition to identifying the barriers of access to care in the healthcare system and exploring mitigation strategies to these barriers.

Learning Outcomes

By the end of this module the participant should be able to:

1. Describe survivor-centered approach
2. Explain the guiding principles to survivor-centered care
3. Identify barriers to accessing and providing effective IPV care
4. Explain the strategies in addressing barriers to effective IPV care

Session Plan

TIME	TOPIC	LEARNING OUTCOME	TEACHING METHODOLOGY	TEACHING AIDS/ MATERIALS
1 hour	Survivor-centered approach	Describe survivor-approach	Group Discussion	Laptop LCD projector Facilitator's guide Participant's manual Power-point slides Flip charts Markers
1 hour	The guiding principles of survivor-centered care	Explain the guiding principles of survivor-centered care	Brainstorming, illustrated lecture and Facilitated discussion	
	Barriers to accessing and providing effective IPV care	Identify barriers to accessing and providing effective IPV care		
	Strategies in addressing barriers to effective IPV care	Explain the strategies in addressing barriers to effective IPV care		

1. WHO clinical and policy guidelines: Responding to intimate partner violence and sexual violence against women.
2. UN Women: Programming Module on Working with the Health Sector to Address Violence against Women and Girls
3. Training Manual on Gender-Based Violence for Health Professionals (Europe): Implement Project

UNIT 1 SURVIVOR-CENTERED CARE APPROACH AND THE GUIDING PRINCIPLES 1 Hour



Facilitator's instructions

1. Introduce the unit and the unit objectives
2. Conduct the "Clarifying Guiding Principles" group activity in the activity box below
3. Complete the activity by clarifying about 'the survivor-centered care' approach using the information in the manual
4. Encourage debate within the group, and be ready to spend some time discussing the issues that arise.
5. Summarize the unit

Unit Objectives

1. To discuss the ethical guiding principles of survivor-centered care
2. To describe the standards of survivor-centered care.

Survivor-Centered Approach and the Guiding Principles

A survivor-centered care approach means that all those who are engaged in IPV care and programming, prioritize the rights, needs, and wishes of the survivor. Essentially, a survivor-centered care approach applies the human rights-based approach to designing and developing programming that ensures that survivor's rights and needs are prioritized. The human rights-based approach requires providers to meet the needs of survivors affected by violence according to ethical, legal and moral obligations.

The survivor-centered approach aims to create a supportive environment in which survivor's rights are upheld and in which he/she is treated with dignity and respect. The approach helps to promote the survivor's recovery and ability to identify and express his/her needs and wishes, as well as to reinforce the capacity to make decisions about possible interventions. Providers must have the skills, resources and tools they need to ensure that such an approach is implemented. The survivor-centered care approach is based on a set of principles designed to guide health care providers in their engagement with survivors who have experienced IPV or other forms of violence.

GUIDING PRINCIPLE	SERVICE SPECIFIC STANDARDS
A rights-based approach	
Right to privacy	<ul style="list-style-type: none"> • Ensure privacy during any conversation between the survivor and provider so that no one can overhear. • In settings where no such space exists, creative measures such as walking to another part of the facility with the survivor might have to be taken.

Right to confidentiality	<ul style="list-style-type: none"> Information regarding a survivor should not be shared without the survivor's informed consent and assent. Measures should be in place so that HCPs only discuss cases with other providers only when necessary. Institute secure measures for confidentiality and secure storage of patient files.
Right to choose/ Autonomy	<ul style="list-style-type: none"> Survivors require all necessary information on any course of action – purpose, benefit and potential risks to be able to choose their preference Respect for survivor's values, preferences and expressed needs Seek informed consent/assent for any examination and tests.
Right to non-discrimination/ Equity	<ul style="list-style-type: none"> Ensure the same level of quality of care for all persons seeking assistance. Ensure that health programmes are age-specific and tailored to different sub-groups with wide access across a variety of settings, including considerations of geographic, cultural and linguistic diversity.
Right to dignity/ Appropriateness	<ul style="list-style-type: none"> Ensure availability of female/male health care provider where requested, and promote bodily integrity in examinations. Remind survivors that violence is not their fault and abuse should not be tolerated
Accessibility	<ul style="list-style-type: none"> Ensure services for survivors and prevention initiatives are free of cost e.g. contraceptives Ensure location of services is accessible and/or provide transportation. Ensure mechanisms for referral and linkages with the community are available.
Safety	<ul style="list-style-type: none"> Ensure safety of the survivor as the paramount concern as well as safety for the staff, and cultivate a working environment that does not minimize or deny potential safety risks. Conduct safety assessments and safety planning.
'Do no Harm'	<ul style="list-style-type: none"> Provide services in a way that does not put the survivor at further risk of harm, especially as a result of unintended consequences

Effectiveness/ Efficiency	<ul style="list-style-type: none"> • IPV service providers should be skilled, gender-sensitive to enable them provide services in accordance with the current MoH guidelines and protocols. • Ensure health policies and programmes are based on evidence. • Monitor and evaluate service provision, seeking participation of service users. • Ensure coordination among multi-sectoral actors.
Urgency	<ul style="list-style-type: none"> • Prioritize provision of immediate response to the urgent needs of IPV survivors, including medical needs • Ensure IPV prevention and response are established before the onset of any emergency

Key messages

When providing care to IPV survivors, it is important to:

- Ensure survivor's rights, needs and wishes are respected
- Avoid any form of discrimination based on; gender, sex, age, race, ethnicity, ability etc.
- Treat the survivor with respect, dignity and avoid victim-blaming attitude
- Avail comprehensive information to survivors for informed decision making
- Ensure linkages through multi-sectoral and multi-stakeholder coordination

UNIT 2 BARRIERS IN THE HEALTHCARE SYSTEM IN ADDRESSING IPV

1 Hour



Facilitator's instructions

1. Introduce the unit and the unit objectives
2. Conduct the activity on 'Barriers to effective healthcare response and mitigation measures' outlined in the activity box
3. Review the content in the manual with the participants
4. Summarize the unit

Unit Objectives

1. To identify the barriers IPV survivors face when accessing health services
2. To explore the barriers faced by health care providers when providing services to IPV survivors
3. To discuss the mitigation measures to the barriers faced by health care providers when providing services to IPV survivors



Activity: Barriers to effective Healthcare Response

Objective

The objective of this exercise is to identify barriers to an effective health care response to IPV and what we as healthcare providers can do about it.

Instructions

- Divide the participants into groups of 4-6 people and assign half the groups survivor barriers and the other half provider barriers.
- Each group should write their barriers and suggestions on how to mitigate the barriers on a piece of flipchart paper. You have 20 minutes time for discussions in the group.
- Each group should assign one rapporteur who will present the points collected on the flipchart to the group.
- After presentations, thank the rapporteurs and review the barriers to effective healthcare response summarized in the manual

Group(s) working on survivor barriers:

1. Which barriers prevent IPV survivors from accessing and receiving health services (survivor barriers)?
2. What can you as a health professional do in your daily work to address these barriers?
3. What support do you need from the management at your health facility in order to address these barriers?

Group(s) working on health system barriers:

1. Which health system barriers exist that hinder IPV service provision?

Barriers faced by survivors in accessing health services and disclosing violence

Barriers operate at the levels of partner relationships, families and the wider community. This requires interventions at multisectoral levels – health, social welfare, legal, security. Health care providers need to be aware of the barriers, in order to be able to provide effective care and referrals to relevant service providers.

Survivor barriers

The following are some of the barriers that survivors may face in accessing health services and disclosing violence:

- Shame, guilt, and the feeling to be solely or partly responsible for the violence suffered
- Fear of reprisals, escalation of violence and further threats from the perpetrator
- Fear of stigma and social exclusion by their families and communities.
- Social isolation and the feeling of having to deal with the experience of violence all by themselves.
- Experiences of violence that can damage person's self-confidence and self-esteem to such an extent that the search for and the acceptance of support becomes difficult.
- Lack of safe options for their children and fear of losing child custody
- Fear of drawing attention of losing status following separation from a violent spouse
- Lack of realistic options (e.g. for financial resources, housing, employment and safety)
- Fear of negative responses from some service providers
- Fear of being blamed for not separating from the abusive partner, in particular when the survivor has received inappropriate and victim-blaming responses from service providers in the past
- Language barriers
- Cultural barriers

Health care systems barriers

- Limited resources – personnel, commodities, infrastructure, finances
- Lack of physical access to health care services for survivors living in remote areas
- Lack of functional referral system mechanisms
- Insufficient clinical / counselling psychologists to provide psychosocial support
- Inadequate physical structures to provide privacy and confidentiality to IPV survivors

Barriers faced by health care providers in providing effective services to IPV survivors


- Language barriers
- Cultural barriers
- Insufficient knowledge about IPV identification, management, including provision of psychosocial support, and referral
- Negative attitudes and misconceptions about IPV
- Own experiences of IPV in the past: may influence how the health professional manages a survivor.

- Lack of information about existing support services and appropriate professional contacts, which could serve as basis for referral.
- Heavy workload
- Lack of intra-institutional supportive structures such as standardized protocols, documentation forms or staff training on dealing with survivors of IPV.
- Uncertainties about legal obligations, such as confidentiality rules or reporting obligations.
- Absence of standard procedures, policies and protocols to ensure that health professionals' response to all survivors of IPV follow standards of good clinical care.
- Cultural factors that promote perception of women and children/victims as inferior and deserving violent/inhumane treatment.

Key messages

In order to ensure demand and utilization of health services by IPV survivors, it is important to:

- Have standardized protocols, SOPs documentation, policies and legal obligations
- Involve the community on matters IPV to avoid stigma, social exclusion, isolation and misconceptions about IPV
- Ensure survivor's accessibility to healthcare services especially in rural areas
- Provide adequate time for medical care and psychosocial support



**MODULE
3**

**IDENTIFICATION
OF INTIMATE
PARTNER
VIOLENCE**

Introduction

Asking survivors about violence is important because it can help providers sensitively identify individuals experiencing IPV and connect them to post violence services. It can also reduce a person's need for health services and may save time and resources by helping providers understand and address violence as an underlying reason behind seeking health services.

Module purpose

This module will explore the rationale for IPV screening, the different types of IPV screening and the WHO recommendation. Here we will discuss tips to apply when asking about IPV and the requirements and criteria to put in place before enquiry. The participants will be introduced to different IPV screening tools and will practice screening for IPV through role play.

Learning outcomes

By the end of this module the participant should be able to:

1. Explain the rationale for IPV enquiry
2. Describe the types of IPV screening and the benefits and risks of each approach
3. Discuss the minimum requirements of an IPV screening program
4. Demonstrate the use of screening tools to screen a suspected case of IPV

Session plan

Time	Topic	Learning outcomes	Teaching Methodologies	Materials /Job aids
30 mins	Rationale for IPV enquiry	Explain the rationale for IPV enquiry	Brainstorming Facilitated Discussion Interactive Lecture	Laptop LCD projector Facilitator's manual
2 hrs	Types of IPV screening	Describe the types of IPV screening	Facilitated Discussion Interactive lecture	Participant's manual Power-point slides
	Minimum requirements of an IPV screening program	Discuss the minimum requirements of an IPV screening program	Interactive Lecture	Flip charts Markers Screening tools Case study
	Use of screening tools to identify IPV	Demonstrate the use of screening tools to identify IPV		

UNIT 1 RATIONALE AND APPROACHES IN THE IDENTIFICATION OF IPV CASES 30 mins

Unit Objectives

1. To explain the rationale of enquiring about IPV in healthcare setting
2. To describe the approaches of IPV identification
3. To outline the minimum requirements that should be in place before enquiring about IPV.

Rationale for Enquiry

Many individuals will have contact with health services several times during their lives. Amongst them, the majority of survivors of violence may never report their experience of violence to health care provider as they seek out these health services. In health care settings where providers are well trained, caring and sensitive, most survivors respond positively to being asked about their exposure to violence. Health care providers are therefore in a unique position to identify survivors and offer them appropriate management and referrals.

Benefits of identification of IPV

- It provides the opportunity for disclosure of IPV and allow victims to know there are resources available
- IPV can often be the root cause of a survivor's health issue, not inquiring about it undermines the quality of care offered to the survivor.
- Identification of IPV is the FIRST stage of intervention
- Asking about abuse helps break the isolation victims and other family members may experience.

Approaches in the Identification Of IPV Cases

In health settings two approaches are used to facilitate the disclosure of IPV: **Routine enquiry** and **case finding (clinical enquiry)**.

Routine Enquiry

Routine enquiry is a structured process to ask all clients in a particular setting about past or current experiences of IPV (e.g., asking all ANC clients or all HTS clients). Routine enquiry should be conducted when assessing conditions that are linked to or worsened by IPV.

According to WHO, some of these settings are: clinical entry point for HIV prevention, testing care and treatment service, settings where Index Case Testing/Partner Notification Services is conducted, PrEP provision, MCH, DICES.

Minimum requirements before enquiry

There is limited usefulness of routine enquiry in settings with very high prevalence and limited intervention options and sustainability. Clients may find repeated enquiry difficult, particularly if no action is taken. This may potentially reduce their uptake of health services.

When enquiring about IPV, health care facilities and providers need to ensure that a number of minimum requirements are in place, while at the same time ensuring safety during enquiry.

The minimum requirements include:

- A protocol or standard operating procedure to guide the intervention
- A standard set of questions to aid enquiry
- Health providers trained on how to ask and respond to women who disclose
- Ensured safety, with privacy and confidentiality considerations
- A system for referrals to post violence services with providers aware of and knowledgeable about resources to refer women to.

This will ensure that the facility is well prepared to address any cases of IPV identified during screening.

Case Finding (Clinical Enquiry)

Case-finding (also known as clinical enquiry) refers to asking clients about IPV if they present with certain clinical symptoms, history and (if appropriate) examination of the client. Health care providers ask about exposure to IPV when assessing conditions that may be caused or complicated by IPV, in order to improve diagnosis/identification and subsequent care. These conditions may include:

- Symptoms of depression, anxiety, Post-Traumatic Stress Disorder (PTSD), sleep disorders
- Suicidality or self-harm
- Alcohol and other substance use
- Unexplained chronic gastrointestinal symptoms
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Chronic pain (unexplained)
- Non adherence / compliance to medication
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

Universal screening

This is asking all clients who present at the health facility about violence. WHO does not recommend universal screening for violence of clients attending health care. WHO encourages healthcare providers to raise the topic with clients who have injuries or conditions that they suspect may be related to violence.

**Facilitator's instructions**

- Introduce the unit and the unit objectives
- Go through the process flow chart on whether it is safe to enquire
- Discuss the recommendations and tips when enquiring about IPV
- Discuss various screening tools outlined in the unit and characteristics of the tools
- Summarize the unit

Unit Objectives

1. To introduce various IPV screening tools used in healthcare settings
2. To practice IPV screening using the recommended MoH screening tool
3. To discuss recommendations and tips to apply when asking about IPV

Tips when asking about IPV

Asking a survivor if he/she has experienced IPV can be challenging for health professionals.

This section is intended to help increase the knowledge and confidence of health professionals in asking about IPV. Once it is determined that minimum requirements have been met, health professionals can begin enquiry.

- Take the initiative to ask about violence, but do not ask about violence in the presence of a partner, family member, or friend.
- Explain that the information will remain confidential (and inform about any limitations)
- Use eye contact and focus all attention on the client
- Be aware of body language (pay special attention to your tone of voice, and the ways in which you sit, hold your head and rest your arms, which all convey a particular message to the survivor about how you perceive the situation)
- Avoid passive listening and non-commenting – demonstrate that you are actively listening
- Show a non-judgmental and supportive attitude, and validate what they say – avoid questions that may imply blame, such as questions that begin with “why”
- Reinforce that IPV cannot be tolerated and is never okay, and reassure that their feelings are normal
- Be patient with IPV survivors, keeping in mind that they are in a state of crisis and may have contradictory feelings
- Do not pressure them to disclose, and explain to them that they can come back for further assistance
- Emphasize that violence is not their fault, and that the perpetrator is responsible for their behaviour

- Use supportive statements such as “I am sorry that this happened to you”, “You did the most important thing you could do in that moment: you survived”, which may encourage the survivor to disclose more information.
- Emphasize that there are options and resources available
- When beginning to ask about IPV, start by using an introductory statement, which explains to the client that IPV affects many people and impacts their health.
- Use language that is appropriate and relevant to the culture and community you are working in. Some clients may not like the words “violence” and “abuse”. Cultures and communities have ways of referring to the problem with other words. It is important to use the words that clients themselves use.

What if you suspect violence but they do not disclose it? `

Do not pressure them; give them time to decide what they want to tell you. Let them know that if it ever happens to them, or someone else, they are welcome to come back and talk about it. Tell them about services that are available if they choose to use them.

Use the referral protocol that is in place to refer them to other services, according to their wishes. Offer information on the effects of violence on one’s health and their children’s health. Offer the survivor of violence a follow-up visit

Screening Tools

IPV screening tools are used to identify individuals at risk of and experience of abuse or injury. Below is the MoH recommended IPV screening tool.

<p>IPV SCREENING TOOL Instructions to the Health Provider The following tool will be used to screen women for IPV occurrence. Answering YES to any of the IPV questions qualifies for presence of IPV and should be put through the intervention</p>			
<p>The following questions are about things that happen to many women and that your current partner or any other partner may have done to you.</p>			
<p>Q1: PSYCHOLOGICAL IPV QUESTIONS</p>			
	<p>A. Has your current partner/ husband / boyfriend ever done any of the following things?</p>	<p>B. In the last 12 months has your partner done any of the following? (If YES, ask C. If NO, proceed to Q2)</p>	<p>C. In the past 12 months would you say this has happened once, a few times or many times?</p>

	Yes	No	YES	NO	ONCE	FEW	MANY
(a) Insulted you or made you feel bad about yourself?							
(b) Belittled or humiliated in front of other people?							
(c) Did things to scare or intimidate you on purpose (e.g. by the way he looked at you, yelling or smashing things)?							
(d) Threatened to hurt you or someone you care about?							

Q2: PHYSICAL IPV QUESTIONS

	A. Has your current partner/ husband / boyfriend ever done any of the following things		B. In the last 12 months has your partner done any of the following? (If YES, ask C. If NO, proceed to Q3)		C. In the past 12 months would you say this has happened once, a few times or many times?		
	Yes	No	YES	NO	ONCE	FEW	MANY
(a) Slapped you or thrown something at you that could hurt you?							
(b) Pushed or shoved you?							
(c) Hit you with his fist or with something else that could hurt you?							
(d) Kicked, dragged, beat you up?							

(e) Choked or burned you on purpose?							
(f) Threatened to use or actually used a gun, knife or other weapon against you?							

Q3. SEXUAL IPV QUESTIONS

	A. Has your current partner/ husband / boyfriend ever done any of the following things		B. In the last 12 months has you partner done any of the following? (If YES, ask C. If NO, proceed to Q4)		C. In the past 12 months would you say this has happened once, a few times or many times?		
	Yes	No	YES	NO	ONCE	FEW	MANY
(a) Physically forced you to have sexual intercourse when you did not want?							
(b) Did you ever have sexual intercourse you did not want because you were afraid of what he might do?							
(c) Forced you to do something sexual that you found degrading or humiliating?							

Q4. REPRODUCTIVE COERCION SCREENING QUESTIONS

1. Have you ever felt pressured or forced by your current partner/spouse or any other person to become pregnant when you do not want to be?							
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2. Does your partner support your decision about when or if you want to become pregnant?							
3. Are you worried your partner will hurt you if you do not do what he wants with the pregnancy?							
4. Has your current partner/spouse or any other person ever made it difficult for you to get or use Family Planning?							
5. Has your current partner/spouse or any other person ever influenced the type of Family Planning method you have to get or use?							
6. Has your current partner/spouse or any other person ever made it difficult for you to get any other RH service?							
1. Psychological violence: Yes.....No..... 2. Physical violence: Yes.....No..... 3. Sexual violence: Yes.....No..... 4. Reproductive Coercion: Yes.....No.....							



Activity: IPV Screening role play (40 Minutes)

STEP 1

Explain that all participants will be taking part in a role play exercise, and will need to get into groups of 3

- Ask participants to form groups of three
- Once groups are formed, explain that each person will get a chance to play three roles: provider, survivor, and observer. Using the **IPV Screening Tool**, the provider will conduct the actual screening by posing the IPV screening process. This process should take five minutes per turn.
- These observations can be written down and will be shared to the group in two minutes.
- Each participant in the groups of 3 should take turns playing each role – i.e., the role of provider, survivor, and observer.

STEP 2

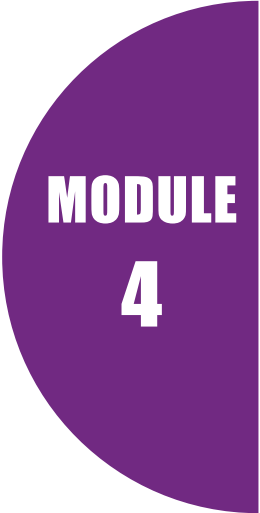
- Once participants have completed the above process, move the session back into plenary, and ask for any comments or observations anyone may have about the exercise.
- After preliminary comments and observations have been addressed, generate specific discussion on how participants felt playing each role.

Discuss and collaboratively address any issues related to:

- Discomfort in asking the questions, and the role of the preamble to the screening questions in reducing potential discomfort for providers and survivors alike
- Discomfort in being asked the questions, and what this means for provider attitudes and presentation of the questions
- Any other observations that observers and other role-players may have, such as areas of improvement for providers asking the questions; possible issues that could arise as a result of how survivors responded to the questions, and how these can be addressed; any issues concerning the translation of the screening questions into the local language (if applicable), etc.

Key messages

- Majority of IPV survivors may never report violence to anyone. It is therefore important that healthcare workers are able to identify them and offer support.
- Healthcare facilities can be a critical entry point for individuals experiencing violence and we need to know when and how to ask about violence
- There are five key minimum requirements when conducting IPV enquiry:
 - A protocol or standard operating procedure to guide the intervention
 - A standard set of questions to aid enquiry
 - Health providers trained on how to ask and respond to women who disclose
 - Ensured safety, with privacy and confidentiality considerations
 - A system for referrals to post violence services with providers aware of and knowledgeable about resources to refer women to.



**MODULE
4**

**FIRST LINE
SUPPORT, RISK
ASSESSMENT
AND SAFETY
PLANNING FOR
IPV SURVIVORS**

Introduction

First line support provides practical care and responds to a survivor's emotional, physical, safety and support needs, without intruding on their privacy. Often, first-line support is the most important care that the health care provider can offer. Even if this is all the HCP can do, they will have greatly helped the survivor.

During risk assessment, it may not be possible to eliminate the risk of violence completely. However, it is possible to enhance the survivor's safety, within their given situation. This involves assessing the survivor's immediate risks of violence, exploring options and available resources, and identifying concrete steps within their control to make them safer. Safety planning is part of the overall process of risk management, which aims at preventing violence by influencing risk factors and protective factors.

Module Purpose

This module is intended to equip health care providers with the necessary knowledge and skills required to care for survivors of IPV. It covers the first-line support given to IPV survivors using the LIVES approach which encompasses - provision of practical care and support, offering comfort and help, offering information, and helping the survivor connect to services and social supports.

Learning Outcomes

By the end of this module the participant should be able to:

1. Define first-line support and its rationale
2. Describe LIVES approach, its purpose in each step and techniques employed in first line support.
3. Define and conduct a survivors' risk assessment, safety planning, stating its rationale
4. State mental preparation and develop a practical checklist

Session Plan

TIME	TOPIC	LEARNING OUTCOMES	TEACHING METHODOLOGY	TEACHING AIDS/ MATERIALS
2hrs	First line support	Define first-line support and its rationale.	Facilitated discussion Brainstorming Role play	Laptop LCD projector Facilitator's guide Participant's manual Power-point slides Flip charts Markers Role play guides Case scenarios
	LIVES approach, its purpose in each step and techniques employed in first line support	Describe LIVES approach, its purpose in each step and techniques employed in first line support		
2hrs	Risk assessment and safety planning	Define and conduct a survivors' risk assessment, safety planning, stating its rationale.	Facilitated discussion Brainstorming Role play	

Unit Objectives

1. To define first line support and its goals
2. To describe the provision of first line support of IPV survivors using the LIVES approach and the purpose and techniques used in each step
3. To apply the LIVES approach in first line support of IPV survivors

First line support

First-line support refers to the minimum level of primarily psychological support and validation of their experience that all survivors who disclose violence to a health-care provider should receive. It helps survivors of violence or those who have been through various upsetting or stressful events to feel connected to others, calm and hopeful.

Its goals include:

- Identifying survivor needs and concerns
- Listening and validating survivor concerns and experiences
- Empowering survivors to be able to help themselves and to ask for help
- Exploring what the survivor's options are
- Respecting survivor's wishes
- Helping the survivor to find social, physical and emotional support
- Enhancing safety.

Remember: When you help the survivor to deal with their practical needs, it helps with their emotional needs.

When you help with their emotional needs, you strengthen their ability to deal with practical needs.

When providing first-line support, you do not need to:

- Solve problems
- Convince the survivor to leave a violent relationship
- Convince the survivor to go to any other services, such as police or the courts
- Ask detailed questions that force the survivor to reveal painful events
- Ask the survivor to analyse what happened or why
- Pressure the survivor to tell you their feelings and reactions to an event
- These actions could do more harm than good.

First line approach using the LIVES approach

First line approach involves 5 simple tasks. It responds to both emotional and practical needs at the same time. The letters in the word 'LIVES' can remind you of these 5 tasks that protect survivors' lives.



LIVES APPROACH TO FIRST-LINE SUPPORT

Listen: Listen to the survivor closely, with empathy, and without judging.

Inquire about needs and concerns: Assess and respond to the survivor's needs and concerns—emotional, physical, social and practical (e.g. childcare)

Validate: Show them that you understand and believe them. Assure them that they are not to blame.

Enhance safety: Discuss a plan to protect themselves from further harm if violence occurs again.

Support: Support them by helping connect to information, services and social support.

Listen

Purpose

To give the survivor a chance to say what she/he want to say in a safe and private place to a caring person who wants to help. This is important to their emotional recovery. Listening is the most important part of good communication and the basis of first-line support. It involves more than just hearing the survivor's words. It means:

- Being aware of the feelings behind their words
- Hearing both what the survivor says and what he/she does not say
- Paying attention to body language – both theirs and yours – including facial expressions, eye contact, gestures
- Sitting or standing at the same level and close enough to the survivor to show concern and attention but not so close as to intrude
- Through empathy, showing understanding of how the survivor feels.

ACTIVE LISTENING DO'S AND DON'T'S

DO'S	DONT'S
<i>How you act</i>	
<ul style="list-style-type: none"> • Be patient and calm. • Let the survivor know you are listening; for example, nod your head or say "hmm..." 	<ul style="list-style-type: none"> • Don't pressure him or her to tell their story. • Don't look at your watch or speak too rapidly. • Don't answer the telephone, look at a computer or write.
<i>Your attitude</i>	
<ul style="list-style-type: none"> • Acknowledge how a survivor is feeling. • Let him or her tell their story at their own pace. 	<ul style="list-style-type: none"> • Don't judge what a survivor have or have not done, or how he/she is feeling. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived", or "Poor you". • Don't rush the survivor.

<i>What you say</i>	
<ul style="list-style-type: none"> • Give a survivor the opportunity to say what he/she want Ask, "How can we help you?" • Encourage the survivor to keep talking if he/she wishes. Ask, "Would you like to tell me more?" • Allow for silence. Give the survivor time to think. • Stay focused on the survivor experience and on offering them support. • Acknowledge what the survivors' want and respect his/her wishes 	<ul style="list-style-type: none"> • Don't assume that you know what is best for them • Don't interrupt. Wait until the survivor have finished before asking questions. • Don't try to finish the survivor's thoughts. • Don't tell him/her someone else's story or talk about your own troubles. • Don't think and act as if you must solve their problems for them.

Inquire about her/his needs and Concerns

Purpose

To learn what is most important for the survivor. Respect the survivor's wishes and respond to his/her needs. As you listen say about the survivors needs and concerns – and what he/she say but implies with words or body language. The survivors may let you know about **physical needs**, **emotional needs**, or **economic needs**, their **safety** concerns or the **social support** she/he needs. You can use the techniques below to help the survivors express what he/she needs and to be sure that you understand.

TECHNIQUES FOR INTERACTING	
Principles	Examples
Phrase your questions as invitations to speak.	"What would you like to talk about?"
Ask open-ended questions to encourage the survivors to talk instead of saying yes or no.	"How do you feel about that?"
Repeat or restate what the person says to check your understanding.	"You mentioned that you feel very frustrated."
Reflect the survivors' feelings.	"It sounds as if you are feeling angry about that..." "You seem upset."
Explore as needed.	"Could you tell me more about that?"
Ask for clarification if you don't understand.	"Can you explain that again, please?"

Help the survivors to identify and express his/her needs and concerns.	<p>"Is there anything that you need or are concerned about?"</p> <p>"It sounds like you may need a place to stay".</p> <p>"It sounds like you are worried about your children."</p>
Sum up what she/he has expressed.	"You seem to be saying that...."
<i>Some things to avoid</i>	
Don't ask leading questions, such as "I would imagine that made you feel upset, didn't it?"	
Don't ask "why" questions, such as "Why did you do that...?" They may sound accusing.	

Validate

Purpose

To let the survivors know that his/her feelings are normal, that it is safe to express them and that he/she has a right to live without violence and fear. Validating another's experience means letting the person know that you are listening attentively, that you understand what he/she is saying, and that you believe what the survivor say without judgment or conditions.

Important things that you can say

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

Helping survivors cope with negative feelings

THE FEELING	SOME WAYS TO RESPOND
Hopelessness	"Many survivors manage to improve their situation. Over time you will likely see that there is hope."
Despair	Focus on survivors' strengths and how he/she has been able to handle a past dangerous or difficult situation.

Powerlessness/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 honour 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 at the 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."

Enhance Safety and Support

Purpose

To help a survivor, assess their situation and make a plan for their future safety. Many survivors who have been subjected to violence have fears about their safety. Others may not think they need a safety plan because they do not expect that the violence will happen again. Explain that partner violence is not likely to stop on its own: It tends to continue and may over time become worse and happen more often. Assessing and planning for safety is an ongoing process – it is not just a one-time conversation. You can help the survivor by discussing their particular needs and situation and exploring their options and resources each time you see them.



GUIDING QUESTIONS FOR DISCUSSION IN PLENARY (30 MINUTES)

- After about 45 minutes, facilitate a plenary discussion for groups to debrief on their experiences (30 min).
- How did you as patients feel about being asked about violence?
 - Probe: Did you disclose abuse? Why or why not?
 - Probe: How did you feel when you disclosed?

- How did you feel as health workers asking about violence and offering LIV:
 - Probe: What made you suspicious about the possibility of violence?
 - Probe: Did you hesitate about asking – if so why?
 - Probe: How did you feel if and when she/he disclosed her experience of violence or if she/he did not disclose?
- How did you as observers feel about what was going on:
 - Probe: how was the verbal and non-verbal communication, how did health workers communicate or not communicate support
 - What did you notice about the survivors' willingness to disclose their experience of violence – did they hesitate, or not?
 - What could the health worker have done better in the situation?

Key Messages

- First line support is about active listening, empathetic response, letting the survivor's needs determine what solutions or options are discussed.
- Health care providers have an important role of providing information and building trust through effective communication even if the survivor does not disclose abuse
- Effective listening even when the survivor is crying is an important support and helps overcome provider concerns about identifying and responding to violence.

Unit Objectives

- (a) To describe risk assessment and safety planning.
- (b) To state the rationale of risk assessment and safety planning.
- (c) To describe the process of conducting risk assessment and make a safety plan with an IPV survivor.

Risk Assessment

Risk assessment and management is an ongoing dynamic process of information gathering, formulation, and decision making that takes place in the context of a therapeutic relationship between healthcare provider and service users and their families, and requires appropriate support from clinical teams, service management, and policy makers.

Assessing immediate risk of intimate partner violence

Some survivors will know when they are in immediate danger and are afraid to go home. If one is worried about his/her safety, it is important to believe them. There are specific questions you can ask to see if it is safe to return to his/her home. It is important to find out if there is an immediate safety concerns.

Questions to assess immediate risk of violence

Survivors who answer “yes” to any the following questions may be at high immediate risk of violence.

- Has the physical violence happened more often or gotten worse over the past 6 months?
- Has he/she ever used a weapon or threatened you with a weapon?
- Has he/she ever tried to strangle you?
- Do you believe he/she could kill you?
- Has he ever beaten you when you were pregnant?

If it is not safe for the survivor to return home, make appropriate referrals for shelter or safehousing, or work with her to identify a safe place she/he can go to (such as a friend's home or church).

What to do when a survivor confirms high immediate risk

- Below are some of the statements that can be used during risk assessment and there seems to be immediate high risk, then you can say
 - “I'm concerned about your safety. Let's discuss what to do so you won't be harmed.”
 - “You can consider options such as contacting the police”.
- Discuss with the survivor how to stay safer at home without putting themselves and their children at more risk of violence.
- Avoid putting the survivor at risk Discuss about abuse with the survivor in privacy.

- Avoid having children overhearing your conversation. If the survivor is accompanied by the children, you can ask a colleague to look after them while in session. Do not discuss the survivor issues in the presence of their partner/spouse or other family members, friends or anyone else who has accompanied them. You can politely excuse yourself to address the survivor privately. You may need to think of an excuse to be able to see the survivor alone.
- Remember to maintain the confidentiality of the survivor's health records. Keep such documents in a safe place, not out on a desk or anywhere else that any unauthorized persons can access them. Explore with the survivor how they will explain where they have been. If they must take paperwork with them e.g. (for the police), discuss how they will handle it.

Safety Planning

Safety planning is an **active client led process** in which you help them identify their own strengths and resources. Safety planning seeks to improve the survivor's well being. All survivors could benefit from having a safety plan. Clients are the expert on their situation and may have ideas or know best on how to keep themselves safe. If the survivor has a plan, he/she will be better able to deal with the situation if violence suddenly occurs.

The following are elements of a safety plan and questions you can ask survivors to help them make a plan.

Safety Planning	
Safe place to go	If you need to leave your home or the room in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbour, a family member, friend, or trusted person you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

Possible resources

Find out what support and resources are available to the survivor in the community. It can help if you have a personal contact to send them at each place.

- Helpline
- Support groups
- Crisis or Gender based Violence Recovery Centre
- Safe spaces and shelter
- Legal support
- Mental health care, Counselling services, Psychological care
- Social worker services
- Child welfare services
- Spiritual care
- Law enforcement services

It may not be possible to deal with all the survivor/s concerns at the first meeting. Let the survivors know that the health care provider is available to meet again to talk about other issues. The health care provider should not expect the survivor to make decisions immediately. It may seem frustrating if the survivor does not seem to be taking steps to change her/his situation. However, the survivor may need to take their time and do what they think is right for them. The health care provider must always respect the survivor/s wishes and decisions.



Activity: Conducting a Risk Assessment a Safety Planning (45 Minutes)

Objective:

- To practice skills on how to conduct a risk assessment and support survivors to make safety plans

Instructions

- Ask participants to form groups of 3 (You can suggest that they can go back to the same group that they had formed earlier for the role play on first-line support).
- Ask one person in the group to volunteer to play the role of a patient/survivor, another to play role of health care provider and a third to be the observer who will provide feedback to the other two.
- Hand out the scenarios (**Participant Handout: Role Play First Line Support (ES) Scenarios**) in Annex V) giving the patient scenario to the survivor, the health care provider one to the person playing the health care provider and the feedback instructions to the observer
- Ask each person to read their scenario/guidance
- The *patient* should disclose the history of violence as per the scenario.

- The *Health Care Provider's* job is to ask relevant questions and provide an empathetic response and treat the illness for which the patient is seeking care. The healthcare provider then has to broach the issue of safety with the patient and assess whether she/he is likely to be safe in their situation (use the safety assessment questions in the participant manual) and if needed help them make a safety plan (using guidance from manual).
- The *Observer's* role is to read and be familiar with the pages in the manual relevant to the risk assessment and provision of social support and provide feedback to the health care provider on their approach to the 'Enhance safety and Social Support (ES)' steps of LIVES.
- After 10 minutes of doing the role play, the observer should stop them. The patient should discuss with their group how she/he felt talking to the provider. The health care provider should be asked to reflect on what he or she can improve on with respect to enhancing safety and providing social support (ES) steps of LIVES. The observer should be asked to provide constructive suggestions on what the health care provider can do differently in relation to performing the ES steps of LIVES.
- Then ask the group of 3 to switch roles so that each person in the group gets to play the health worker, observer and patient at least once and can practice skills in enhancing safety and providing social support.

**Adapted from WHO Training on VAW 2018*




GUIDING QUESTIONS FOR DISCUSSION IN PLENARY (30 MINUTES)

- After about 45 minutes, facilitate a plenary discussion for groups to debrief on their experiences
- How did you as a survivor feel about the safety assessment?
- How did you feel as health care provider doing safety assessment and providing social support?
- How you did as observers feel about what was going on?
 - Probe: How did the health care provider perform with respect to providing warm referral
 - What did you notice about the survivor's willingness to take up the referrals being made?
 - What could the health care provider have done better in the situation?

Key messages

- Assessing for risks and safety planning is an ongoing process.
- Helping a survivor with safety concerns requires providers to discuss the survivors needs and situations and exploring their options and available resources.
- Regardless of whether the survivors are facing serious immediate risk or not, it may help them to have a plan for safety in case an emergency situation arises.
- Prior collaborations and networking with organizations that the survivors are referred to can be helpful.



**MODULE
5**

**PSYCHOSOCIAL
SUPPORT AND
COUNSELLING**

Introduction

Counselling is both a relationship and opportunity to enable a survivor explore a personal problem and for the counsellor to offer an understanding of the personal meaning of his/her experience. This encounter gives the survivor increased awareness of the choices they have in dealing with the problem and further assists them to make an informed decision in dealing with their problem. The aim of counselling is to enable change in relation to the survivors past, present and future.

For successful counselling to occur there needs to be a survivor, counsellor, an organized counselling session, content of counselling and a sort of plan going forward. Counselling can either be an individual or group counselling

Psychosocial support is a process of facilitating resilience within individuals, families and communities [enabling individuals and families to bounce back from the impact of crises and helping them to deal with such events in the future. Health care providers' needs are as important as those of the clients. One may have strong reactions or emotions when listening to or talking about violence. This is especially true if the health care provider has experienced abuse or violence – or is experiencing it now

Purpose of the Module

The purpose of this module is give the participants an overview on psychosocial trauma counselling and introduce them to IPV counselling. It aims at enhancing the knowledge and skills of the providers in psychosocial support of IPV survivors. The module addresses various psychosocial interventions employed in care of IPV survivors and providers support in IPV survivors care.

Learning Outcomes

By the end of this module the participants will be able to:

- Describe counselling for IPV survivors
- Discuss provision of psychosocial support
- Describe the process of individual counselling
- Discuss the stages of group counselling
- Apply the counselling skills and techniques learnt
- Describe the care for caregivers

Session Plan

TIME	UNIT	LEARNING OUTCOME	METHODOLOGY	TEACHING AIDS/ MATERIALS
40 min	Counselling of IPV survivors	Discuss counselling of IPV survivors	Brainstorming Facilitated Discussion	Laptop LCD projector Power-point slides Flip charts Markers Job-aids

40 min	Provision of psychosocial support	Discuss provision of psychosocial support	Brainstorming Facilitated Discussion Group activity	
1hr	The process of individual counselling	Describe the process of individual counselling	Facilitated discussion, Demonstration Role play	
1hr	Stages of group counselling	Discuss the stages of group counselling	Facilitated discussion Role play	
40 min	Care for care-givers	Describe the care for care-givers	Facilitated discussion Group activity	



Facilitator's instructions

1. Introduce the unit and the unit objectives
2. Ask participants to brainstorm about the purpose of counselling
3. Introduce counselling, discuss fundamental principles and ethical guidance for counsellors
4. Brainstorm and discuss basic skills of counselling
5. Summarize the unit and the key take away messages

Unit Objectives

1. To review the definition counselling and its purpose
2. To review the fundamental principles of counselling
3. To review the ethical guidance for counsellors
4. To outline the basic skills of counselling

The aim of a counselling session is to enable change by making an informed decision in dealing with their problem through;

- Understanding their situation more clearly
- Identifying a range of options for improving the situation
- Making choices which fit their values, feelings and needs
- Making their own decisions and act on them
- Coping better with their issues
- Developing life skills such as being able to talk about sex with a partner
- Providing support for others while preserving their own strength.

An IPV survivor would present to a counsellor either through health care provider, self or third party referral, spontaneously during an unrelated event. The health care provider then needs to have the awareness that a counselling session may be initiated in different ways. When this happens, the provider must have at hand the basic skills, techniques and tools that would support counselling.

Fundamental Principles of Counselling

The fundamental principles provide standards on quality of services, quality of training and the duty of protecting their survivors. These principles of counselling are: Autonomy, Beneficence, Non-Maleficence and Justice or Fairness.

Autonomy – Right of survivors to make decisions on their own behalf

- (a) Respect the survivor's right to be self-governing. Avoid manipulating a survivor against their will for any socially beneficial ends.
- (b) Seek Informed consent/assent and allow the survivor to participate in the counselling on a voluntary basis.
- (c) Informing survivors on the goals of counselling, techniques, procedures, possible risks and other factors that can affect decisions to begin therapy.

Beneficence – Acting in the best interests of the survivor

- (a) Provide service based on training and experience in assessment and interventions
- (b) Willingness of a counsellor to seek consultation is a sign of professional maturity and is in the best interest of the survivor
- (c) Be aware of your limits in handling survivor needs, seek supervision and refer where appropriate.
- (d) Keeps information shared confidential and its consequences.
- (e) Keep your knowledge up to date through continuous education.

Non Maleficence – Avoiding harm to the survivor

- (a) Avoid sexual, financial and emotional or any form of exploitation
- (b) Do not accept any payment, help or aid from a survivor
- (c) Do not exploit the weaker dependent vulnerable position of the survivor.
- (d) Be aware of your own values, attitudes and belief system and how they impact on your relationships with survivors.

Justice or Fairness – To be impartial and give adequate services to all

- (a) Take note that counselling is an interaction between persons from different cultural backgrounds. Avoid discrimination based on a survivor's social or personal characteristics.
- (b) Respect human rights and dignity of the survivor.

Ethical Guidelines for Counsellors

Counsellors need to be aware of what their own needs are, what they are getting from their work, and how their own behaviour and needs influence their survivors.

The following are the essential ethical guidelines for counsellors;

- Professional training and experience for the assessments and interventions.
- Being aware of their limits in handling survivors' needs, seek supervision and refer where appropriate
- Knowledge of the community resources and structures to enable them make appropriate solutions.
- Up-to-date knowledge and skills through continuous education
- Professionalism in regards to relationships with survivors that could be a threat to therapy.
- Skills on shared confidentiality and its consequences
- Awareness of their own values, attitudes and belief system and how they can impact on their relationships with survivors
- Skills on informing their survivors about the goals of counselling, techniques, procedures, possible risks associated with relationships, and any other factors that are likely to affect the survivor's decision to begin therapy.
- Ability to realize that they teach their survivors through setting examples.
- Counselling takes place in the context of the interaction of cultural backgrounds.
- Capacity to deal with ethical dilemmas, realizing that most ethical issues are complex and defy simple solutions.
- Willingness of a counsellor to seek consultation is a sign of professional maturity.

Basic Counselling Skills and Techniques

The following are the basic counselling skills and techniques:

- Attending skills
- Active listening
- Core condition – Unconditional Positive Regard (UPR), Congruency and Empathy
- Confidentiality
- Questioning skills
- Reflecting skills
- Mirroring skills
- Paraphrasing
- Immediacy
- Transference and counter transference
- Confrontation
- Challenging

Showing empathy

Empathy is the ability to experience life as the other person does by entering the world of their thoughts, feelings, emotions and meanings. Empathy is really important in a session as it generates greater levels of trust between the survivor and counsellor and higher levels of self-understanding and security for the survivor. Empathy is shown to survivors by matching facial expression, physical movement, affect vocal tone, inflection and energy level. Other ways to show empathy include; not interrupting the survivor, not dismissing the survivor's beliefs, not being judgmental and "not talking too much".

Remaining patient and calm

These are difficult and often deeply disturbing issues for the survivor and perhaps you as well. It is vitally important that you remain tranquil so that the survivor does not have to worry about you and can instead concentrate on herself. If it takes her awhile to explain the details, don't get frustrated— you may be the first person she's ever told about any of this. It is your responsibility to maintain self-control

Being sincere

Your survivor will be able to tell when you're being genuine and when you aren't.

Asking for clarification

If you are confused about something, ask for clarification as soon as possible, not only does this help you to understand better, but it also indicates to the survivor that you are listening

Asking open-ended questions

In the process of counselling the counsellor needs to talk to the survivor without pressuring her or indicating that she should be feeling, acting or thinking in a certain way. When a counsellor does this it creates a non-judgmental environment and fosters a feeling of safeness and respect. Use words like: when, where, what, who, which, how, and could. Try to avoid words like: is, are, and do.

Being okay with silence

Attentively listening to another person's messages without verbal response leaves responsibility for problems clearly with the person who "owns" it. Silent pauses allow time for both you and the survivor to process her thoughts and feelings. Don't overuse pauses, however as the survivor did come to talk.

Having good body language

Body language is the conscious or unconscious movement and posture through which attitudes and feelings are communicated. In a counselling session, there are two skills around body language that a counsellor needs to have; these are; watching their body language and picking up body language nonverbal cues from the survivor.

Counsellor Body language

It is advisable that a counsellor should maintain an open posture, sit squarely, leaning forward and maintaining eye contact. Be careful with eye contact as it can be interpreted as threatening or staring. In addition to eye contact, remember to ask before you touch and never assume that physical contact even in the form of a gentle touch or hug will be comforting to the victim. In the first few weeks of an assault many victims avoid even simple touch from those who they love and trust.

The Acronym **SOLER** is used to convey the key aspects of good body language

- S** - Sit squarely
- O** - Open posture
- L** - Lean forward
- E** - Eye contact
- R** - Relax

Survivor Body language

The body language expressed by the survivor is a valuable opportunity to augment listening skills. A general advice in listening is "listen to the said and unsaid". The unsaid can include the tone of voice, silence, murmuring and crying. Other signals one can watch out for include; facial gaze, proximity, is the survivor mirroring you, head movements, positions of arms and hand signals.

As a counsellor be sensitive to when a survivor is uncomfortable about a situation or subject and also listen for feeling words like angry, dejected or terrified etc. Be careful about extending counselling beyond when the survivor is comfortable to talk there is just so much you can do in one session.

Listening reflectively

A key skill in the counselling session that a counsellor needs to have is listening. Listening reflectively is very important because it is the foundation upon which problems can be identified and clarification sought. When you hear conflicting or contrasting feelings in the survivor, let her know that you detect them.

Tips for good reflective listening:

- Listen for feeling words like angry, dejected, terrified etc.
- Pay attention to non-verbal cues like tone of voice, silence, murmuring, and crying;
- Use as many different feeling words as you can

Often people are so caught up in their problems, that merely clarifying their feelings helps. Feeding back the survivor's own words for verification accomplishes a number of important things, such as:

- Retaining ownership of the problem for the survivor
- Making sure you and your survivor are on the same page as to what the situation is
- Showing that you are actually listening
- Helping the survivor to look at her situation from a removed, objective viewpoint

Summarizing/ Documentation of findings

A counselling session is incomplete if the counsellor is not able to document what they talked about in the session. Documentation is important as it keeps track of what was discussed however it should not be an obstacle to communication and confidentiality should be maintained.

During sessions it is also important to summarize conversations so as to prevent mere repetition, give the conversation direction and also move the patient forward when they are stuck.

Key messages

- Counselling is both a relationship and opportunity to enable a survivor explore a personal problem and the counsellor to offer an understanding of the personal meaning of his/her experience
- In counselling there needs to be a survivor, counsellor, an organized counselling session, content of counselling and a sort of plan going forward for successful counselling to occur.
- Some skills needed by a counsellor include (listening, Acceptance, Non-Judgmental, empathetic, ability not to be involved, ability to engage the survivor and provide safeness among others) during and out of the session.
- The fundamental principles of counselling are Autonomy, Beneficence, Non-Maleficence and Justice or Fairness.

Ethics is really important in guiding the counselling profession. The principles are: Empathy, Sincerity, Integrity, Resilience, Respect, Humility, Competence, Fairness, Wisdom, Courage



Facilitator's instructions

1. Introduce the unit and the specific objectives
2. Ask participants to brainstorm on what psychosocial support means
3. Define psychosocial support and its rationale
4. Discuss basic psychosocial support
5. Ask participants to brainstorm on mental health conditions associated with IPV
6. If time allows undertake the stress reduction activities in the activity box
7. Summarize the unit and the key take away messages

Unit Objectives

- (a) To define psychosocial support and its rationale
- (b) To describe the provision of basic psychosocial support
- (c) To list the mental health conditions associated with IPV
- (d) To discuss stress reduction activities and techniques

Basic Psychosocial Support

After intimate partner violence basic psychosocial support may be sufficient for the first 1–3 months, this is because in this period you want to focus on strengthening the survivor's positive coping methods, exploring the availability of social support while at the same time monitoring for severe mental health problems.

Basic psychosocial support involves;

- Offering first-line support at each meeting (see LIVES- Module on First Line Support)
- Helping strengthen the survivor's positive coping methods
- Exploring the availability of social support
- Making regular follow-up appointments for further support
- Teaching and demonstrating **stress reduction** exercises (*See activity on stress reduction techniques next page*).



Activity: Individual Counselling role play (45 Minutes)

Objective:

- To practice skills in how to carry out individual counselling using the counselling skills learnt in unit 1 and stages 1-4 of how to conduct individual counselling outlined in this unit.

Instructions

- Ask participants to form groups of 3 (You can suggest that they can go back to the same group that they had formed earlier for the role play on first-line support).
- Ask one person in the group to volunteer to play the role of a survivor, another to play role of health worker and a third to be the observer who will provide feedback to the other two.
- Hand out the patient scenarios (**Participant Handout: Role Play Individual Counselling Scenarios**) in Anne IX to the survivor,
- The *survivor* should disclose the history of violence as per the scenario.
- The *Health care provider's* job is to use the counselling skills learnt in this module and the questions in the steps to counselling to guide the session
- The *Observer's* role is to provide feedback to the health care provider on their approach and skills
- After 10 minutes of doing the role play, the observer should stop them. The survivor should discuss with her group how she felt talking to the provider. The health care provider should be asked to reflect on what he or she can improve on with respect to counselling about violence and the observer should be asked to provide constructive suggestions on what the health care provider can do differently in relation to counselling about violence.
- Then ask the group of 3 to switch roles so that each person in the group gets to play the health worker, observer and patient at least once and can practice skills in asking about violence, and performing first line support.
- After 45 minutes the facilitator should stop the exercise and return to plenary to discuss what was experienced and observed.

Helping strengthen the survivor's positive coping strategies

After a violent event the survivor may find it difficult to return to their normal routine. Encourage them to take small and simple steps. Talk to the survivor about their life and activities. Discuss and plan together.

Encourage them to:

- Build on their strengths and abilities. Ask the survivor to describe what is going well currently and how they have 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.
- Encourage them to return for a counselling visit if these suggestions are not helping.

Explore the availability of social support

Good social support is one of the most important protections for any survivor suffering from stress-related problems. When the survivors experience abuse or violence, they often feel cut off from normal social circles or are unable to connect with them. This may be because they lack energy or feel ashamed. You can ask:

- “When you are not feeling well, who do you like to be with?”
- “Who do you turn to for advice?”
- “Who do you feel most comfortable sharing your problems with?”

Note: Explain to the survivor that even if there is no one with whom they wish to share what has happened to them, they can still connect with family and friends. Spending time with people they enjoy can distract them from their distress.

Help them to identify past social activities or resources that may provide direct or indirect psychosocial support (for example, family gatherings, visits with neighbours, sports, community and religious activities). Encourage them to participate in these activities.

Collaborate with social workers, case managers or other trusted people in the community to connect the survivor with resources for social support such as:

- Community centres
- Self-help and support groups
- Income-generating activities and other vocational activities
- Formal/informal education

Mental Health Conditions Associated with IPV

Intimate partner violence can result into profound and long lasting consequences. These consequences can present in a variety of ways among the survivors and these may include psychological and social problems. Some of the problems could include and are not limited to;

- Depressed mood
- Anxiety
- Feelings of guilt and shame
- Increased risk of substance abuse
- Gastrointestinal problems due to stress
- High risk sexual behaviour
- Low self esteem
- Self-harm and suicide
- Inability to trust others
- Difficulty in maintaining a Job

Key messages

- Intimate partner violence can result into profound and long lasting consequences.
- Basic psychosocial support involves;
 - Offering first-line support at each meeting (see LIVES- Module on First Line Support)
 - Helping strengthen the survivor's positive coping methods
 - Exploring the availability of social support
 - Teaching and demonstrating stress reduction exercises
 - Making regular follow up appointments for further support.

**Facilitator's instructions**

1. Introduce the unit and the unit objectives
2. Ask participants to brainstorm about the stages when conducting individual counselling
3. Describe the stages in individual counselling
4. Conduct the role play in the activity box, and debrief the activity
5. Summarize the unit and the key take away messages

Unit objectives

- (a) To describe the stages in individual counselling
- (b) To practice conducting individual counselling

Individual Counselling

Individual counselling is a process through which clients work one-on-one with a professional counsellor in a safe, caring, and confidential environment. The following are the five main stages of individual counselling session. It is not advisable to resolve a survivor's case in one session. You should take your time with each survivor progressing at a slow and steady pace through their situation, and making sure they feel as much at ease as is possible. These stages are merely the skeleton of the progression of a counselling relationship.

1. Establishing Rapport

- Extend a friendly, culturally acceptable greeting. *"I'm glad you came to talk to me."*
- Recognize and respond to the survivor's feelings
- Convey caring and concern through your words, tone of voice, facial expressions, and body language
- Take your time easing into the problem to establish a solid base of trust and comfort
- Ask open-ended questions: *How are you feeling about this now?*
- Allow your survivor to talk about whatever they want. *Take your time. We can talk about anything you like.*
- Facilitate the flow of the conversation. *Would you like to talk about what happened?*

2. Inquiry and Clarification Definition

- Explore the nature of the problem
- Encourage the survivor to be specific and open
- Focus on how the survivor feels about what happened
- Discover what previous efforts the survivor has made to get help
- Paraphrase the survivor's answers and state them back to her e.g. *what I hear you saying is... I'm picking up that you... Could it be that...? Do you feel a little...? Correct me if I'm wrong, but... I'm not sure if I understand, do you mean that...?*

- Don't question the validity of the survivor's feelings, just accept them
- Assess the presence (or absence) of a support system. Have you told anyone else about this? What did they say when you told them?

3. Exploration of Alternatives

- Explore alternatives and resources.
- Don't rush in with advice, only suggest your ideas after the survivor has expressed their own. *What have you thought about doing? What ideas have you considered?*
- Don't push the survivor to take any action that they are not comfortable with
- Let the survivor take control of the process of planning and executing whatever solution you decide on
- Weigh the pros and cons of each

4. Termination

- Agree on a concrete plan of action to be completed before the next session
- Don't promise things you can't deliver
- Give an appointment or return date if possible
- Allow the survivor to give feedback of the counselling session
- Always ask if there is anything else that the survivor wants to talk about, often there is another problem that may be more serious, shameful, or embarrassing than the problem you have just spent your time discussing.

5. Post-Session (debriefing)

Being a counsellor is not necessarily an uplifting experience. Counselling can feel like a "thankless" job, and you may feel that you aren't really making an impact. One may also feel that they've failed if the survivor they are counselling doesn't succeed. As a counsellor, one should accept that their actions may not cause immediate change, but that every little bit one does makes a difference. It is very important that you take care of yourself as well as the survivor because it may lead to burnout.

Key messages

- There are 5 main stages in counselling i.e. establish rapport, clarification and reflection, exploration of alternatives, termination and debriefing
- Take time with each survivor progressing at a slow but steady pace through their situation
- As a counsellor you should accept that your actions may not cause immediate change

UNIT 4 GROUP COUNSELLING

1 Hours



Facilitator's instructions

1. Introduce the unit and the unit objectives
2. Define group counselling and their role
3. Discuss the formation and the facilitation of support groups and group dynamics
4. Summarize the unit and the key take away messages

Unit Objectives

- (a) To define group counselling
- (b) To state the role of group counselling
- (c) To describe the formation and facilitation of support groups
- (d) To explain group dynamics

Group Counselling

Group counselling is a form of therapy where people with similar experiences/issues come together with a professional counsellor. The counsellor runs the session, but generally everyone contributes in some way, listening to others and talking themselves.

One of the main principals behind group counselling is that meeting other people who are dealing with something similar and hearing their story lets people know that they are not alone. Intimate partner violence can be really isolating and make you feel like you are facing the world alone. Group counselling can be a good way of getting over those feelings of isolation, and realising there are other people in the same boat. It can also be easier to talk to people who share the same issue. They can understand how you feel more than family members or friends who have not had first-hand experience of the problem you are dealing with.

FORMATION OF SUPPORT GROUPS

Before initiating the support group, the counsellor should discuss and decide the following:

- **Profile of participants:** who is the group for?
- **Aim of the group:** the overall goal you intend to achieve by organizing the group.
- **Objectives of the group:** results that need to be achieved during group work in order to realize the aim.
- **Key learning points:** what information, skills and attitudes need to be acquired by group members in order to achieve the objectives?

Creating awareness about the support group

How the support group is promoted will depend on the participants. If the group is meant for users of your health facility only, and screening is provided through your regular service, promotion simply means providing accurate information to the survivors about the support group i.e. start date, venue, time of the meeting, duration, profile of prospective participants, and any other relevant parameters.

Facilitating The Support Group

There are several factors that should be considered when running the group. The following section lists some of the issues that will arise, and suggestions as to how you can deal with them.

Initial one-to-one session It is important to meet every survivor who is referred to the support group before it starts. This initial meeting is an opportunity to carry out a risk assessment, to talk about the group, and to discuss each person's expectations.

Confidentiality and data protection

Participants, facilitators and potentially the administrative staff of the organisation offering the support group will inevitably get to know certain sensitive information about participants of the group. Participants, facilitators and administrative staff all need to be clear about their rights and obligations regarding sensitive data and confidentiality. Ideally, such information should be provided as written guidelines to the staff, and that they become part of the written agreement or contract between the participant and the facilitator/organisation.

Complaints procedure

It is good practice to have a complaints procedure in place before the group starts. This will help deal with any problems that arise within the group, for example if the survivors have any complaints (e.g. about the venue or the facilitator). At the first session, the survivors must be made aware of the complaints reporting procedure.

Facilitator support

It is important that support mechanisms are in place for the facilitators. For example, it is good practice for the facilitators to have supervision sessions with a manager, who is in a position to advise and support. It is a good idea to create a network of facilitators, the network can then meet regularly as a space for trouble shooting, to discuss the support groups they run, share information and offer suggestions on how to improve, for example, funding, exercises or group work

Financing and infrastructural support: planning expenditure

It is recommended that you secure the sustainability of any project before you start. Not only is this good practice, but also it is important for the survivors to know that the group will be able to continue for the duration of the programme, and will not be interrupted by any financial burdens of your organization

Group Format

- The optimal size for group work is between six and fourteen people
- The frequency of meetings can vary according to the specific needs of members; however, once a week is optimal. Frequent meetings increase trust and mutual familiarity between members
- A total duration of three months for a support group gives enough time for personal development, without undue pressure

Group Rules

Norms and rules may be used in order to:

- Provide predictable group interaction
- Provide stability for a group and to support the main goals of group communication – trust, acceptance, and respect
- Outline patterns of communication and coordination
- Act as a guide to agreed behaviour, particularly if in written form. This may be useful if some participants violate agreed rules.
- At the beginning of the programme, it is important to explain that group rules are necessary, and that having process guidelines in place helps to facilitate group discussions.
- It is a useful and positive exercise to involve group members in the process of developing group regulations. By creating their own rules, participants are more motivated to follow them.

Basic process guidelines

The following are important points to cover, although each group can come up with additional rules.

- **Give everyone an opportunity to speak.** Each person should avoid dominating the discussion (including the facilitator/s).
- **Good listening is important.** We should hear what a person is saying before speaking. Don't interrupt others.
- **Speak from your own experience**
- **Be honest**
- **Value and validate others' differences and experiences**
- **Confidentiality.** All discussion and contributions are confidential – no personal information ever leaves the room without express consent/assent.
- **Arrive on time**
- **Attend regularly.** Members need to contact the facilitator if they are unable to attend a meeting; and if they have decided to leave the group for the time being they should try to come to one more session, or, if this is not possible, contact the facilitator to explain their reasons.

Group Dynamics

A support group can be one of the best ways to empower survivors of IPV. When support groups are meeting for a pre-determined period, there should be a starting phase, a phase of active participation, and a concluding phase.

Starting phase

In order for survivors to feel comfortable talking about their abuse and sharing their stories, there must be a sense of the group belonging together and of a mutual trust between members. Therefore, it is essential that this phase allows time for informal communication to enable positive personal contact between group members, e.g. ice-breakers and name-games.

The phase of active participation

During the phase of active participation, the group members usually perceive the group as an essential, or even an indispensable, part of their lives. However, it is important for a group to assess its 'health' periodically. In this context, a 'healthy' group would mean that meetings are stimulating and constructive, participants are motivated, co-operative and interested, and misunderstandings or problems are solvable.

Concluding phase

It is good practice to remind the members half way through the programme that the group will be coming to an end in the near future. Once the group starts approaching the end, it is important to prepare the members by incorporating discussions on closure within the last few sessions.

Key messages

- Group counselling is a form of therapy where people with similar experiences/ issues come together with a professional counsellor
- The group formed should have an objective and aim
- Confidentiality and data protection is important
- Groups should be guided by norms and rules
- Each group should have a starting, active and concluding phase

**Facilitator's instructions**

1. Introduce the unit and the unit objectives
2. Discuss the rationale for care for counsellors
3. Define burn-out and secondary trauma and discuss its manifestations
4. Ask the participants to brainstorm on how health providers can care for themselves
5. Outline the strategies of care for the caregivers
6. Conduct the care for caregivers activity in the activity box, and debrief the activity
7. Summarize the unit and the key take away messages.

Unit Objectives

- (a) To gain an understanding of burnout, compassion fatigue, and vicarious/secondary trauma
- (b) To understand the impact of vicarious trauma on the health and well being of health care providers
- (c) To identify signs and symptoms of distress
- (d) To identify strategies that can help health care providers cope with these stressors.

Rationale for Self-Care for Caregivers

Witnessing the incredible resilience of survivors of violence can be fulfilling. Frequently listening to the trauma of IPV survivors and empathizing with and caring for them can also take a toll on health care providers' health and wellbeing. This toll can be more pronounced if the provider is a survivor of violence or resources are insufficient to meet their needs. It is important to be able to recognize when work is negatively impacting the health of providers and take the steps to address it.

Burnout ("All I do is work, I don't have a life.")

This is as a prolonged response to chronic emotional and interpersonal stressors on the job which consists of three components:

- Exhaustion,
- Depersonalization (defined as: disengagement or detachment from the world around you) and
- Diminished feelings of self-efficacy in the workplace. It reflects a form of "energy depletion".

Burnout is associated with depression and secondary (vicarious) traumatization. It may arise from feeling either permanently overworked or under-challenged, being time-pressured, or having conflicts with colleagues. Over-commitment that leads people to neglect their own needs may also significantly contribute to burnout.

Secondary Trauma (“I feel hurt and afraid, too!”)

Secondary trauma (Vicarious Trauma) is defined as “*transformation in the inner experience of the health care provider that comes about as a result of empathic engagement with survivors’ traumatic material*”. This concept describes the reactions to the emotional demands on health care providers from exposure to trauma survivors’ terrifying, horrifying, and shocking images; strong, chaotic affect; and intrusive traumatic memories.

This term is often used interchangeably with Secondary Traumatic Stress (STS). Be aware of your emotional, cognitive, behavioural, biological and interpersonal responses to secondary trauma (Vicarious Trauma) and take the opportunity to understand yourself better. The table below describes the manifestations of secondary trauma experienced by health care providers.

Compassion Fatigue

This builds up over time, in which a provider can no longer emotionally respond to or handle a client’s needs. Providers experiencing compassion fatigue may experience symptoms, such as loss of productivity, depression, intrusive thoughts, jumpiness, tiredness, feelings of being on edge or trapped, or inability to separate personal and professional life. They stop experiencing compassion satisfaction and the positive emotions associated with helping others, such as happiness, pride and satisfaction.

Cognitive	Emotional	Behavioral	Spiritual	Interpersonal	Physical
<ul style="list-style-type: none"> • Diminished concentration • Confusion • Spaciness • Loss of meaning • Decreased self-esteem • Preoccupation with trauma • Trauma imagery • Apathy • Rigidity • Disorientation • Whirling thoughts • Thoughts of self-harm or harm toward others • Self-doubt • Perfectionism • Minimization 	<ul style="list-style-type: none"> • Powerlessness • Anxiety • Guilt • Survivor guilt • Shutdown • Numbness • Fear • Helplessness • Sadness • Depression • Hypersensitivity • Emotional roller coaster • Overwhelmed • Depleted 	<ul style="list-style-type: none"> • Clingy • Impatient • Irritable • Withdrawn • Moody • Regression • Sleep disturbances • Appetite changes • Nightmares • Hyper vigilance • Elevated startle response • Use of negative coping (smoking, alcohol or other substance misuse) • Accident proneness • Losing things • Self-harm behaviours 	<ul style="list-style-type: none"> • Questioning the meaning of life • Loss of purpose • Lack of self satisfaction • Pervasive hopelessness • Ennui • Anger at God • Questioning of prior religious beliefs 	<ul style="list-style-type: none"> • Withdrawn • Decreased interest in intimacy or sex • Mistrust • Isolation from friends • Impact on parenting (protectiveness, concern about aggression) • Projection of anger or blame • Intolerance • Loneliness 	<ul style="list-style-type: none"> • Shock • Swearing • Rapid heartbeat • Breathing difficulties • Somatic reactions • Aches and pains • Dizziness • Impaired immune system

Figure 5: The manifestations of secondary trauma experienced by health care providers.

Strategies for Self-Care

The following are methods that counsellors can use to care for themselves:

Personal therapy

Counsellors should see a counsellor for personal issues to address secondary trauma on monthly basis

Self-care

The care giver should routinely use the following self-care tips to prevent secondary stress:

- Be aware of their emotional reactions and distress when confronting others' traumatic experiences, and know what traumatic material may trigger them.
- Connect with others by talking about their reactions with trusted colleagues or others who will listen.
- Maintain a balance between their professional and personal lives, with a focus on self-care (e.g., relaxation, exercise, stress management, spiritual care etc.) to prevent, and lessen the effects of workplace stress.

Counsellor support supervision

This is a facilitative approach of supervision that promotes mentorship, joint problem solving and communication between supervisors and supervisees. Supervision also enables health care provider to develop their skills and knowledge on an ongoing basis with a focus to ensuring effective delivery of services to IPV survivors. Ongoing professional supervision is crucial to developing health care providers' case management skills, as well as preventing vicarious traumatization and burnout. This is conducted for individual or group therapy for service providers facilitated by a professional supervisor.

Debriefing (Critical incidence debriefing)

This is emotional-first aid for those who have experienced a traumatic, emotionally upsetting or stressful experience. Its goals are to discuss the actions and thought processes involved in dealing with IPV, encourage reflection on those actions and thought processes, and incorporate improvement into future performance. The function of debriefing is to identify aspects of team performance that went well, and those that did not.



Activity: Skit on safety and self-care (30 Minutes)

1. Divide the participants into groups of 3
2. Ask one person in the group to volunteer to play the role of the survivor, another to play role of health worker and a third to be the observer
3. Give each group 2 different scenarios from **Annex X: Care for Caregivers Case Scenarios**. Ask the participants to focus on what they feel or think.
4. Stop the skit after five minutes and ask the participants to reflect with the small group on the skit:
 - What did you feel when the woman told her story? Did it make you angry, afraid, happy, sad?
 - What was the first thing you wanted to do after hearing it?
 - In which way did the responses of the 'health worker' influence the interaction with the survivor?
 - For scene 2, how did the presence of the husband influence your feelings?
5. Discuss for 10 minutes and let them switch roles and play the other skit and to discuss them afterwards.

Large group discussion (45 min)

1. Draw the dummy-table like the one below on a flipchart

Emotion	Emotional Response	What can you do
Eg. Overwhelmed	<ul style="list-style-type: none">• By lack of options and resources for survivors.• By hearing too many painful, scary stories.• By anxiety because you cannot control survivor's fate.• By anxiety because survivor's safety is questionable.	<ul style="list-style-type: none">• Establish realistic goals.• Determine your own limits• Talk about it!• Check expectations for yourself and for survivors• Use support networks

2. Discuss with the participants which kind of emotions/feelings/thoughts e.g fear/denial/etc. they experience when working with people who experience violence and to be specific.
3. After listing the different emotions/feelings of the different sorts of fear, discuss what a health care worker could do to cope with these emotions. Encourage the participants to come with 'practical' solutions, like 'talk with someone' or 'check expectations of survivor.
4. Fill in all the columns and add any other emotions that come across
5. Ask one of the participants to summarize briefly what you've discussed and let each participant mention one intervention that he/she wants to remember and use in their own consultations.

Key messages

- Counsellors also get burn out and need to be taken care of
- Modalities for self care for health service providers
 - Personal therapy
 - Self-care
 - Counsellor support supervision
 - Debriefing (Critical incidence debriefing)



MODULE

6

**REFERRAL
LINKAGES AND
COORDINATION
IN IPV
RESPONSE**

Introduction

Services offered to survivors need to be well planned, coordinated and monitored to help support and manage the survivor adequately. In the event of some services not being available there should be a clearly defined protocol for the referral and linkages to be done. As a long-term measure there is need to involve individuals identify some of the preventive strategies they can apply for their safe being.

Purpose of the Module

This module is intended to equip the health Care provider with knowledge and skills in identifying and developing a process flow map for facility level referrals which may include referrals to other health professionals for specialized services. In addition, the participants will learn to identify and develop multi sectoral linkages and referrals for IPV survivors.

Learning Outcomes

By the end of this module the participants should be able to:

1. Describe the IPV referral process
2. Identify appropriate support services and referral mechanisms
3. Create a context-specific referral directory and flow map
4. Identify the coordination of IPV services at facility and community level

Session Plan

Time	Unit	Learning outcome	Teaching methodology	TEACHING AIDS/ MATERIALS
30 mins	Referral process for an IPV survivor	Describe the referral process for an IPV survivor	Facilitated discussion Illustrated lecture	Laptop LCD projector Facilitator's guide Participant's manual Power-point slides Flip charts Markers Job-aids Coordination and referral Character cards
30 min	Appropriate support services and referral mechanisms	Identify appropriate support services and referral mechanisms	Facilitated discussion	
1 hr	Creating a referral directory and flow map	Create a context-specific referral directory and flow map	Group work Facilitated discussion	
30 min	Coordination of IPV services at facility and community level	Identify the coordination of IPV services at facility and community level	Facilitated discussion	

UNIT 1 INTIMATE PARTNER VIOLENCE REFERRAL

1 Hour 30Min



Facilitator's instructions

1. Introduce the unit and the unit objectives.
2. Discuss the definition of referral
3. Conduct the group activity: Coordination and referrals in the activity box
4. Reconvene the plenary and discuss the activity using the guiding questions in the facilitator box
5. Discuss the take away messages on the activity.

Unit Objectives

1. To explain referral and its purpose
2. To discuss IPV survivor's experience as they seek support, through a group activity

Referral Process and its Purpose

Referral is the process by which survivor's immediate needs for care, prevention, and supportive services are assessed, prioritized and the survivor is provided with assistance in accessing the necessary services. Referral helps IPV survivors' access better services in a timely manner and can improve the survivors' outcome/recovery, can aid in psychological and emotional support, diagnosis, treatment, forensic medical investigation and evidence management and specialized care.

Health care providers are often the first point of contact for survivors of IPV as they are well positioned to identify IPV and provide the survivors with first line support medical care, and also to refer them to other necessary services. This may include referrals to other health care providers within the same or at another health care facility, for example, referring to mental health care providers or HIV specialists, reproductive health services and referrals to other services, such as shelters or organizations providing psychosocial or legal counselling. In turn, health care providers may also receive referrals of survivors, for instance from police, shelters or other health care professionals.

Objective

- To highlight the importance of having a survivor-centered referral pathway that minimizes trauma
- To develop an appropriate referral pathway that keeps the survivors needs at the centre.

Instructions

- Prepare character cards for the 10 different roles with instructions written on the front and back (**Annex XI: Participant Handout: Coordination and Referrals**).
- Get adequate space and ask the participants to form a group -if more than 15-20 they can form 2 groups.

- In each group ask 9 volunteers to come to the front and form a circle. Ask the 10th volunteer to be in the centre to play the role of a violence survivor. Ask the rest to be outside the circle and to observe the situation.
- Give each volunteer in the circle a character card with instructions at the bottom as to what they are supposed to do
- The survivor is called Rose and is given a description of her situation
- Read out Rose's story to the group. Rose is a 28-year-old woman who has been experiencing physical and sexual abuse from her boyfriend for the last 6 months. She does not know what to do so she first approaches her sister asking for help. Ask Rose to enact her character and approach her sister. Give Rose a ball of red thread and ask her to keep the ball with her and give one end of it to her sister
- Ask the sister to respond to Rose as per instructions at bottom and then keep the other end of the red thread with her. Thereafter each character should be asked to enact their role as per their card and read the instructions on assigned card and respond to Rose. Each time, Rose should keep the ball of red thread with her, but give one end of the string to whoever she interacts with.
 1. Rose (You are a 28-year-old woman who has been experiencing physical and sexual abuse from her boyfriend for the last 6 months. You don't know what to do)
 2. Sister (send woman to the Community/religious Leader)
 3. Community/religious Leader (send Rose to the Women's Group for support)
 4. Women's Group (Send Rose to the doctor/clinic for health care)
 5. Doctor/Clinic #1 (Send Rose to Police #1 for official medical reporting form)
 6. Police #1 (Send Rose back to doctor/clinic #2; explain that no charges can be filed without medical proof)
 7. Doctor/Clinic #2 (Send Rose back to police with medical proof)
 8. Police #2 (Send Rose to legal aid services)
 9. Legal aid lawyer (On the bottom of the card: ask her to tell her story, review her document, prepare the case and ask her to practice telling her story in court again)
 10. Court (Ask Rose to re-tell her story at court)
- By the end of the story, Rose has re-told her story to multiple people and should be standing in the middle of a tangled web of red thread.



GUIDING QUESTIONS FOR DISCUSSION IN PLENARY

Reconvene in Plenary and ask the group to reflect on the following questions (30 minutes).

- Ask Rose, how did this she feel repeating her story multiple times?
- Ask those who played the other characters: How many times did you talk with Rose or with others about her?- Do they remember the details?
- Ask the observers: How many times did Rose have to repeat her story?
- What did they see in the middle of this circle?

Ask the whole group:

- Is this situation realistic or reflecting what happens in your setting?
- What could have been done to avoid making this web of string?
- What steps can be taken to minimize the need for the woman to repeat her story multiple times?

Key messages

- Survivors needs are usually beyond what can be provided in the health care set up; it is important to ask the survivor what is/are the most important needs
- Support can come from multiple sources – both formal (health, security, social welfare) and community / informal
- Always keep the survivor's best interests first – think safeguarding during referral, limit risk of further violence occurrence or re-traumatization
- Recognize that it is difficult for survivors to always follow up on referrals that are given.

**Facilitator's instructions**

1. Introduce the unit and the unit objectives.
2. Ask participants to brainstorm on:
3. Why should IPV survivors be referred?
4. When should IPV survivors be referred?
5. How should IPV survivors be referred?
6. Define a referral system
7. Discuss the content in the manual on making referrals, an effective referral process and facility and community level coordination
8. Summarize the unit.

Unit Objectives

1. To explain the rationale for a referral system in IPV response
2. To explain when, why, how IPV survivors should be referred
3. To understand the wide range of formal and informal actors who play a role in referrals
4. To describe an effective referral process for IPV survivor
5. To discuss facility and community level coordination

Definition of a Referral System

A referral system is a mechanism that enables a patient's health needs to be comprehensively managed using resources beyond those available at the location they access care from, be it in a community unit, dispensary, health centre or a higher level health facility.

An Effective Referral Process

An effective referral process requires that the health care providers and the other multisectoral actors who provide IPV services are expected to be:

- Readily available;
- Express caring and reassurance, and uphold the survivor's privacy and confidentiality;
- Able to recognize IPV and provide first line support and response services
- Able to facilitate the disclosure of IPV
- Able to assess the survivor's situation, needs and risks. If there is a high risk, the survivor requires immediate crisis intervention, such as immediate medical or psychological support and/or access to a shelter. If the assessed risk is not high, referrals to other social, psychological or legal support might be appropriate.
- Are knowledgeable about national laws that are related to domestic violence (IPV is a form of domestic violence) including definitions of relevant criminal offences, about available protection measures and any reporting obligations on their part. This knowledge is required only to the extent of relevant professional obligations.
- Be suitably trained on communication skills when dealing with the survivors;

Principles of an effective referral system

- Have one lead 'case manager' responsible for following the referral through
- Be clear why you are making the referral, and to whom, and for what
- Be sure that the required support can be provided at the referral point
- Ensure that the survivor knows why and agrees to the referral being made
- Only refer to places that the client can get to
- Always get consent from the client before making the referral
- Always obtain the consent of the survivor before sharing information about their case with other agencies or health care providers and follow the procedure that protects the survivor's confidentiality.
- If possible, have a referral or case management information system, that can confirm the referral has been made and track onward and counter-referrals

Making Effective Referrals

- 1. Knowing when to refer.** Health care providers need to be clear about the limitations of the service they can provide, as well as being aware of their own assumptions and personal limitations. Service providers also need to know what to do in terms of the procedures they are required to follow in their capacity. Sometimes referral is needed when there is a concern for the welfare of the person.
- 2. Knowing the reason for referral.** A referral process enables an IPV survivor to receive comprehensive services from different people who have different skills. This could be to access to specialized services, like medical services, assessment of injuries or check for sexually transmitted infections, legal services etc. Typically, a well-coordinated referral process can reduce stress and workload for individual service providers.
- 3. Knowing how to make a referral.** The health care provider should ensure the following:
 - Observe the four principles of the survivor-centred approach. Always prioritise the privacy, confidentiality and security of survivors. Reduce the risk of exposing survivor-provider relationship
 - Be sure that the referral addresses the survivor's (most important) needs or concerns. If the survivor expresses problems with going for a referral for any reason, think creatively with them about solutions. Problems you might discuss:
 - No one to leave the children with.
 - The partner might find out and try to prevent it.
 - The survivor doesn't have transport.
 - Provide a 'warm referral'. Often survivors do not follow up on referrals from health-care providers. You can help make it more likely that the survivor gets the help that you have recommended.


Tips on making 'Warm Referrals'


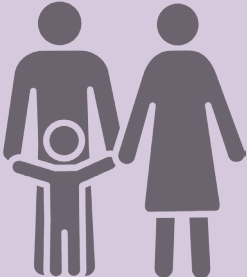

- Inform the person what you are planning to do and get their informed consent
- Call ahead to sensitize the service organization to the future referral
- If the survivor accepts a referral, here are some things you can do to make it easier for them:
 - Tell the survivor about the service (location, how to get there, who they will see).



- Offer to call to make an appointment for them if this would be of help (for example, they do not have a phone or a safe place to make a call).
- If the survivor wants it, provide the written information that the survivor needs – time, location, how to get there, name of person they may / will see. Ask the survivor to think how they will make sure that no one else sees the referral note.
- If possible, accompany the survivor to the referral point or alternatively arrange for a trusted person to accompany them on the first appointment.
- Always check to see if there are any questions or concerns and to be sure that they have understood.
- It is important for the survivor to know they can always request to have a chapter one or their preferred gender of health care worker to attend to them if available.

4. Know where to refer a survivor

- Ideally refer clients to services or support within a reasonable distance and provide options for the services you are referring to
- Have a referral directory - list of local organizations, agencies and networks is essential.
- There's need to adhere to SOPs for multi-sectoral / disciplinary coordination and referrals or mechanisms for coordination across the various sectors, with a focal person in each
- Check with co-workers and networks in the region to find out if there are any other options of service providers.
- Check what community support systems are available.
- Establish mechanisms for easy networking and consultation

Service Provider	Key Roles
<p data-bbox="145 1205 299 1262">Health care providers</p> 	<ul style="list-style-type: none"> • Examination and history taking & appropriate treatment • Provides appropriate counseling • Completes PRC forms and other documentation • Collection of forensic evidence / exhibit • Preserve and maintain chain of custody of evidence • Forensic laboratory investigations • Treatment of injuries • Referrals of survivors to police • Expert witness in court

<p>Police</p> 	<ul style="list-style-type: none"> • Recording incident in the OB and issuance of OB number • Writing of statement • Issuing P3 forms – including request for medical examination • Collect duly filled copies of PRC (original PRC copy) • Escorting the survivor and suspects to the hospital for medical examination • Refer survivors for further requisite services • Provide security for suspects admitted in hospital • Bond medical personnel to testify in court • Collecting the evidence from the hospital • Maintain proper chain of custody of exhibits • Apprehending the suspect • Conducting investigations • Protecting the crime scene • Preserving the evidence and exhibits, and their presentation in court • Notifying the survivor, witness and health provider on the scheduled court proceedings
<p>Department of Children's Services</p> 	<ul style="list-style-type: none"> • Rescuing children from environment that is propagating GBV • Recommending rescued children to be sent to shelters/ rescue homes • Supervising the welfare of rescued children • Recommending child offenders to Borstal institutions • Provide psychosocial support to child survivors • Support judicial process by providing social enquiry report
<p>Safe Shelters/ Rescue Homes (actors)</p> 	<ul style="list-style-type: none"> • Providing shelter to survivors • Providing counseling to survivors • Providing social support – education, income generating activities, • Facilitating adoption of children born due to rape

<p>Government administrators (Chief, asst. chief, Village elders)</p> 	<ul style="list-style-type: none"> • Creating awareness on SGBV and facilitate forwarding of exhibits and evidence to the police • Arresting the accused perpetrator • Referring /escorting the survivor to the service delivery points • Recommending cases for rescue i.e. shelters • Supporting the police in investigations • Respect the rights of the clients (survivor and suspect)
<p>Paralegals</p> 	<ul style="list-style-type: none"> • Interview survivors and other relevant persons in order to collect relevant information on the GBV cases, • Organize and/or evaluate available information for use by the legal team • Carry out case management of survivors in the community • Monitor the status of cases to ensure appropriate action is taken in a timely manner by liaising with investigating officers, the lawyers and other legal representatives of survivors. • Provide basic legal advice to survivors of SGBV • Link survivors to available legal aid at the community level



Facility and Community Level Coordination

Facility-level coordination ensures that all those engaging with the survivors within a facility are doing so according to the same standards and protocols. Facility-level coordination can also facilitate logistical oversight of equipment and supplies, as well as monitoring of quality of care. Facility-level coordination should be overseen by management of the facility.

Community-level coordination ensures that representatives from the health facility are part of a larger multisectoral network of providers and activists. Community-level coordination assists health facilities in linking with and working collaboratively with a local coordination network to:

- Establish ethical and safe referral pathways;
- Make rational and efficient use of local resources by avoiding duplication of efforts and harmonizing services;
- Develop allies and minimize discord;
- Promote transparency among service providers;
- Improve monitoring of multisectoral responses;
- Link with county and national coordination mechanisms.

Some of the key community roles include

<p>Community members</p> 	<ul style="list-style-type: none"> • Report SGBV cases to the police and promptly refer to the health care facility • Collaborate with the police in arrest of suspects of SGBV • Assist police to trace witness • Provide places of safety for survivors • Prevention and reporting of harmful practices • In collaboration with probation and other stakeholders, they help in reintegration of ex-convicts
<p>Community leaders</p> 	<ul style="list-style-type: none"> • Inform clients not to destroy evidence or wash cloths • Advice clients to store cloths in khaki bag • Assist survivors to visit the health facility • Support reintegration of survivors • Avoid re-traumatizing, stigmatize and discrimination • Provide safe places for survivors • Support clients to take treatment (e.g. PEP) • Report crime • To avoid kangaroo courts – they should not promote out of court reconciliation for cases of sexual violence

Successful community coordination should be driven by a core set of principles that reflect and reinforce human rights and survivor-centred approaches. It is important for coordination actors to remember:

- The needs of survivors and those at risk of violence are the primary focus of coordination work;
- The coordination process should be well-structured in order to respect the time and participation of coordination partners.
- Coordination should also be action-oriented and motivational, as well as provide an opportunity for reflection, social cohesion and networking.

A major benefit of effective coordination is establishing relationships with referral partners and creating standards for confidential and efficient referrals. However, participating in coordination is not the only method for identifying referral networks. Each health facility should be responsible for ensuring that they are able to provide survivors who disclose violence with information about where additional services, such as counselling, shelters, legal assistance, social and material support, can be sought. Health facilities therefore have an obligation to find out what services exist in their communities and create a referral directory.

Key Messages

- Where some services are not available its essential for the health care provider to refer the client
- Always prioritize the privacy, confidentiality and security of the client
- Explain what you want to do and why and get informed consent
- Strengthen facility and community level coordination

UNIT 3 CREATING A REFERRAL DIRECTORY

1 Hour 30 Minutes



Facilitator's instructions

1. Introduce the unit and the unit objectives.
2. Discuss the content in the manual on establishing a referral directory
3. Conduct the activity on creating a referral directory and flow map in the activity box
4. Have each group present their directory and flow map and invite discussion
5. Summarize the unit.

Unit Objective

- (a) To gain knowledge on how to establish coordination and referrals
- (b) To create a context-specific referral directory and flow map

Establishing a Referral Directory

Referral directory and flow map (Annex xii: Participant Handout: Typical Pathway For Care for IPV survivors) are essential during any service provision. They help reduce waiting time and also help identify which next step or facility one can use to refer the survivor who either needs specialized care within the same facility or another facility.

Mapping out the adjacent sites for specialized care is paramount and getting their contacts and hours of operation. This directory should be widely circulated with the health facility for ease of access when in need. When establishing a referral directory, health facilities can follow the steps outlined below:

STEP 1: Determine the geographic area to be included in the referral network. Where do most of your survivors live? How far can they travel to seek services? If the institution has clinics in several parts of the city or the country, each site may need a different directory to ensure that the services are geographically accessible to the survivors.

STEP 2: Identify institutions in the area that provide services that are relevant for survivors who experience violence. This list can include medical, psychological, social and legal organizations, as well as local police contacts. You may also want to consider including institutions that address secondary issues related to violence, such as alcohol and drug abuse, as well as those that offer services for children who have experienced or have been exposed to violence. Each institution may be able to name other local institutions that can be included in the directory

STEP 3: Call or (ideally) visit each institution to gather key information about its services. To ensure that you gather up-to-date information about each institution, and to have the opportunity to see the services first-hand, it is best to conduct a brief, informal interview in person with a staff member from the organization where services are provided.

STEP 4: Organize the information into a directory. You can organize information about referral institutions in different ways (for example, by location, type of service offered, etc.). If the number of referral services available in the community is small, then the directory may be very concise. If the directory is long, an index of institutions by name and type of service can make a directory more user-friendly.

STEP 5: Distribute the directory among health care providers. Ideally, a health programme should distribute a copy of the directory to each health care provider so that all staff members who interact with IPV survivors have access to this information. If resource constraints make it difficult to print this many copies, then every clinic should have a directory available to the staff in a convenient, accessible place.

STEP 6: Gather feedback from providers about how well the directory is working. Managers should take the time to discuss the directory with providers soon after it is introduced to make sure that the format is workable and that the providers have not had any difficulties with the process of making referrals. Once providers have used the directory for a period of time, they may know what referral services are or are not in fact accessible to their survivors.

STEP 7: Formalize relationships with referral institutions. After creating a directory, the next step is to create more formal partnerships with other agencies. This may include setting up formal referral and counter-referral systems, as well as collaborating on projects. Ideally, organizations involved in a referral network should be in contact with one another on a regular basis to give feedback, stay up-to-date, and provide at least minimal follow-up to selected cases and other issues related to this work.

STEP 8: Update the information in the directory on a regular basis. It is essential for health programs to update the information in the directory on a regular basis (for example, every six months) to avoid giving misinformation to survivors in need. Not only can misinformation waste the survivor's time, money and energy, but it can also put them at risk in a number of ways. Remember that services can close, relocate, raise their costs, or change their procedures.



ACTIVITY: CREATING A REFERRAL DIRECTORY (1 HOUR)

- Divide the participants into groups based on their facilities/regions/counties
- The participants should use the step by step guide and the sample referral chart to create a referral directory
- The participants should first identify resources/services that IPV survivors can be referred to that are accessible to the survivor
- Then use the Annex xiii: Sample Referral Chart to put down those resources, the contact information(check online or make the necessary calls if possible) and person responsible for follow-up
- Next the group should map out what their referral process should look like in their settings

- After 30 minutes reconvene the plenary and give each group 5 minutes to present their referral chart and flow map
- Request feedback from the plenary and give concise input
- Remind the participants that what they have created is just a beginning, when they return to their health facilities they should go through steps 3 to 8 to ensure they have an effective referral directory

Key Messages

- Each facility needs to develop a clear, functional referral directory and ensure that it's accessible and known to all healthcare providers in the facility.
- Referral may be to other health professionals within the same or another health care facility or to other service providers in other sectors
- When creating your referral directory, identify your own existing and potential range of actors who can provide support for clients at risk of or experiencing violence.



MODULE

7

**INTIMATE
PARTNER
VIOLENCE
IN SPECIAL
SITUATIONS**

Introduction

While any woman is at risk of experiencing IPV, simply because of her gender, not all women experience the same degree of vulnerability. Certain groups of women, girls and men are especially vulnerable to violence, including adolescent girls, women living with disabilities, and women in conflict/humanitarian situations. In this module, we also discuss the issue of IPV with men as victims and how health providers can support these survivors.

Purpose of the Module

This module highlights special considerations related to IPV among adolescents, persons living with disabilities and during humanitarian situations

Learning Outcomes

By the end of this module, the participant should be able to:

1. Identify vulnerable populations in our communities
2. Describe the predisposing factors to vulnerability
3. Discuss the vulnerability of the special population to IPV
4. Discuss considerations when addressing IPV among specific populations and situations of vulnerability

Session Plan

Time	Topic	Learning outcome	Teaching Methodology	Materials
	Vulnerable populations in our communities	<ul style="list-style-type: none">• Identify vulnerable populations in our communities	<ul style="list-style-type: none">• Facilitated discussion	Laptop LCD projector
	Predisposing factors to vulnerability	<ul style="list-style-type: none">• Describe the predisposing factors to vulnerability	<ul style="list-style-type: none">• Practical session	Facilitator's guide Participant's manual
	Vulnerability of the special population to IPV	<ul style="list-style-type: none">• Discuss the vulnerability of the special population to IPV	<ul style="list-style-type: none">• Brainstorming	Power-point slides
	Considerations when addressing IPV among specific populations and situations of vulnerability	<ul style="list-style-type: none">• Discuss considerations when addressing IPV among specific populations and situations of vulnerability	<ul style="list-style-type: none">• Group work	Flip charts Markers Job-aids



Facilitator's instructions

1. Introduce the unit and the unit objectives.
2. Ask participants to brainstorm about groups and situations vulnerable to IPV
3. Discuss special considerations when addressing IPV among specific populations
4. Summarize the module.

Married Adolescents

Adolescence has been generally described as the *transitional period from childhood to adulthood that begins at puberty, and is often characterized by individual changes occurring in growth and development within the ages of between 10-17 years.*

One important risk factor for intimate-partner violence may be the young age of the wife: Research suggests that girls who are married early are at greater risk of violence than those who marry late, especially when the age discrepancy between the girl and her husband is significant. In some communities girls who are forced into marriage—exemplified to the extreme in 'abduction marriages' customary in certain parts of Africa, Eastern Europe and Asia—also typically suffer the added trauma of forced sexual initiation.

Girls are also more likely to be socially isolated by virtue of their age and lack of independent resources, and therefore less likely to be able to seek assistance for domestic violence. Girls may additionally be more likely to accept the abuse by their partner as part of the power differential in their marriage. Young women in many parts of the world also experience dating violence, including controlling behaviours by boyfriends, verbal and physical abuse, and date rape.

Even though adolescence can be a particularly vulnerable period for exposure to multiple forms of violence, many health programmes are not designed to recognize and address the special needs of adolescent girls. Some of the various factors linked with adolescent girls' difficult in accessing health services include:

Factors linked with adolescent difficult in accessing health services

CATEGORY	FACTORS
Self	<ul style="list-style-type: none"> • Embarrassment • Ignorance • Fear
Families	<ul style="list-style-type: none"> • Lack of health knowledge • Poverty • Low priority of sexual and reproductive health
Providers	<ul style="list-style-type: none"> • Judgmental attitudes • Inability to talk/listen to/treat adolescents • Legislative restrictions
Facilities	<ul style="list-style-type: none"> • Accessibility • Overcrowding • Long waiting times • Insufficient supplies

In order to overcome these barriers, facilities should provide youth friendly services as outlined in the National Guidelines.



WHO FRAMEWORK FOR YOUTH-FRIENDLY SERVICES

To be considered youth-friendly, services should be:

- **Accessible:** Adolescents are able to obtain the health services that are available.
- **Acceptable:** Services are provided in a way that meets the expectation of adolescents
- **Equitable:** All adolescents, not just selected groups, are able to obtain the health services that are available.
- **Appropriate:** The right health services (i.e. the ones they need) are provided to them
- **Effective:** The right health services are provided in the right way, and make a positive contribution to their health.

Other specific characteristics that make services youth friendly include:

- Procedures to facilitate easy confidential registration
- Short waiting and referral times
- Capacity to see patients without an appointment
- Providers that are non-judgmental and competent in adolescent specific areas
- Compassionate support staff.
- Convenient facilities
- Privacy
- Community based outreach and peer and peer dialogue to increase coverage and accessibility.

All married female adolescents should be considered high-risk and screened accordingly for violence. Maternal Child Health (MCH) services are a key entry point to reach girls in child marriage, at the time of first pregnancy. Health care providers at the MCH should be trained to educate and treat girls in child marriages with sensitivity to their risks, vulnerabilities, and needs, including pre-term labour, adequate nutrition, importance of emergency obstetric care, referral for voluntary counselling and testing, etc.

The minors who are married be referred to relevant government agencies for support and taken back to school.

Persons Living with Disabilities

The concept of "disabilities" covers a multitude of conditions, with different vulnerabilities and needs. When identifying and addressing risks for violence among disabled persons, it is important to focus on particular types of disabilities (i.e. those involving sensory impairment, physical impairment, psychiatric impairment, cognitive impairment, etc.) as well as particular types of violence, and develop research and programming accordingly.

In general and regardless of the disability health care providers should at minimum understand that persons with disabilities may be at higher risk for violence than those without disabilities due to issues of power and control. In order to assist persons with disabilities, health programs should develop specific policies for health care provider's persons leaving with disability. Health facilities should also consider the following strategies:

- 1. Conduct community outreaches:** persons with disabilities may face challenges accessing treatment because they may be isolated in their homes, or in institutions, and in some instances may have limited knowledge about their bodies and sexual and reproductive health and therefore not understand the importance of receiving care.
- 2. Improve facility infrastructure to meet the needs of persons with disabilities:** This may include providing wheelchairs and wheelchair access, interpreters for the deaf, special examination equipment that prioritizes comfort for those with physical impairments, etc. Health facilities can engage local organizations working specifically with disabled people to determine what other accommodations should be made.
- 3. Recognize and address the specific vulnerabilities to violence that persons with disabilities may face.**

Develop screening protocols that recognize some of the particular tactics associated with abuse of disabled women and girls, including manipulation of medication; financial exploitation; destruction of or withholding of assistive devices; neglect or refusal to help with personal care (such as toileting); emotional abuse that is specifically focused on a victim's disability.

Linkage with relevant support systems
e.g. APDK, counselling.

Screening for IPV among women with disabilities

Develop screening questions that identify how living with disability contributes to their vulnerability to IPV; what services and resources are available to them and; identify possible barriers to accessing these services and resources.

Men as Victims of IPV

According to the Kenya Demographic and Health Survey, 10.9% of men reported having ever experienced some form of intimate partner violence with 6.9% reporting having experienced it in the last 12 months. Men are also less likely to report IPV because of stereotypes that male survivors of IPV are seen as weak and less of men and are often the perpetrators not the victims. Health providers should ensure to treat male survivors of IPV with the same seriousness as women and not to belittle their experience based on the stereotypes.

Humanitarian Situations

A humanitarian situation is an event or series of events which represents a critical threat to the health, safety, security or wellbeing of a community or other large group of people, usually over a wide area.

A humanitarian emergency arises when such an event affects vulnerable populations who are unable to withstand the negative consequences by themselves. Humanitarian crisis include drought, floods, terrorism and armed conflict among others. Women and girls are particularly vulnerable to all forms of GBV especially sexual violence especially during armed conflict.

While sexual violence is the most immediate and dangerous type of GBV occurring in acute emergencies ,Later in a more stabilized phase and during rehabilitation and recovery other forms of GBV occur and/or are reported with increasing frequency including IPV

Key messages

- Special groups for IPV include, married adolescents, PLWD and people in humanitarian situations
- Married adolescents should be considered for clinical enquiry since they are at a higher risk for IPV
- Maternal and child health services provide an entry point to reach girls in child marriage
- Conduct community outreach to improve access to IPV services for PLWD
- Humanitarian situations may increase IPV risk for girls and women



**MODULE
8**

**DOCUMENTATION,
RECORD KEEPING,
MONITORING AND
EVALUATION**

Introduction

Effective data management for IPV is important at all levels in order to ensure the provision of cohesive, coordinated and quality services to survivors of IPV. Proper documentation and record keeping is critical in generation of evidence and facilitation of access to justice for survivors of IPV. Data also serves as the basis for planning, advocacy, resource mobilization and awareness creation.

Monitoring and evaluation helps to track and assess progress in achieving expected results, identify bottle necks in implementation of programs and highlight whether there are any unintended effects.

Purpose of the Module

To equip participants with knowledge on appropriate data management practices including documentation and reporting, and the concepts of monitoring and evaluation in relation to IPV.

Learning Outcomes

By the end of this module, the participant should be able to:

1. Explain the importance of documentation of IPV services
2. Describe various the dimensions of quality data
3. Discuss the role of monitoring and evaluation in IPV

Session Plan

Time	Topic	Learning outcome	Teaching Methodology	Materials/Job aids
1 Hour	The importance of documentation of IPV services	Explain the importance of documentation of IPV services	Facilitated discussion Interactive lecture	Laptop LCD projector Facilitator's guide Participant's manual Power-point slides Flip charts Markers Data tools
	Dimensions of quality data	Describe various the dimensions of quality data	Facilitated discussion Interactive lecture	
40 Mins	Role of monitoring and evaluation in IPV	Discuss the role of monitoring and evaluation in IPV	Interactive lecture Brainstorming	



Facilitator's instructions

1. Introduce the module and the learning outcomes
2. Ask participants to brainstorm on the importance of documentation, monitoring and evaluation of IPV services
3. Take the participants through the session in an interactive lecture using the power point presentations. Ensure active participation by asking questions and facilitating short plenary discussions
4. Summarize the module using the key messages.

Documentation of IPV services

Documentation of IPV survivors' information should be done at any point of care, such as at the outpatient department/clinic, gynaecology ward and female wards. The client information documented in health facilities is known as health records which includes; personal identifying information, contact information, medical/surgical history, current medical examination and investigation results, relevant social information, diagnosis and prescribed care.

The sources of IPV client health records are; Outpatient registers, client's inpatient notes and client discharge notes/summary.

Importance of documentation of IPV services

- Act as evidence of care given to the clients
- Facilitates provision of quality services for IPV survivors
- Provides a method of communicating with other team members concerning the client's condition and the basis for the current management
- Satisfy legal and ethical obligations in client management

Uses of Data/Information

IPV service provision data/information can be used to inform;

- Decision making
- Allocation of resources
- Mobilization of resources
- Where to concentrate efforts for quality improvement
- Planning
- Monitoring progress/trends
- Development of (new) evidence based interventions

Sources of IPV Data

- Registers
- Summary reports
- KHIS
- Surveys e.g. KDHS
- Research reports
- Health Facility Assessment

Dimensions of quality data

Dimension	How to ensure quality
Completeness	All the data elements that should have been reported are reported for a given period
Timeliness	Reports are submitted by a deadline set for each level
Accuracy	Data that has been reported matches the primary source documents at the point of collection
Reliability	Data collection is aligned with protocols and procedures that do not change depending on the data collector or when or how often they are used; data is reliable because it is collected consistently
Precision	Data contains sufficient detail. For example, if an indicator requires "the number of clients receiving family planning methods by type and visit type," then the tool would lack precision if one records the method type and not the visit of the individual who received the method.
Integrity	The data collection system is protected from bias or manipulation
Confidentiality	Personal client data is not inappropriately disclosed or left unsecured

Reporting for IPV services

Health reports are a compilation of clients' information on a monthly basis and this information is obtained from the source documents such as registers. The clients' records are summarized, compiled and reported in MoH reporting documents/system which are; MoH 711 and uploaded into KHIS.

NOTE: The main IPV indicator that is reported currently is the number of IPV survivors accessing health services.

Data Flow

Data movement should follow the national standard data flow same as other health service data, from the source documents (registers) to the monthly reporting tools (MoH 711) then uploaded into KHIS

Monitoring and Evaluation In IPV

Monitoring

Monitoring is an ongoing systematic collection, analysis and use of information for decision making. Monitoring should be incorporated into everyday program work to track the progress and check the quality of the program against set criteria and adherence to established standards. It tracks the implementation of the programme

toward reaching its objective in relation to inputs and outputs such as:

- Interventions/activities
- Reporting and documentation
- Finances and budgets
- Supplies and equipment

Monitoring uses a set of core indicators and targets to provide timely and accurate information to government and other stakeholders in order to inform progress, performance and policy.

Monitoring seeks to answer questions such as:

- Were inputs made available to program/ project in the quantities and at the time specified by the program/project work plan?
- Were the scheduled activities carried out as planned?
- How well were they carried out?
- Did the expected changes occur at the program/project level, in terms of people reached, materials distributed?

Evaluation

Evaluation involves assessing the extent to which program activities have met the expected objectives. Evaluation builds upon the monitoring data but the analysis goes much deeper, taking into account contextual changes, addressing questions of attribution, and looking at counterfactual situations.

Evaluations take place at specific times during interventions. It is common to start with baseline assessment at the beginning of an intervention so as to obtain information with which subsequent changes can be compared. The objective of carrying out an evaluation is to be able to make conclusions about the: Relevance

- Effectiveness
- Efficiency
- Impact
- Sustainability

Based on the information, it can be determined whether any changes need to be made in a programme or policy level, and if so, what they are. What went well, where is the room for improvement?

Evaluation has a learning function; (i) the lessons learned need to be incorporated into future proposals or policy, (ii) review the implementation of policy based on objectives and resources mobilized.

Evaluation seeks to answer questions such as:

- Did the expected change occur at the population level (not necessarily attributable to program/project)? How much change occurred?
- Can improved health outcomes be attributed to program efforts?
- Did the target population benefit from the program and at what cost?

Characteristics of Monitoring and Evaluation

Monitoring	Evaluation
Routine assessment of activities	Analysis of activities
Is continuous	Is periodic
Reports progress	Records lessons learnt
Keeps track of daily activities	Keeps track of outputs
Works towards targets	Measures progress and questions the adequacy of targets
Accepts policies, rules and procedures	Questions the pertinence of policies, rules and procedures
Stresses the conversion of inputs into outputs	Emphasizes the achievement of purpose

Approaches and methods used in monitoring and evaluation

Approach	Methods used
Formal evaluations at baseline, midterm and follow-up	<ul style="list-style-type: none"> • Structured questionnaires • Focussed Group Discussions (FGDs) e.g. with providers and survivors • Randomly sampled record reviews • Direct observations • In-depth interviews with key informants
Small-scale case studies to evaluate new policies or tools	<ul style="list-style-type: none"> • Routine service statistics • Focus groups with staff • Focus groups with survivors
Information systems to collect systematic service data	<ul style="list-style-type: none"> • Routine service statistics on key indicators
Regular meetings with staff to discuss new policies and tools	<ul style="list-style-type: none"> • Informal discussions and dialogue among frontline staff and managers
Individual efforts of managers to track the progress of needed reforms in the organization	<ul style="list-style-type: none"> • Checklists • Strategic plans • Personal observation
Individual efforts of managers to monitor the morale and performance of staff	<ul style="list-style-type: none"> • Routine service statistics • Informal reviews of medical records • Informal discussions with staff members
Provider knowledge and skills before and after training	<ul style="list-style-type: none"> • Pre-tests and post-tests • Questionnaires • Informal group discussions

Key messages

Importance of documentation of IPV services

- Act as evidence of care given to the clients
- Facilitates provision of quality services for IPV survivors
- Provides a method of communicating with other team members concerning the client's condition and the basis for the current management
- Satisfy legal and ethical obligations in client management

Monitoring and evaluation is important to:

- Establish if the resources are utilized effectively and efficiently i.e. accountability tool
- Assess if interventions implemented in the programme are effective
- Track the progress of the program goals
- Guide decision making in management and overall quality improvement of health services
- Aids in replanning or reprogramming to achieve a goal or address the priority issue.

Example of a Monitoring Checklist of Minimum Key Elements of Quality Health Care for IPV cases

All health organizations have an ethical obligation to assess the quality of care that they provide to all survivor, whether through full evaluations and/or ongoing, routine monitoring activities. An assessment could also look at the minimum elements required to protect women's safety and provide quality care in light of widespread gender-based violence, as listed below:

1. **Institutional values and commitment:** Has the institution made a commitment to addressing violence against men and women, incorporating a "system's approach"? Are senior managers aware of gender-based violence against women as a public health problem and a human rights violation, and have they voiced their support for efforts to improve the health service response to violence?
2. **Alliances and referral networks:** Has the institution developed a referral network of services in the community, including to women's groups and other supports? Is this information accessible to all health care providers?
3. **Privacy and confidentiality:** Does the institution have a separate, private, safe space for women to meet with health care providers? Are there protocols for safeguarding women's privacy, confidentiality and safety, including confidentiality of records? Do providers and all who come into contact with the women or have access to records understand the protocols?
4. **Understanding of and compliance with local and national legislation:** Are all providers familiar with local and national laws about gender-based violence, including what constitutes a crime, how to preserve forensic evidence, what rights women have with regard to bringing charges against a perpetrator and protecting themselves from future violence, and what steps women need to take in order to separate from a violent spouse?

Do health care providers understand their obligations under the law, as well as regulations governing who has access to medical records (for example, whether parents have the right to access the medical records of adolescents)? Does the institution facilitate and support full compliance with obligations?

5. **Ongoing provider sensitization and training:** Does the institution provide or collaborate with organizations to provide ongoing training for staff around gender-based violence, harmful norms and practices, legal obligations and proper medical management of cases?
6. **Protocols for caring for cases of gender-based violence:** Does the institution have clear, readily available protocols for screening, care and referral of cases of gender-based violence? Were these protocols developed in a participatory manner, incorporating feedback from staff at all levels as well as survivors? Are all staff aware of and able to implement the protocols?
7. **Post-exposure prophylaxis, Emergency contraception and other supplies:** Does the institution have supplies readily available, and are staff properly trained on their dissemination and use?
8. **Informational and educational materials:** Is information about violence against women visible and available, including on women's rights and local services women can turn to for help?
9. **Medical records and information systems:** Are systems in place for documenting information about violence against women as well as collating standardized data and service statistics on the number of victims of violence? Are records kept in a safe, secure manner?
10. **Monitoring and evaluation:** Does the institution integrate mechanisms for ongoing monitoring and evaluation of their work, including receiving feedback from all staff as well as from survivors seeking services? Are there regular opportunities for providers and managers to exchange feedback? Is there a mechanism for survivors to provide feedback regarding care?

Source: adapted from Bott, Guedes and Claramunt 2004

(Pick no more than 4-5 depending on time)

1. Women are just as violent as men in relationships.

Points for facilitator to emphasize: Few population-based that have examined women's perpetration of violence have found that violence experienced by men at the hands of their female partners is much lower than violence experienced by women at the hands of their male partners. Exploratory studies have found that the violence is not as severe in terms of physical injuries resulting and that oftentimes the violence is in response to violence perpetrated by the men.

2. Most women are abused by strangers. Women are safe when they are home

Points for facilitator to emphasize: Studies show that in most settings the majority of the perpetrators of sexual abuse are known to the survivors. Moreover, intimate partner violence – that is physical and/or sexual violence is the most common form of violence experienced by women. Therefore, unfortunately for many women, home is not necessarily a safe space.

3. A woman can say “no” if she doesn't want to have sex with her husband.

Points for facilitator to emphasize: Every woman has the right to bodily integrity and the right to refuse sex or say no to sex. In many settings however, gender norms socialize women and men into believing that once you are married, the man is entitled to have sex with his wife whenever he wants and in many countries, forced sex with your spouse is not considered to be rape. However, women always have the right to control their own bodies and sexuality and this means that they can say no to sex with their husbands.

4. Men cannot control themselves. Violence is simply a part of their nature.

Points for facilitator to emphasize: Perpetrating violence is always a choice for the perpetrators. It is not part of nature nor inevitable. Violence is often a learned behaviour. Data show that children who are either subjected to violence themselves or witness violence in their homes are more likely to perpetrate or experience intimate partner violence when they grow up.

5. Intimate partner violence/domestic-violence is a private matter and outsiders should not interfere.

Points for facilitator to emphasize: Gender-based violence is a public health issue with grave effects on the health of women and families, economic impacts as a result of need to treat and respond to health impacts as well as the negative impact on survivors' economic productivity, as well as compounding effects on children/witnesses of violence who may become violent themselves, drop out of school, or otherwise are unable to lead productive lives as a result of the violence to which they were exposed.

6. Men sometimes have a good reason to use violence against their partners.

Points for facilitator to emphasize: There is never any excuse or justification for any type of violence. It should never be used as a form of power or control.

7. As a health worker, how I respond to a woman who has suffered violence from a partner violence or sexual abuse is very important.

Points for facilitator to emphasize: Women subjected to violence often do not disclose their experience of violence to anyone because of fear of being blamed or stigmatized

or that no one will believe them. As a health care provider, even if a woman does not disclose violence to you, studies show that such women are more likely to seek health care for a range of related conditions. Hence you will likely come in contact with survivors. Women also indicate that an empathetic response from a health care provider can gain their trust in disclosing their experience. Therefore, an empathetic, validating and non-judgmental response to a survivor is very important to the survivor and to putting her on a path to healing.

8. If a woman stays with a violent partner, it is her fault.

Points for facilitator to emphasize: There are many reasons why a woman might stay with a violent partner. It is not our place to judge these women. In fact, leaving a violent relationship can also result in increased risk of violence from a controlling, violent partner. Other reasons such as economic dependence and social pressures not to break up the family can also prevent a woman from leaving her violent partner.

9. Domestic violence only happens in poor families

Points for facilitator to emphasize: Although it is argued that poverty exacerbates domestic violence, in the sense that a woman's options of other financial and practical support are very limited or non-existent, and that financial problems can place strain on a relationship, it is not true that it is a problem specific to poorer families. Domestic violence cuts across all boundaries: economic (class), social, ethnic, cultural, religious and professional. Many women who have careers are abused and caught up in the same cycle of abuse as women who work at home.

10. Abusers must come from violent backgrounds

Points for facilitator to emphasize: Whilst there is a recognized pattern of abusers and abused continuing to abuse and be abused in their adult lives, it is not always the case. Many abusers do not come from violent backgrounds, and many families in which violence occurs do not produce violent men. The family is not the only formative influence on behaviour. Furthermore, this statement is dangerous because it can be used as an excuse for the abuser's behaviour, both by the abuser and the abused.

11. All abusers are alcoholics or drug addicts, it's the drug that causes the violence

Points for facilitator to emphasize: Alcohol or drug abuse is often mistakenly perceived as a cause of violence. An abuser may say that he lost control or didn't know what he was doing because of his alcoholism or drug abuse, but he is, nevertheless responsible for his actions. The drug may reduce the abuser's inhibitions, but his actions are his own, not the drug's. While substance abuse is related to violent behaviour, successful treatment of that problem will not necessarily put an end to the violence.

12. Batterers are just violent people, they're like that with everyone.

Points for facilitator to emphasize: Often the batterer is capable of being a delightful friend to others. This is why friends of the family may find the stories of his violence unbelievable, and why they wife may deny the seriousness or the presence of the abuse as well. The truth is that the batterer chooses brutality as a way to dominate his wife.

Patient and Healthcare Provider are both sitting in chairs facing one another. Provider is making eye contact, and not writing in a medical record.

Provider: We've spoken about your concerns regarding your health. You said that you have repeated headaches. Headaches could be related to stress. Are you experiencing any stress?

Patient: I don't know. Sometimes I feel overwhelmed at home.

Provider: Is there anything specific at home that could be causing you to feel like this? Talking about this may help us understand your health better.

Provider: OK, if you think it will help.

Provider: I do think it's important and might help. I have seen women with health problems like yours who have been experiencing trouble at home. Problems in your relationship can affect your health. Could we speak more about your relationship?

Patient: OK.

Provider: Before we continue, I want you to know what you tell me is confidential, and that means I won't tell anyone not involved with your care about what you share with me.

Patient: OK.

Provider: Is everything ok with your husband or partner?

Patient: I am not sure. He has been under a lot of stress

Provider: I see. What happens when he has a lot of stress?

Patient: He gets very angry at me and sometimes he does not calm down easily

Provider: OK. Has your husband or partner threatened to hurt you or physically harmed you in some way when he gets angry?

Patient: It has happened. He hit me a few times last year, but then it stopped. Now he has threatened me a few times in the last couple of months. *Patient pauses and looks down. She seems uncomfortable.*

Provider: *nods head and waits a few seconds.* This can be hard to talk about.

Patient: *is silent. She nods her head then looks up again.*

Provider: *Provider leans in slightly towards patient, looking concerned.* Can you tell me about the last time it happened?

Patient: *She pauses.* Well, when he came home yesterday he was really mad about something, and he threatened to hit me when I asked him why he was so mad.

Provider: *Pauses, giving patient time to think.* How do you feel about that?

Patient: It makes me sad and afraid. I'm not sure what to do when he gets mad. It makes me anxious just thinking about it. *She looks like she might cry, then recovers.*

Provider: *Pauses.* Feeling anxious is common when you feel threatened at home. It's important to know that it's not your fault. Everybody deserves to feel safe at home.

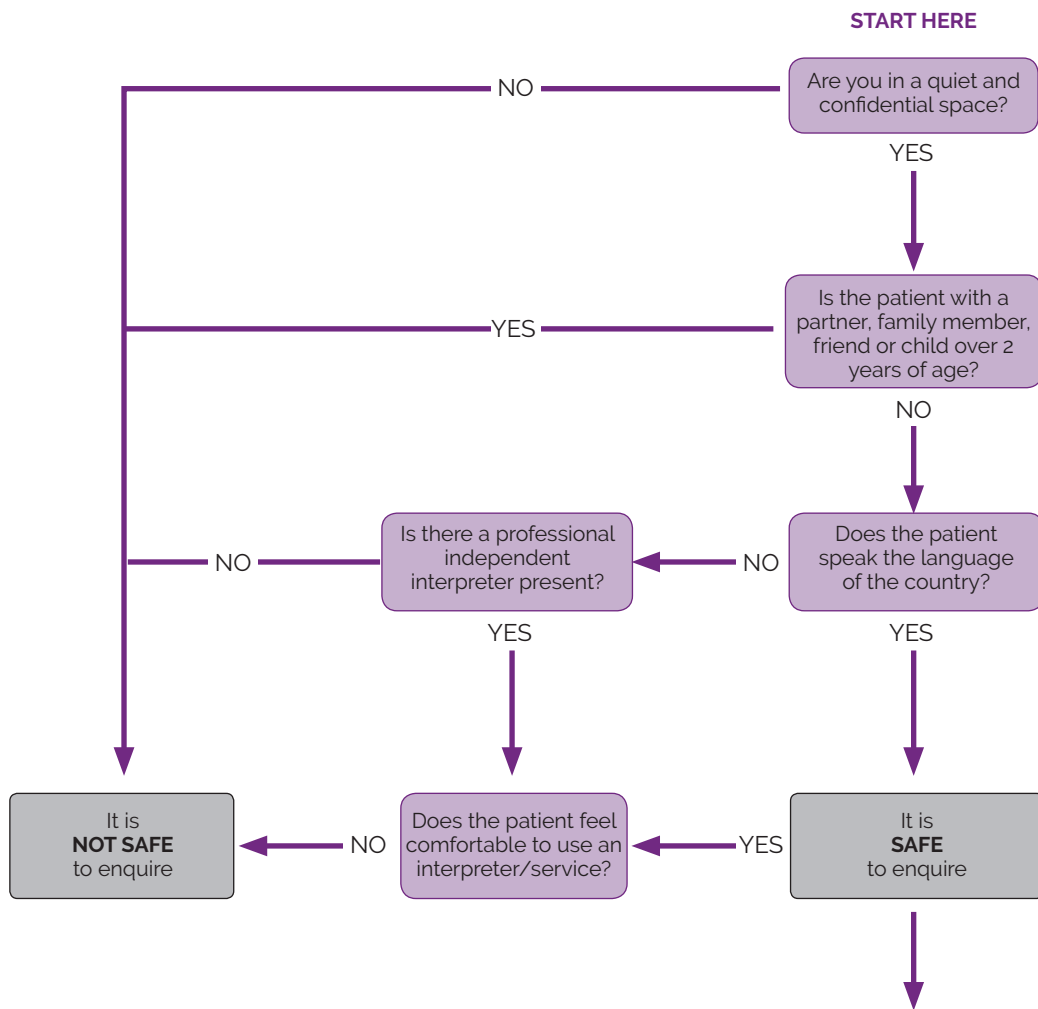
Patient: I am anxious but I don't think he would hit me again like he did last year.

Provider: Is there anything you need or want to feel less anxious?

Patient: No, I think this is fine

Provider: There are specific exercises that can be helpful to feel calmer when you are feeling anxious. Would you like me to share a method with you to help you with this?

Patient: Yes that would be great, thank you.



If the health care provide is in quiet and confidential space, alone, speaks the language of the patient, or agrees to the interpreter being present, it is safe to enquire. At this point, it is important to explain confidentiality.

EXPLAIN CONFIDENTIALITY

Information may be shared if?

- The patient gives consent
- There is a statutory to share information (e.g court order)
- It is in the best public interest (including safeguarding children)

You will not inform the partner about the discussion around GBV

HOW TO ASK ABOUT GBV

- Take the initiative to ask about violence
- Explain confidentiality
- Use eye contact and be aware of body language
- Use supportive comments and avoid passive listening
- Show a non judgmental and supportive attitude
- Reinforce that GBV cannot be tolerated
- Be patient and do not pressure patient to disclose
- Emphasize that there are options and resources available

IPV SCREENING TOOL

Instructions to the Health Provider

The following tool will be used to screen women for IPV occurrence. Answering **YES** to any of the IPV questions qualifies for presence of IPV and should be put through the intervention

The following questions are about things that happen to many women and that your current partner or any other partner may have done to you.

Q1: PSYCHOLOGICAL IPV QUESTIONS

	A. Has your current partner/ husband / boyfriend ever done any of the following things?		B. In the last 12 months has your partner done any of the following? (If YES, ask C. If NO, proceed to Q2)		C. In the past 12 months would you say this has happened once, a few times or many times?		
	Yes	No	YES	NO	ONCE	FEW	MANY
(a) Insulted you or made you feel bad about yourself?							
(b) Belittled or humiliated in front of other people?							
(c) Did things to scare or intimidate you on purpose (e.g. by the way he looked at you, yelling or smashing things)?							
(d) Threatened to hurt you or someone you care about?							

Q2: PHYSICAL IPV QUESTIONS

	A. Has your current partner/ husband / boyfriend ever done any of the following things		B. In the last 12 months has your partner done any of the following? (If YES, ask C. If NO, proceed to Q3)		C. In the past 12 months would you say this has happened once, a few times or many times?		
	Yes	No	YES	NO	ONCE	FEW	MANY
(a) Slapped you or thrown something at you that could hurt you?							
(b) Pushed or shoved you?							
(c) Hit you with his fist or with something else that could hurt you?							
(d) Kicked, dragged, beat you up?							
(e) Choked or burned you on purpose?							
(f) Threatened to use or actually used a gun, knife or other weapon against you?							

Q3. SEXUAL IPV QUESTIONS

	A. Has your current partner/ husband / boyfriend ever done any of the following things		B. In the last 12 months has you partner done any of the following? (If YES, ask C		C. In the past 12 months would you say this has happened once, a few times or many times?		

	Yes	No	YES	NO	ONCE	FEW	MANY
a. Physically forced you to have sexual intercourse when you did not want?							
b. Did you ever have sexual intercourse you did not want because you were afraid of what he might do?							
c. Forced you to do something sexual that you found degrading or humiliating?							
Q4. REPRODUCTIVE COERCION SCREENING QUESTIONS							
1. Have you ever felt pressured or forced by your current partner/spouse or any other person to become pregnant when you do not want to be?							
2. Does your partner support your decision about when or if you want to become pregnant?							
3. Are you worried your partner will hurt you if you do not do what he wants with the pregnancy?							

4. Has your current partner/spouse or any other person ever made it difficult for you to get or use Family Planning?							
5. Has your current partner/spouse or any other person ever influenced the type of Family Planning method you have to get or use?							
6. Has your current partner/spouse or any other person ever made it difficult for you to get any other RH service?							
1. Psychological violence: Yes.....No..... 2. Physical violence: Yes.....No..... 3. Sexual violence: Yes.....No..... 4. Reproductive Coercion: Yes.....No.....							

PATIENT
SCENARIO 1

Read out to provider: I am a 55 year old woman living in Kisumu. I am here for gynaecological examination because I have been having yellow and bad smelling vaginal discharge. My back hurts and I would like some medications to help with the back spasms. I am not sure how I can pay for the medications however. Your hair is messy and your clothes seem a bit dirty

Read to yourself, only share when asked details by the provider: You have been married for over 37 years and have 5 children aged 34 to 18 years old (three of them live with her, the others moved away). You are a stay-at-home wife. For the past month you have been agitated and stressed, and often your day is ruined by terrible headaches. You are very tired as you have not slept well in a month and you have also gained a lot of weight. You are feeling ugly, stupid and worthless, and have been having occasional suicidal thoughts.

Your husband has abused you in many ways throughout the 37 years of marriage. He often calls you by offensive names and belittles you in front of your children. In the last 5 years you have spent a night at the local shelter 3 times when your husband was more violent than usual, like when he broke your arm or he threatened to kill you.

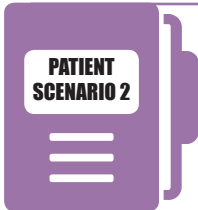
You returned to him primarily for financial reasons and because he apologized and promised to stop the violence. He had been nonviolent most of this past year until he knocked you down a few days ago and your back started hurting more than usual and went into the spasm. You partly blame yourself because your husband recently lost his job and has been too stressed lately. You would like to find work to help cover the family's expenses, but have not yet been able to.

For this health care visit: Express concern that your back is paining intensely and that you have some yellow discharge that you would like to get it checked out. When the health provider asks to examine you, also inform that you have also have fading bruises on your hips as well from a fall that you had a few days ago. Initially you refuse to tell him how you fell because you are scared of your husband finding out somehow.

PROVIDER
SCENARIO 1

You are a 48 year old male gynaecologist practicing in Kisumu for the last 20 years. You are working in a busy clinic that provides maternal and reproductive health services to women. It is a busy clinic with lots of patients to see every day and you often do not have more than 5 minutes to spend per patient. You are aware that many women are experiencing violence, but think this is culturally the norm and you don't really know if you can do anything about it.

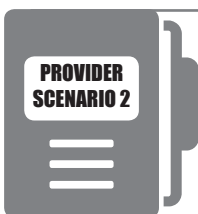
The patient presents complaining about several things including yellow bad smelling discharge and back spasm. You take her to the examination room with at least 3 others waiting outside and notice the discharge and also some bruises on her hips.
What do you do?



Read out to provider: I am a 35 year old woman living in a town about 3 hours from Nakuru. The health issues I am presenting are: fractured small bones in y right hand, I am anxious, and pose many questions about the duration of the bruises and the need for medications.

Read to yourself, only share when asked details by the provider: You have been married for 20 years with a prestigious businessman in town who is also an active participant in all local church activities. You work as a primary school teacher. You have 3 children (10 to 15 years old). You have partial loss of hearing/sight on your right side due to an assault by your husband 20 years ago when he beat you very severely. When you told health care providers of the assaults, they ignored the information and merely treated the injuries. In the last 10 years, you often received medical attention for a variety of injuries due to the assaults.

For this health visit: You express concern about losing your hearing in your "good ear" on the left side. Initially you report that your current bruise is from a fall when cleaning up the house; eventually you acknowledge that it is the result of your husband striking you. You are very concerned about anyone finding out about your husband hitting you. You consider saying nothing because you think no one will believe you since he is so well-known and enjoys a positive reputation in your town.



You are a young female physician – 27 years old who has been sent to the county referral hospital in Nakuru. You are engaged to be married, but not as yet married. Your fiancé is in Nairobi. You have 6 months to finish your rotation before you go back to Nairobi. You are aware that domestic violence happens, but you have never had any experience with patients who face this in their life. You wanted to be a doctor because you wanted to help people so you are keen to help this woman with her injuries.

The patient presents with a complaint of losing hearing on one side – her good ear as she describes. She says she already is having difficulties hearing in the other ear. You examine her and you also notice bruises on her arms and ask her about them. She does not say anything and keeps saying that she bumped into door, but the patterns of injury don't make sense to you.

What do you do?



**PATIENT
SCENARIO 3**

Read out to the provider: I am a 30 year old woman with 2 daughters (7 and 5 years) living in Mombasa. I have come to the Ob/Gyn clinic because I am pregnant again. This is my fifth pregnancy in the last 8 years. I had one miscarriage already. I also had an abortion last year. I have not had my periods since the last 3 months and I am constantly tired, nauseous. Two days ago, I fainted so I am worried about this pregnancy and had fainted the other day so she is worried about this pregnancy.

Read to yourself and only share when asked details by the provider.

I have been married for 12 years. My parents got me married to this man as soon as I completed my high school. Immediately I was under pressure to become pregnant. I got pregnant the first time within a year of marriage, but I lost the baby after 3 months. I was very sad when that happened. My in-laws thought I should have another baby right away so we tried again and this time also I miscarried. My in-laws then started taunting me that I was unable to give them grandchildren.

So after waiting for another year, we tried for a baby again. This time I got pregnant and gave birth to a girl. But my husband and in-laws started verbally abusing me because I gave birth to a daughter. They pressured me to give them a son. A couple of years later when I got pregnant again, I prayed that it was a son, but this time also it was a daughter. Since then, my husband beats me regularly and shouts me and forces me to have sex so that I can get pregnant and give his parents a grandson they want. My in-laws humiliate me. Last year I was pregnant and this time I checked secretly whether I was carrying a boy or a girl. When I found out it was a girl, I had an abortion because I was very scared that my husband would throw me out of the house.

For this health visit: you tell the doctor that you have not had your period for 3 months and you think you are pregnant. You fainted the other day and that you are constantly tired. You tell them that you don't really want a third child and that you have been pregnant several times, but have been miscarrying.

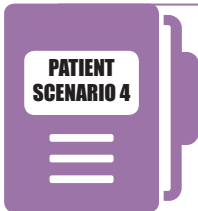


**PROVIDER
SCENARIO 3**

You are a young male Obstetrician (33 years old) who has been practicing in this primary health clinic for last 2 years). You see pregnant women coming with anaemia and multiple pregnancies all the time. You are overworked and you are just trying to get some experience and some money before you start your own private practice.

When this woman comes to you, you suspect that she is anaemic. You recall that she had come to you last year wanting an abortion but in line with the laws of the land, you declined. So you are surprised to see her again within a short time pregnant again. A first she does not say anything, but on probing she says that last time she had an

abortion because she was carrying a female and her husband and in-laws forced her to undergo the abortion. Her husband and in-laws are pressuring her for a son. Even though she has told her husband that they should wait to have another child as she is weak, he refuses to listen to her and shouts and calls her name and so does her mother-in-law. He forces her to have sex and refuses to let her use anything to prevent having another child even though she does not want any more children.

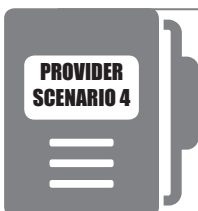


Read out to provider: I am a 20 year old woman living in Machakos. I had unprotected sex with my boyfriend a two days ago and I am worried about becoming pregnant. I pose multiple questions to you how I can avoid becoming pregnant as my last child was born only 1 year ago.

Read to yourself, only share when asked details by the provider: I am unmarried, have been in a relationship with 26 year-old boyfriend for 2 years. I have one child who was born a year ago. I dropped out of college when I first became pregnant and now work as a part-time secretary. I have plans to finish college and become a teacher. During the consultation, your manner is intense and highly anxious. I am very afraid of becoming pregnant again. I also suspect that Michael is being unfaithful.

I have tried to convince my boyfriend many times to use condoms but he refuses. He replies that he loves me, and he has been faithful to me and that his wearing a condom would mean I don't trust him. In our last talk about this, he grabbed my arms, shook me, and threatened to leave you if I brought the topic up again. He has forced me to have sex with him a couple of times and the last time was two days before the consultation. I love him and want to make the relationship work and keep the family together. I believe that my baby girl should grow up with her father. I do not think his behaviour towards me is so bad because I have several friends who tell me that this is how boyfriends usually behave.

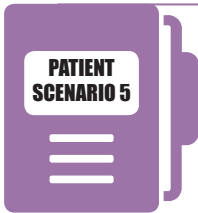
For this health care visit: You tell the nurse that you are worried about becoming pregnant and want to get a method to avoid pregnancy because your partner is not using condoms. You tell her that you have tried using the pill once before but it really did not suit you and you kept forgetting to take it.



You are a 42 year old nurse who is working in a hospital in Machakos. You are married with 1 daughter who is 20 years old. Your partner has died and your daughter is in college so you work long hours and multiple shifts at the hospital to earn more money. You enjoy your work and like to talk to patients and explain to them about how the reproductive anatomy works to prevent pregnancies.

When this young woman comes to you, you think of your daughter and how it would be for her and immediately feel a sense of empathy for her. You ask her many questions about her boyfriend. You also ask her why the pill did not suit her. During the course of the conversation, she really bonds with you and it comes out that her boyfriend has coerced her to have sex with him several times.

What do you do?



Read to the provider: I am a 22 year old student studying to be a mid-wife in Nairobi. I live near one of the largest slums in Nairobi. I have 1 more year to go before I complete my studies. Last week a mobile HIV testing from van came to my university and encouraged university students to get tested, so I went not thinking much about it. To my shock I was told that I tested HIV positive. They told me immediately to go to this clinic for further treatment and care. I arrive at this clinic not believing that this could be possible. I have only been with my boyfriend for the last 2 years and have also been on the pill so that I don't get pregnant.

Read to yourself, share only when provider asks: You met your current boyfriend who is 38 years old about 2 years ago at a party that your friend had for your birthday. Soon after you started having sex with him. Initially, it was with condoms, but after a few months he persuaded you to get on the pill so that he could stop using condoms – telling you that didn't you trust and love him. So you agreed. The two of you have been together since, but about a year ago, you noticed that he started disappearing after making a date to see you.

Around that time he also started making snide comments that you were putting on weight and that it was making you unattractive. You were hurt, but thought perhaps you should exercise more and eat less.

However, he continued his disappearing act and also his verbal attacks on you got worse. You confided in a friend who told you that this is normal and that I should be grateful to have a boyfriend.

For this health care visit: You are shocked to find out your HIV test result and cannot comprehend how this can be when you have only been with your boyfriend. You are also scared that if you tell him your results, he will blame you and get really angry at you.

Lately he has been more and more verbally abusive to you – shouting and getting angry and calling you names. You tell the HIV counsellor that you suspect that your boyfriend may have been unfaithful to you



You are a HIV counsellor in the tertiary hospital in Nairobi who has been working there for the past 7 years. During this time you have provided counselling to many patients. You always advise them to disclose their HIV status to their partners or spouses because you believe that it may bring them support and at least that onward HIV transmission can be prevented. However, you have also seen that many, especially, women are afraid to tell their partners about their HIV result.

When this young mid-wifery student comes to you with her HIV result and tells you that she has only been with her boyfriend, you immediately guess that like many others her boyfriend must have been unfaithful to her.

Initially you think you can convince her to tell him and surely after initial challenges, the two of them can perhaps go together and have him tested so that both can get the treatment and care they will need. But she seems very reluctant to tell him about her HIV result.

What do you do?

This story continues from the first-line support role play. However the ending here is different. The patient here does not say that she thinks her partner will not hurt her. She says something different.

Patient: *She pauses.* Well, when he came home yesterday he was really mad about something, and he threatened to hit me when I asked him why he was so mad.

Provider: *Pauses, giving patient time to think.* How do you feel about that?

Patient: It makes me sad and afraid. I'm not sure what to do when he gets mad. It makes me anxious just thinking about it. *She looks like she might cry, then recovers.*

Provider: *Pauses.* Feeling anxious is common when you feel threatened at home. It's important to know that it's not your fault. Everybody deserves to feel safe at home.

Patient: What if I don't feel safe at home?

Provider: There are many ways to feel safer at home. Before we talk about that, can I ask a few more questions about your safety at home?

Patient: OK. *She looks hopeful.*

Provider: Has your husband or partner forced you into sex or forced you to have any sexual contact you did not want?

Patient: No, that hasn't happened.

Provider: *Pauses.* Has your husband or partner threatened to kill you?

Patient: No, he hasn't.

Provider: Are you afraid of your husband?

Patient: Sometimes

Provider: I want to make sure we talk about your safety. You've told me that you have been threatened by your husband, that he has hurt you in the past, but that you haven't experienced forced sex, or threats to kill you. Relationships can change quickly, so if any of these things happen, or if you feel you or your children are in danger, please know that you can talk to me about it, or we can work together to find you help as quickly as possible. *Pauses.*

Patient: *pauses* I do worry a lot.

Provider: Feeling unsafe can cause a lot of worry. We want to make sure you stay healthy and get the support you need.

Patient: I'm not sure who I can talk to when I feel worried about what my husband might do.

Provider: Have you thought about sharing your concerns with anyone?

Patient: My sister knows. Her husband treats her badly you see. She thinks I am the fortunate one. It's not as bad. He just gets angry sometimes.

Provider: Remember, everyone deserves to feel safe at home. I want to make sure you have some supports in place in addition to your family, if you feel you need it. Is there someone else in your surroundings who could support you? Maybe a neighbour or a friend.

Patient: No, I don't feel comfortable telling anyone about this.

Provider: I understand. Would you feel comfortable and have you ever considered talking with a counsellor or calling the local Crisis Line?

Patient: *Looks uncertain.* Isn't that only for women who are beaten by their husband?

Provider: The Crisis Line helps women who are wondering about safety in relationships – not just those who are experiencing physical violence at the moment. They talk with all women about safety in relationships and healthy and unhealthy relationships. Women call the Crisis Line when they are concerned about safety.

Patient: Hmm.

Provider: You may be concerned about others finding out that you called the Crisis Line or talked with a counsellor. I don't know if that is a concern for you...

Patient: *nods.*

Provider: The team at Crisis Line provides confidential care – you can tell them as much or as little about your situation as you chose. They will not ask your name, and will keep your information private

Patient: *Sighs.* I'll think about it.

Provider: *nods head and waits a few seconds.* Ok. It would also be good to think about what to do if your husband does become violent again. Would you have any place to go?

Patient: Yes, I can go to my mother. She does not know about this, but I can always go there and take the children with me.

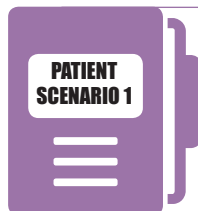
Provider: So you have some plan. Please do know that we care about your safety. If anything changes, or if you feel like you would like more support, you can always come here again.

Patient: Ok, thank you.

Safety Planning	
<p>Safe place to go</p> 	<p>If you need to leave your home in a hurry, where could you go?</p>
<p>Planning for children</p> 	<p>Would you go alone or take your children with you?</p>
<p>Transport</p> 	<p>How will you get there?</p>
<p>Items to take with you</p> 	<p>Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?</p> <p>Can you put together items in a safe place or leave them with someone, just in case?</p>
<p>Financial</p> 	<p>Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?</p>
<p>Support of someone close by</p> 	<p>Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?</p>

Instructions for participants

- **Patient:** Read the entire scenario to yourself. Do not initially share the details with others in your group. When instructed by the facilitator read the part that says “**Read to provider**” to the person playing role of health worker.
- Your role as patient is to describe your situation with respect to the history violence and respond to the questions asked by health worker.
- **Health worker:** Read the provider scenario, listen to what patient is saying about the history of violence then broach the issue of safety with the patient and assess whether she is likely to be safe in her situation (use the safety assessment questions from the participant manual) and if needed, help her make a safety plan (using guidance from participant manual. Further, the health care provider needs to identify what other referral services the patient needs and provide a “warm referral” using the guidance from the manual.
- **Observer:** Pay close attention to the exchange. Use the guidance on enhance safety and provision of social support from the manual to provide feedback to the provider:
 - How did the provider apply the tips for safety assessment and planning?
 - Did they keep the woman’s needs, choices at the centre and communicate in an empowering manner?
 - How did the provider address the issue of warm referral?
- You have 10 minutes to practice the role play before providing feedback for another 5 minutes and then switching roles within your group.



Read to provider: I am a 55-year old woman living in Kisumu. I am here for a follow up to my gynaecological examination because I had yellow and bad smelling vaginal discharge. My back was hurting and I would like some more medications to help with the pain. I am not sure how I can pay for the medications however.

I have been married for over 37 years and have 5 children aged 34 to 18 years old (three of them live with her, the others moved away). I am a stay-at-home wife. For the past month I have been agitated and stressed, and often my day is ruined by terrible headaches. I am very tired as I have not slept well in a month and I have also gained a lot of weight. I am feeling ugly, stupid and worthless, and have been having occasional suicidal thoughts. My husband has abused me in many ways throughout the 37 years of marriage. He often calls me by offensive names and belittles me in front of your children.

Read to yourself, only share when asked details by the provider:

In the last 5 years you have spent a night at the local shelter 3 times when your husband was more violent than usual, like when he broke your arm or he threatened to kill you. You returned to him primarily for financial reasons and because he apologized and promised to stop the violence. He had been nonviolent most of this past year

until he knocked you down a few days ago and your back started hurting more than usual and went into a spasm. You partly blame yourself because your husband recently lost his job and has been too stressed lately. You would like to find work to help cover the family's expenses, but have not yet been able to.

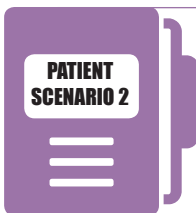
For this health care visit: you have come back to this doctor for a follow up that your doctor requested in order to see how your back pain and STI symptoms were improving. The provider asks you how are things at home with your husband, as the previous time you had told him about the abuse. You tell him that things are stressful as your husband has lost his job and you are really worried about the children.



You are a 48-year-old male gynaecologist practicing in Kisumu for the last 20 years. You are working in a busy community polyclinic that provides maternal and reproductive health services to women. It is a busy clinic with lots of patients to see every day and you often do not have more than 5 minutes to spend per patient.

You look at the record for this patient and ask about her back pain and symptoms of discharge. You also recall that she had told you about problems with her husband and so you ask her about how things are going. She tells you that it is very stressful and she is worried about the children because her husband has lost his job. You are concerned about what she has said, but also have few other patients waiting outside.

What do you do?



Read to provider: I am a 35-year-old woman living in a town about 3 hours from Nakuru. The health issues I am presenting are: fractured small bones in my right hand, I am anxious, and pose many questions about the duration of the bruises and the need for medications.

I have been married for 20 years to a prestigious businessman in town who is also an active participant in all mosque related activities. I work as a primary school teacher. I have 3 children (10 to 15 years old). I have partial loss of hearing/sight on my right-side due to an assault by my husband 20 years ago when he beat me very severely.

In the past when I told health care providers of the assaults, they ignored the information and merely treated the injuries. In the last 10 years, I have often received medical attention for a variety of injuries due to the assaults.

Read to yourself, only share when asked details by the provider:

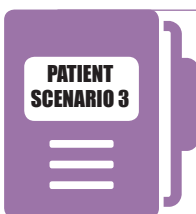
At your last visit to the doctor, you were seen by this nice young doctor who asked you what was happening and she was very sympathetic, so you told her about your situation at home. You had told her that you were worried about losing hearing in your "good ear", so she sent you to a specialist for further tests. She had also seen your bruises, which you had first said were from a fall. Eventually you told her that it was because your husband hit you. The doctor assured you that she would keep your information confidential, so you felt reassured.

For this health visit: Today you have gone back to discuss the results of your ear examination with the specialist. Lately your husband has been travelling so things are good at home, but he is coming back from his trip in a few days, so you are anxious that the tensions in the home will resume when he returns. You tell your doctor about feeling anxious about his return.



You are a young female physician– 27 years old who has been sent to the county referral hospital in Nakuru. You are engaged to be married, but not as yet married. Your fiancé is in Nairobi. You have 6 months to finish your rotation before you go back to Nairobi. You are aware that domestic violence happens, but this patient is one of the few that you have asked about it, because her injuries seemed so bad when you last saw her. The patient comes for a follow up that you asked her to do after the results of her ear examination came back from the specialist. You want to discuss the results and give her advice on how to prevent further loss of hearing in her "good ear". She seems really anxious during this visit, so you ask her about it, and she tells you that she is worried about her husband's return after a long trip.

What do you do?



Read out to the provider: I am a 30-year-old woman with 2 daughters (7 and 5 years) living in Mombasa. I have come to the Ob/Gyn clinic because I am pregnant again. This is my fifth pregnancy in the last 8 years. I had one miscarriage already. I also had an abortion last year.

I have been married for 12 years. I have been under pressure to become pregnant and give birth to a boy. My husband beats me regularly and shouts me and forces me to have sex so that I can get pregnant and give his parents a grandson they want. My in-laws humiliate me. I have had an abortion before because I found out I was carrying a girl. This time if I end up with a girl, I am afraid that my husband and in-laws will throw me out of the house. I came to this doctor because I was nauseous and had fainted and thought I might be pregnant. They confirmed that I was and prescribed medicines because I did not have enough iron in my body. I have come back to this clinic because they asked me to come back for regular check-ups.

Read to yourself and only share when asked details by the provider.

You have mixed feelings about this baby. What if it is a girl? You are desperate to find out if it is a girl or a boy. If it is a girl, you don't want to continue with the pregnancy, because you know that your situation at home will get worse. But you have learned through the television that it is illegal to find out about the sex of the baby and to abort after. You are really scared and worried about what to do

For this health visit:

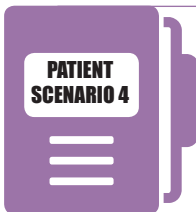
You tell the doctor who attended to you last time that the medicines he gave for the iron problem are making you feel better. However, you are really worried. You tell him that your family will not be happy if it is another girl. If it turns out to be another girl, things at home will get really bad for you. You want to find out if there is any way to know now, so that you can take care of things.



You are a young male Ob/Gyn (33 years old) who has been practicing in this primary health clinic for last 2 years. You see pregnant women coming with anaemia and multiple pregnancies all the time. You are overworked and you are just trying to get some experience and some money before you start your own private practice.

You have asked this woman to come back for regular antenatal check-ups after prescribing iron supplements. She comes back for the check-up. The nurse who sees her first, comes to you and discretely tells you that she is worried about carrying a girl. You are aware that things are not good in her home, as she already has two daughters and is under pressure to have a son. But you also know that it is illegal to determine the sex of the foetus and abort a female foetus. You really want to help her.

What do you do?



Read out to provider. I am a 20 year old woman living in Machakos. I had unprotected sex with my boyfriend and I am worried about becoming pregnant again as my child was born only 1 year ago.

I am unmarried, have been in a relationship with my 26 year-old boyfriend for 2 years. I dropped out of college when I first became pregnant and now work as a part-time secretary. I have plans to finish college and become a teacher. I also suspect that my boyfriend is being unfaithful. I have tried to convince my boyfriend many times to use condoms but he refuses. He has threatened to leave me if I insist on condom use. He has forced me to have sex with him a couple of times. I love him and want to make the relationship work and keep the family together. I went back on the pill after a consultation with the nurse who urged me to continue saying that the difficulties usually ease over time.

Read to yourself, only share when asked details by the provider.

You continue to have some difficulties with the pill and recently your boyfriend saw the stash hidden away in your closet and got really angry that you had not consulted him about the contraceptives. You had a big fight. He not only shouted at you, but slapped you hard and then stormed out of the apartment. You have come back to see if there are any other options for avoiding a pregnancy. You are also confused about what to do. Your boyfriend came back a few days later and apologized and was very sweet to you.

However, you are really shocked that he slapped you, and are not sure whether to accept him back or not.

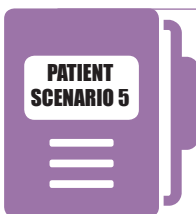
For this health care visit: You tell the nurse that you really don't like the pill. When your boyfriend found out he became very angry, and you both had a fight. You ask her what else you can do.



You are a 42 year old nurse who is working in a hospital in Machakos. You are married with 1 daughter who is 20 years old. Your partner has died and your daughter is in college so you work long hours and multiple shifts at the hospital to earn more money. You enjoy your work and like to talk to patients and explain to them about how the reproductive anatomy works to prevent pregnancies.

You have really taken to this young woman because she reminds you of your daughter. At her last visit, you urged her to continue with the pill, telling her that it would become better over time. But she has come back, telling you that she really does not want to remain on the pill and that she and her boyfriend had a big fight. She seems really upset and bursts into tears when you ask her if she is ok.

What do you do?



Read to the provider: I am a 22 year old student studying to be a mid-wife in Nairobi. I live near one of the largest slums in Nairobi. I have 1 more year to go before I complete my studies. Last week a mobile HIV testing from van came to my university and encouraged university students to get tested, so I went not thinking much about it. To my shock I was told that I tested HIV positive. They told me immediately to go to this clinic for further treatment and care. I arrive at this clinic not believing that this could be possible. I have only been with my boyfriend for the last 2 years and have also been on the pill so that I don't get pregnant.

My boyfriend and I have been together for 2 years now. He is 38 years old. We stopped using condoms a few months after we started going out and I started using the pill as I did not want to be pregnant. A year after we met, he started verbally abusing me and would often disappear and not keep our dates. He has been really mean to me about my weight and making me feel unattractive.

Read to yourself, share only when provider asks: Your boyfriend and you have been having many fights where he calls you names. You suspect that he is being unfaithful to you. You have been asked to tell him about the HIV positive results, but you are really afraid that he will blame you and get angry with you. You have not told your boyfriend about the HIV positive result, as things have been very tense between you lately. You have had several very bad fights and he yelled and called you all sorts of names.

For this health care visit: You have come back to the clinic today to get your CD4+ count done and to find out whether you need to get on treatment. Priority is given for treatment to pregnant women so you don't know whether you will be put on treatment or not. You are still in shock and really upset and confused with all that is happening. You have been referred to an HIV positive support group to help you cope with my results and it has been helpful, but you really don't know if they will understand your boyfriend problems.



You are a HIV counsellor in the tertiary hospital in Nairobi who has been working there for the past 7 years. You have provided counselling to many patients. You always advise them to disclose their HIV status to their partners, because you believe that it may bring them support and at least that onward HIV transmission can be prevented. However, you have also seen that many, especially, women are afraid to tell their partners about their HIV result.

This young woman has been told of her HIV positive result the previous time and you had advised her to come back with her boyfriend so that he could get tested, as you suspect that he is the one who infected her. She seemed very reluctant to tell him about her HIV result. She has come back for her CD4+ count and to get counselling on whether she needs to be on ARVs or not. She has come on her own and you inquire how things are going. She seems really tense.

You ask her if she has started the HIV positive support group and she nods. You ask her how things are going with her boyfriend. She tells you that she has not talked to him about her HIV result, as things are not good between them. You are concerned about her, especially because you know that HIV status disclosure can be a difficult experience.

What do you do?

**Case Scenario 1:**

A 25 year old female, 15 weeks pregnant, presents for a routine visit. She is noted to have a swollen, bruised left arm.

The patient discloses that she has been in a long-standing abusive relationship with her current partner. The pregnancy was unexpected, but she is happy about having a child. Her partner, however is not. Historically, the partner had only been verbally abusive. He would tell her that she is worthless without him and that she is too stupid to hold a job or make it her own. He had never been physically abusive until yesterday, when he grabbed her by her arm and threw her against the wall. She is scared to report him and feels she needs to forgive him because she relies on him financially. She is afraid she will not be able to support herself or the baby without him, since he has a "good job" as a banker. She has a sister who lives nearby, but she hates the idea of "crawling back to my family"

**Case Scenario 2:**

A 30 year-old female presents to the GBV Center. She says her husband, Edward, has abused her for five years. She is very scared and can't take it anymore. Everything started when he got jealous of her spending time with her friends and family. The last time they fought he told her he beat her badly, told her he hated her and called her bad names. She reported to the police and he was arrested but released because she withdrew the case. She tells you she loves him very much, he is the only man who can love her. She thinks she's ugly with very unattractive body. He is very abusive when he is drunk. He always calls her a fat cow. Sometimes she wants to die.

**Case Scenario 3:**

A 36 year-old female is referred to the facility by the police to be assisted. She is really confused and shaken. Her ex-boyfriend and father of her last born child, who she left because of physical and sexual abuse, broke into her house at 2am the previous night and raped her while she was drunk.

**Case Scenario 1:**

A woman is at the health clinic with a sprained wrist, accompanied by her husband. While treating the woman for her injury, the husband is giving the history of it, while his wife is completely silent. As a health worker, you get the feeling that the story of the husband is not what actually has happened. Start the skit at the beginning of the conversation.

The story of the husband:

The husband says that his wife fell down a few days ago, but he can't explain exactly how the accident happened. The husband tells the problem is very urgent, because she is not able to cook for him.

The story of the wife:

When asked explicitly, she confesses that her partner twisted her wrist and told her not to come in for treatment. The only reason they came in was because she couldn't do any work at home and he was getting angry with her for not cooking. She thinks the violence is her fault.

**Case Scenario 2:**

A woman is at the VCT clinic to be tested for HIV. After greeting the survivor, the VCT counsellor uses the interview guide to start a conversation about violence. The woman answers the questions based on her current situation. Start the skit at the beginning of the conversation about violence.

The Survivor's Story:

She is living with her husband right now, but she just returned from staying with her mother, because her husband was beating her. She came back to him, because he told her he would change. But now he is seeing another woman openly. Also, he is trying to tell her what to do all the time. He doesn't know she is being tested, because he has told her that if she ever gets HIV he will beat her. She fears he will abandon her if she is HIV positive. She doesn't want to disclose her results or tell him that she was tested.

Write out each role on a separate sheet and give to each person taking up role

Rose

You are Rose, a 28 year-old woman who has been experiencing physical and sexual abuse from her boyfriend for the last 6 months. You don't know what to do therefore you go to your sister for support and advice

Sister

Listen to Rose, talk to her and then send Rose to the community/religious leader for advice

**Community/
religious leader**

Listen to Rose, talk to her and then send Rose to the Women's group for support

Women's group

Listen to Rose, talk to her and then send Rose to the doctor/health clinic for health care

Doctor/ Clinic #1

Listen to Rose, talk to her and then send Rose to the police #1 for official medical reporting form

Police #1



Listen to Rose, talk to her and then send Rose back to the doctor/clinic #2 (doctor 1 is not available). Explain that no charges can be filed without medical proof

Doctor/ Clinic #2



Listen to Rose, talk to her, take her history, perform a medical examination and then send Rose back to the police #2 with medical details

Police # 2



Listen to Rose, talk to her and then send Rose to legal aid

Legal Aid Lawyer

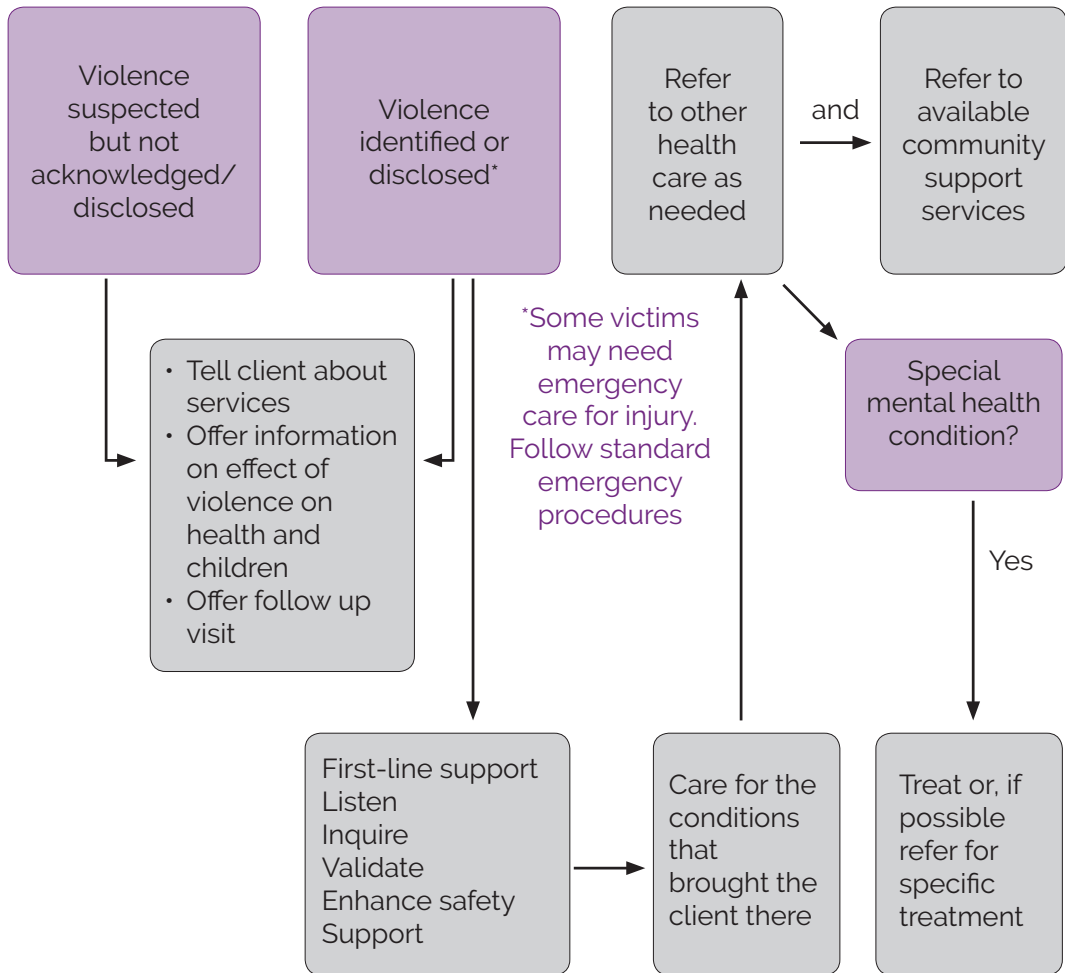


Ask Rose to tell her story, ask for all the documents, prepare her case and make her practice saying her story in court again

Court



Welcome Rose and instruct her to re-tell her story at court



Sample Referral Chart

What to refer for	Where/Who to refer to	Contact info	Responsibility for follow up
Forensics			
Shelter/housing			
Crisis centre			
Financial aid			
Legal aid			
Support groups			
Counselling			
Mental health care			
Community level services			
Child welfare services offered at the children's department			
Other			

What is Intimate partner Violence (IPV)?

This is behaviour by an intimate partner that causes harm including other controlling behaviours.

Harm: Physical, Sexual, psychological, economic, acts of aggression, verbal abuse, sexual coercion, reproductive coercion among others.

Partner: refers to both current and former spouses or other intimate persons

Who can experience IPV: IPV happens to women and girls as well as men and boys

What are the predisposing factors to IPV?**(a) Individual factors**

Some of the most consistent factors associated with a man's increased likelihood of committing violence against his partner(s) are: Young age; Low level of education; Witnessing or experiencing violence as a child; Harmful use of alcohol and drugs; Personality disorders; Acceptance of violence (e.g. Feeling it is acceptable for a man to beat his partner) and past history of abusing partners;

Factors consistently associated with a woman's increased likelihood of experiencing violence by her partner(s) across different settings include: Low level of education; Exposure to violence between parents; Sexual abuse during childhood; Acceptance of violence; Exposure to other forms of prior abuse and Living with disability.

(b) Relationship factors

Factors associated with the risk of both victimization of women and perpetration by men include: Conflict or dissatisfaction in the relationship; Male dominance in the family; Economic stress; Man having multiple partners; Disparity in educational attainment, i.e. Where a woman has a higher level of education than her male partner.

(c) Community and societal factors

The following factors have been found across studies: Gender-inequitable social norms (especially those that link notions of manhood to dominance and aggression); Poverty; Low social and economic status of women; Weak legal sanctions against IPV within marriage; Lack of women's civil rights, including restrictive or inequitable divorce and marriage laws; Weak community sanctions against IPV; Broad social acceptance of violence as a way to resolve conflict; Armed conflict and high levels of general violence in society.

How do you prevent IPV in the community?

Communities should:

- Advocate for change of harmful attitudes and behaviours that perpetuate violence and prevent it from happening

- Address root causes at the communities
- Address the immediate needs of the survivor after a violent incident has occurred to reduce re-victimization.
- Identify IPV cases through tell-tale signs and refer as appropriate for services
- Community should minimize further harm by addressing stigma caused by IPV
- Community should minimize long-term consequences faced by survivors of violence, including those that focus on rehabilitation and reintegration.

What should I do if I experience IPV?

Get to a safe place and seek help from the nearest health facility, police station or speak to someone you trust as soon as possible. If it is sexual abuse or bodily injury, seek medical attention within 72 hours for time bound prevention services.

At the health facility you will get:

- (a) Medical evaluation and attention for your injuries
- (b) Counselling support
- (c) Treatments to prevent infection with HIV and sexually transmitted infection; prevention of pregnancy among others
- (d) Referral for other services as you may require e.g. Trauma Counselling, mental health care, legal services among others.

What the community should know about the signs of one going through IPV

Needs to be very aware that trauma related psychological symptoms can;

- Be present right after the event and **will or not disappear**
- They will not be present just after the event and will appear months (sometimes years) afterwards (most of the time after a trigger life event as the death of a loved one or loss of job).

Most common symptoms are:

- constant sadness,
- sleeping disturbance,
- feeling dizzy or irritated,
- constant mood changing,
- nightmares and "flashbacks"

Note: seeking care in time might prevent consequences such as:

- **Physical Harm** – Injuries, functional impairments, permanent disabilities
- **Risky Health Behaviours** – 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 infections /HIV, unwanted/unplanned pregnancy, forced contraceptive

use, contraceptive sabotage, miscarriage/abortion, unsafe abortion, pregnancy complications, low birth weight, denial to seek RH services,

- **Psychological Consequences** – Post Traumatic Stress Disorder, depression, anxiety, fears, sleeping disorders, eating disorders, suicidal thoughts, low/lack of sexual drive, and low self-esteem
- **Negative social outcomes**-separation, divorce, dysfunctional families, stigma and discrimination
- **Reduced life expectancy** – reduced expected survival due to the impact of IPV
- **Death** – fatal outcomes as immediate result of a survivor 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)

What should I NOT do if I experience IPV?

- You should not keep quiet
- You should not blame yourself. It is not your fault that the violence happened
- You should not feel guilty
- Do not normalize. It is unusual to undergo violence
- Do not take your partner's excuses
- Do not take threats lightly
- Do not feel ashamed to seek help
- You should not stay in a room where there are weapons
- Avoid disclosing to non-trusting persons. This may lead to more harm
- Do not justify violence
- Do not decline help or assistance from a concerned person
- Do not reiterate
- Do not ignore threats or tell-tale signs of grievous harm

Remember: It is the person that violated you who is wrong. What has happened is NOT your fault

Survivors of IPV fear to report violence due to the following reasons:

- Stigma and discrimination
- Powerlessness
- Traumatic sexualisation; Not wanting to relive the event
- Fear of conflict
- Social embarrassment
- 'Compensation' from perpetrator
- Threats from the perpetrator

What should happen once a person reports IPV at the police station?

- All acts of violence should be reported
- Records should be accurately recorded, according to the survivor's words
- Once reported:
 - Perpetrator should be tried in court and convicted according to the law.
 - Survivor should be educated and counselled.
 - Survivor should be provided with support from the community, the law, the family.
 - Accurately Document the violence incidence in the Occurrence Book (OB)
 - Collect, label, preserve and store the evidence securely e.g. weapon, clothing, photographs of injuries, used condom
 - Submit the evidence to the Government chemist for analysis
 - Issue the survivor with a P3 form which will be filled by the health service provider. The survivor, with support of the CHV will ensure that the PRC form is filled
 - Escort the survivor to the health facility if he/she opts to seek security services first
 - Visit the scene of crime and carry out investigations as required
 - Arrest alleged perpetrators and document their statements
 - Refer survivor for other non- clinical services as appropriate e.g. legal, counselling, etc.
 - Prepare court files and ensure cases are booked in court
 - Fill in charge a sheet with the charged crime as per the corresponding legislation e.g. Sexual Offences Act 2006, Protection against Domestic Violence Act (2015) Act, Matrimonial Act, Penal Code etc.
 - Contact survivor and witness for case mentioning and feedback on cases
 - Offer protection to survivors and witness while the case is in court.

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