



Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia

A Resource Package



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PART I

Guidance for health care professionals in strengthening health system responses to gender-based violence

PART II

Training package for health care professionals on strengthening health system responses to gender-based violence

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Foreword

Gender-based violence both reflects and reinforces inequalities between men and women and compromises the health, dignity, security, and autonomy of survivors. UNFPA puts special emphasis on protecting women and girls' human rights in line with its vision that every girl and woman is treated with dignity and respect.

UNFPA's Regional Office for Eastern Europe and Central Asia recognises that any form of GBV, including harmful traditional practices, results in poor reproductive, mental, and physical health outcomes; reduces educational attainment, productivity, and social functioning; and imposes high costs in terms of public funds required to respond to survivors' needs and deal with perpetrators. Notably, the ICPD Beyond 2014 Global Review conducted in 2013 revealed that 'ending gender-based violence' was among the issues to which the highest proportion of governments (88 per cent) were committed (UN Secretary-General 2014). This means that eliminating gender-based violence will remain a key priority in the ICPD Beyond 2014 and post-2015 global development agendas.

Effective responses to violence against women depend on a well-functioning system that can provide survivors with immediate care and safety through quality mental, physical, and reproductive health services; protection and shelter; and social and justice services. By ensuring the availability of an effective support system, the state sends a message that violence against women is a serious crime and will not be tolerated.

UNFPA in Eastern Europe and Central Asia makes every effort to help break the silence and ensure that the voices of women are heard. Levels of violence vary between and within countries in the region, with an average of 25.4 per cent of women in Eastern Europe and Central Asia reporting experiences of physical or sexual violence by an intimate partner or sexual violence by a non-partner (WHO 2013). In most cases survivors of gender-based violence require multi-level assistance from health service providers. In response, UNFPA has been working with the European network Women Against Violence Europe (WAVE) since 2011 to provide sustainable solutions to improve the health-sector response to gender-based violence. This resource package is the outcome of this partnership and aims to strengthen the capacities of healthcare professionals at both the level of health facilities/management and of frontline service providers, a key prerequisite for an improved health-system response to gender-based violence. WAVE and UNFPA would like to acknowledge the technical comments received from experts and practitioners in the Eastern Europe and Central Asia region and beyond, which provided valuable guidance in the process of developing the resource package. Notable among them were a Reference Group of experts convened in 2013 as well as the participants of a regional training workshop held in 2012 on strengthening health-sector responses to gender-based violence in Eastern Europe and Central Asia.

UNFPA is pleased to introduce this practical tool to advance the knowledge and capacities of healthcare professionals in preventing gender-based violence and providing support and care to survivors. UNFPA and WAVE will continue their efforts to establish effective responses to gender-based violence in the region that envision improvements in service delivery, heightening of community awareness, improvement of policy, and the collecting of experiences that may be shared within the public health sector across the region.

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INTRODUCTION

Gender-based violence (GBV) against women and girls is one of the most widespread violations of human rights, with a significant impact on physical, psychological, sexual and reproductive health. According to a recent study, 25,4% of women in Europe and Central Asia have experienced physical or sexual violence by an intimate partner or sexual violence by a non-partner (WHO et al 2013).

The health sector is a critical entry point for identifying GBV, providing medical care to women and girls survivors and referring them to other essential services, such as shelters, counselling centres or specialized medical care. Indeed, for many survivors of violence, a visit to a health professional is the first, and sometimes only, step enabling them to access support and care. Therefore, strengthening the capacity of health care professionals to identify and support women and girls survivors of violence is crucial to the prevention of and response to GBV.

Many countries in Eastern Europe and Central Asia (EECA) have made significant progress in acknowledging the problem of GBV and taking steps to prevent and respond to the issue. While governments and health facilities have adopted policies and programmes addressing the role of the health sector, for instance through developing health protocols and guidelines or designing and implementing training programmes for health professionals, GBV is still being addressed primarily as a law enforcement concern, rather than a public health issue. In many countries, there is need to further improve the policy framework for strengthening the health systems response and to translate this framework into an institutionalized response at the level of health facilities with appropriate referral pathways, supported by adequate knowledge and skills on the part of health care providers to identify and respond to GBV.

To address these shortcomings, UNFPA, the United Nations Populations Fund Regional Office for Eastern Europe and Central Asia (EECARO) and its Implementing Partner Women Against Violence Europe (WAVE) are working together to support capacity development of health professionals in the region in order to strengthen the response of health systems to GBV. The main result of this partnership which commenced in 2011 has been the development of a resource package that offers practical guidance for health care professionals, health facility management and policy makers available at www.health-genderviolence.org. In 2013 and 2014, the package underwent a complete revision to further improve its relevance in strengthening health system responses to GBV and to update it in line with recent international developments.

AIM OF THIS PUBLICATION



Overall, the UNFPA-WAVE resource package seeks to provide health care professionals in EECA with evidence and tools to promote laws, policies and programmes, with the overall aim of achieving a comprehensive multi-sectorial response to GBV, of which the health sector is an important part.

More specifically, the package:

- » offers in-depth background information to health care practitioners in order to better understand the nature and dynamics of GBV and the role of the health sector in the response to GBV;
- » identifies practical steps and recommendations to design, implement, monitor and evaluate interventions to more effectively integrate the response to GBV into the health sector;
- » provides practical guidance for creating new, or strengthening existing, referral systems, highlighting the importance of multi-agency cooperation in the response to GBV;
- » seeks to support efforts to strengthen the capacities of health professionals to understand GBV and its symptoms, to identify instances of GBV and to provide survivors with appropriate care and support.

In doing so, the resource package builds on international standards and guidelines, including, but not limited to, the 2013 WHO clinical and policy guidelines on health sector responses to violence against women. It also makes reference to existing good practice examples from East and Western Europe and Central Asia.

The resource package is supplemented by a compilation of country-specific resources from the region of Eastern Europe and Central Asia. Health care professionals and policy makers are encouraged to visit this collection of resources at the “Country Info” corner at www.health-genderviolence.org. It offers useful background information that may be used to further tailor the recommendations and guidelines provided in the present package to the needs of specific country contexts.

TO WHOM DOES THIS RESOURCE PACKAGE APPLY?

Geographic scope: The resource package applies to health care professionals in the region of Eastern Europe and Central Asia. The roll-out of the package will be supported by UNFPA EECARO in the following countries and territories: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kosovo (UNSCR 1244), Kyrgyz Republic, Republic of Moldova, Serbia, Tajikistan, the Former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, and Uzbekistan.

Level of health care provision: The resource package mainly addresses the level of non-specialized primary health care, which normally provides the first and most critical point of contact for women survivors of GBV seeking medical help. Additionally, the package may also provide relevant guidance for secondary health care settings, where women survivors may be referred to by primary health care providers.

Target group: The resource package primarily addresses health care staff providing direct services to survivors of GBV. This includes doctors, but also nurses and midwives, who, in the EECA region, are of particular importance in remote rural regions. Keeping in mind that transforming a sector’s response to GBV requires an institutionalized approach, the package also seeks to provide guidance to the management of health facilities (such as hospitals, health centres or doctors’ offices), as well as, where relevant, policy makers.

THEMATIC SCOPE OF THE RESOURCE PACKAGE

Forms of violence covered: While both women and men can become survivors of GBV, women and girls worldwide constitute the majority of those affected, as a result of prevailing unequal power relationships between women and men. Therefore, the resource package addresses the health sector responses to GBV which is used interchangeably with violence against women, in line with United Nations (UN) standards. The guidance and training package provided in the present resource package mainly focus on violence committed by intimate partners, which is the form of GBV that affects women most. However, many of the provisions are also relevant to other forms of violence against women.

STRUCTURE OF THE RESOURCE PACKAGE

□ **Part I (Guidance for health facilities and health care professionals in strengthening health sector responses to gender-based violence)** provides background information and practical guidelines to support policies and programmes in strengthening health system responses to GBV. It provides an overview of the causes, dynamics and consequences of GBV (chapter 1) and addresses the role of health care professionals in the response to GBV with a focus on international human rights standards and key principles for service provision (chapter 2). Chapter 3 leads through the different steps of a health care provider's intervention in a presumed case of GBV, starting from identification to the medical examination and provision of care, the documentation of GBV, risk assessment and safety planning up to referrals to other service providers. Chapter 4 addresses referral pathways for survivors of GBV, addressing issues such as the actors involved as well as necessary steps in setting up and implementing referral mechanisms. Part I concludes with an introduction to monitoring and evaluation (M&E) of health sector interventions to GBV, explaining key concepts and principles of M&E and proposing specific steps in setting up and implementing evaluations (chapter 5).

□ **Part II (Training package for health care professionals on strengthening health system responses to gender-based violence)** offers a ready-made and user-friendly training curriculum to strengthen the knowledge and skills of health care professionals to understand GBV, to identify patients who have experienced GBV and to provide survivors with appropriate care, support and referrals. After a number of practical tips and recommendations for preparing trainings, it provides a training package consisting of ten modules, as follows:

- 1 Introduction and getting to know each other
- 2 Understanding GBV – definition, causes, dynamics and consequences
- 3 The role of health professionals in the response to GBV
- 4 International standards and principles for services
- 5 Identifying GBV
- 6 Undertaking a medical examination and providing medical care
- 7 Documenting GBV
- 8 Risk assessment and safety planning
- 9 Referrals to other service providers
- 10 Evaluation of the training and closing

Each module provides the trainer with

- » an outline of the training session, including key messages and content,
- » references to relevant chapters contained in part I of the package that trainers may consult as background information,
- » a PowerPoint presentation, group exercises and handouts.

Trainers may wish to apply the training package as included in the present publication, or adapt it in line with specific country needs and contexts.

The package seeks to make a contribution to the important work undertaken by health care professionals and policy makers in the EECA region to strengthen health system responses to GBV, be it in the process of developing or revising policies or protocols, implementing training programmes or setting up referral mechanisms. Any comments or requests should be directed to info@health-genderviolence.org.

PART I

**Guidance for health care
professionals in strengthening
health system responses to
gender-based violence**

CHAPTER 1

Understanding gender-based violence

Gender-based violence (GBV) against women is a human rights violation and both, a cause and a consequence of unequal power relationships between men and women. It is a public health issue with serious consequences on women's physical, sexual, reproductive and mental health.

In order to be able to effectively identify and respond to GBV, health care professionals need to have a sound understanding of the concept of GBV, its causes and consequences. Therefore, this chapter discusses the definition and forms of GBV (1.1) and the scope of the problem, both globally and in the EECA region (1.2). It addresses the causes of GBV (1.3), the dynamics of violence in intimate partner relationships (1.4) as well as myths surrounding GBV (1.5). It explains how women belonging to specific groups may be at higher risk of GBV and/or face specific obstacles when seeking support and protection (1.6) and provides an overview of the consequences of GBV on women's health (1.7).

1.1. DEFINITION AND FORMS OF GENDER-BASED VIOLENCE

The terms of GBV and violence against women are often used interchangeably, as most violence against women is gender-based, and most GBV is inflicted by men on women and girls. International human rights law documents provide the following definitions of violence against women and GBV (box 1).

Box 1: Defining gender-based violence against women

Violence against women

(...) is "a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of women's full advancement. [...] [V]iolence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men" (DEVAW, preamble).

(...) constitutes a violation of human rights and a form of discrimination against women. It means all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psy-

chological 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" (Article 1 DEVAW, Article 3 Istanbul Convention).

Gender-based violence is "violence that is directed against a woman because she is a woman or that affects women disproportionately" (CEDAW GR 19, Article 3 Istanbul Convention).

(continued on page 16)

Forms and contexts of gender-based violence against women: “Violence against women shall be understood to encompass, but not be limited to, the following:

(a) Physical, sexual and psychological violence *occurring in the family*; including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation.

(b) Physical, sexual and psychological violence *occurring within the general community*, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence *perpetrated or condoned by the State*, wherever it occurs” (Article 2 DEVAW).

(continued from page 15)

From these international definitions, we may understand the term GBV as follows:

VIOLENCE AGAINST WOMEN IS GENDER-BASED: IT DOES NOT OCCUR TO WOMEN RANDOMLY.

Rather, such violence is directed against women *because they are women or affects women disproportionately*. Gender-based violence is a *structural problem* that is deeply embedded in unequal power relationships between men and women. Such violence is perpetuated by harmful social and cultural expectations about gender roles typically associated with being a woman or being a man, a girl or a boy. It functions as a mechanism for enforcing and sustaining gender inequality. Women and girls who are subjected to violence receive the message that they are worth less than others and that they do not have control over their own lives and bodies. This has direct consequences with respect to their health, employment and participation in social and political life (Kelly 2005). In order to be able to address violence against women as a gender-based phenomenon and to integrate GBV into the health-care system, it is critical to understand the meaning of gender as opposed to sex.

Box 2: Gender versus sex

Sex refers to the biological and physiological differences between men and women. At the same time, it may not always be possible to define sex along the dichotomous lines of male-female only, as is made evident by inter-sex individuals (CEDAW GR 28, MWIA 2002).

Gender refers to socially constructed identities, attributes and roles for women and men, and the social and cultural meaning attached to biological differences between women and men that result in hierarchical relationships between women and men and in an unequal distribution of power and rights that favours men and disadvantages women.

Gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationship between women and men, girls and boys. While sex and its associated biological functions are programmed genetically, gender roles and the power relations they reflect are a social construct – they vary across cultures and through time, and thus are subject to change (CEDAW GR 28, MWIA 2002).

Gender equality implies equality of women and men, without discrimination on the basis of gender. Gender equality encompasses equality of women and men, both, before the law (formal equality) and de facto (substantive equality). Accordingly, state measures to achieve gender equality must go beyond identical treatment of women and men equal before the law. Instead, laws and policies must aim at equal opportunities of women with men, with the ultimate view to achieving equal enjoyment of rights, income levels and participation and influence in decision-making, as well as freedom from violence for both, women and men. This requires effective strategies aimed at overcoming gender-based stereotypes and other root causes of discrimination, with a view to a redistribution of resources and power between men and women (CEDAW GR 25).

(continued on page 17)

Gender-based discrimination can in general be understood as any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms which prevents a person from enjoying human rights. International law defines gender-based discrimination against women as “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field” (Article 1 CEDAW). Such discrimination can be either direct (when a law, policy

or practice explicitly discriminates against women) or indirect (when laws, policies or practices despite being seemingly gender-neutral have a detrimental effect on women) (CEDAW GR 25). States are obliged to eliminate all forms of discrimination against women, no matter whether it is perpetrated by state authorities or private organizations, enterprises or individuals (Article 1 CEDAW, CEDAW GR 19, CEDAW GR 28).

(continued from page 17)

It is important to note that GBV also includes violence perpetrated against men and boys. For instance, boys may become subjected to sexual abuse by family members or trafficked for the purpose of sexual exploitation. There are also instances where men have become survivors of domestic violence – by partners or children (Bloom 2008). In some settings, sexual violence against males may even be more prevalent compared to females, for example, in prisons and the armed forces (WHO 2003). Nevertheless, as highlighted earlier, because of the unequal distribution of power between men and women, women and girls constitute the vast majority of persons affected by GBV, with the majority of perpetrators being male.

Box 3: Gender dimensions of violence against women

Gender-based violence mainly affects women and girls. **Women and men experience violence in different contexts:** while men are more likely to die as a result of armed conflict, violence by strangers and suicide, women are more likely to die at the hands of somebody they know, including intimate partners. **In many societies, prevailing attitudes subordinate women to men and entitle men to use violence to control women.** These attitudes serve to justify, tolerate or condone violence against women.

Women survivors of violence face specific barriers when seeking access to support services. This is because women have fewer resources and options to access justice, care and support, as a result of discrimination and their lower position in society. **Often, legal systems and the authorities implementing the laws ignore or fail to adequately respond** to violence against women.

Source: adapted from WHO/PAHO 2012a

GENDER BASED VIOLENCE IS A VIOLATION OF WOMEN’S HUMAN RIGHTS AND A FORM OF DISCRIMINATION AGAINST WOMEN.

GBV violates a number of women’s rights, including the right to life, the right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment, the right to equal protection under the law, the right to equality in the family, or the right to the highest standard attainable of physical and mental health (CEDAW 1992). For further information on state obligations under international human rights law, see chapter 2.1.1.

WOMEN EXPERIENCE GBV IN ALL AREAS OF LIFE – BOTH THE PRIVATE AND THE PUBLIC SPHERE.

Violence against women occurs in many settings - the family, at the work place, at school or university, on the street, in political life, or in state institutions such as prisons or health institutions. Perpetrators can therefore be private persons, such as intimate partners, other family members, acquaintances, employers, co-workers, or strangers, as well as state officials, such as police officers, prison guards or soldiers.

While GBV occurs to women in all areas of life, the family is the place where women experience the most violence. According to WHO estimates, nearly one-third (30%) of all women worldwide who have ever lived in a relationship have experienced physical and/or sexual violence from an intimate partner (WHO et al 2013). Furthermore, women are disproportionately affected by killings committed by intimate partners and other family members, as confirmed by the latest UNODC Global Homicide Study: While more women do represent about 20% of homicide victims worldwide, they make up almost two thirds of all persons killed by an intimate partner and other family members (UNODC 2014).

Two terms commonly used to refer to violence experienced by women in the household are domestic violence and intimate partner violence (see box 4):

Box 4 – International definitions of domestic violence and intimate partner violence

Domestic violence means “all acts of physical, sexual, psychological or economic violence within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim”. The two main forms of domestic violence are intimate partner violence between current or former spouses or partners and inter-generational violence which typically occurs between parents and children (Article 3 Istanbul Convention and Explanatory Report).

Intimate partner violence is defined as “behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. (It) covers violence by both current and former spouses and other intimate partners” (WHO et al 2013).

GBV ENCOMPASSES A BROAD RANGE OF HARMFUL ACTS, INCLUDING PHYSICAL, SEXUAL, PSYCHOLOGICAL AND ECONOMIC VIOLENCE.

For health care professionals, it is important to keep in mind that GBV has many facets. Apart from physical and sexual violence that cause injuries and might therefore be easier to detect, women’s experiences of psychological and economic violence should not be overlooked as they may also have significant negative consequences on women’s health (see chapter 1.7 for more information). Further, women and girls experience harmful practices such as child/early marriage, forced marriages or gender-biased sex-selection. Therefore, it is important for health care professionals to understand and recognize the full range of acts that may constitute GBV (see table 1)

Table 1: Examples of acts of gender-based violence against women

Physical violence	Physical force that results in bodily injury, pain, or impairment. The severity of injury ranges from minimal tissue damage, broken bones to permanent injury and death. Acts of physical violence include: <ul style="list-style-type: none"> • slapping, shoving, pushing, punching, beating, scratching, choking, biting, grabbing, shaking, spitting, burning, twisting of a body part, forcing the ingestion of an unwanted substance; • restraining a woman to prevent her from seeking medical treatment or other help; and • using household objects to hit or stab a woman, using weapons (knives, guns).
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Sexual violence	<p>Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality, using coercion, by any person, regardless of their relationship to the victim, in any setting, including, but not limited to home and work (WHO 2002, cited in WHO 2013). Acts of sexual violence include:</p> <ul style="list-style-type: none"> • rape, other forms of sexual assault; • unwanted sexual advances or sexual harassment (including demands for sex in exchange for job promotion or advancement or higher school marks or grades); • trafficking for the purpose of sexual exploitation; • forced exposure to pornography; • forced pregnancy, forced sterilization, forced abortion; • forced marriage, early/child marriage; • female genital mutilation; • virginity testing; and • incest.
Psychological violence (sometimes also referred to as emotional violence)	<p>An action or set of actions that directly impair the woman's psychological integrity. Acts of psychological violence include:</p> <ul style="list-style-type: none"> • threats of violence and harm against the woman or somebody close to her, through words or actions (e.g. through stalking or displaying weapons); • harassment and mobbing at the work place; • humiliating and insulting comments; and • isolation and restrictions on communication (e.g. through locking her up in the house, forcing her to quit her job or prohibiting her from seeing a doctor), • use of children by a violent intimate partner to control or hurt the woman (e.g. through attacking a child, forcing children to watch attacks against their mother, threatening to take children away, or kidnapping the child). These acts constitute both, violence against children as well as violence against women.
Economic violence	<p>Used to deny and control a woman's access to resources, including time, money, transportation, food or clothing. Acts of economic violence include:</p> <ul style="list-style-type: none"> • prohibiting a woman from working; • excluding her from financial decision making in the family; • withholding money or financial information; • refusing to pay bills or maintenance for her or the children; and • destroying jointly owned assets.

Sources: adapted from Warshaw/Ganley 1996, WHO 2003, WHO 2013

Table 2 provides a snapshot of examples of GBV documented in the EECA region. It does not include domestic and intimate partner violence in their several forms, which are addressed by a range of national prevalence studies (see separate table 4). This table is not exhaustive; nor does it imply that certain forms are common only in the EECA region and/or only in the countries listed as examples.

Table 2: Examples of GBV documented in the EECA region

Form of violence	Examples of countries and references
Bride kidnapping and other forms of forced marriage	Kazakhstan, Kyrgyzstan, Turkey ¹
Early/child marriage	Observed in most countries of the region ²
Gender-biased sex-selection in favour of boys	Albania, Armenia, Azerbaijan, Georgia ³
Ill-treatment and torture in detention	Observed in many countries of the region
Killings in the name of honour	Albania, Turkey ⁴
Sexual harassment at the work place	Observed in many countries of the region
Sexual violence used as a weapon of war	Observed in many countries of the region
Suicides following experiences of domestic violence; suicide instigated by family members	Observed in many countries of the region
Trafficking in women	Observed in many countries of the region
Violence and harassment committed against sex workers	Observed in many countries of the region

1.2. THE SCOPE OF GENDER-BASED VIOLENCE GLOBALLY AND IN THE EECA REGION

Women experience GBV in all countries and regions world-wide. Since the second half of the 1990s, there has been an increase in studies seeking to measure the scope of violence against women. These studies provide an important evidence base for laws and policies to end GBV. At the same time, gaps in the knowledge base on all forms of GBV persist. Many countries still lack reliable data on GBV and if studies exist, they are often not comparable, due to differences in methodologies used. Further, few countries collect data on GBV on a regular basis, which would enable measuring changes over time. Existing data collection and research efforts have so far mainly focused on intimate partner violence, sexual violence, child abuse and female genital mutilation, while at the same time, many forms of GBV are under-documented. This includes femicide; sexual violence in conflict; trafficking in women and girls; sexual harassment and violence in workplaces, schools and institutional settings, including health facilities, prisons and detention centres (UN Secretary-General 2006).

Prevalence studies are the only reliable method to measure the scope of GBV. Usually, prevalence research is undertaken through population-based surveys. These surveys use randomly selected samples; therefore, their results are representative of the larger population. Thus, different from administrative data from administrative records, such as shelters, police, courts or hospitals, which cover only those women who have reported the violence or accessed services, population survey data allows for accurate conclusions on the actual scope of GBV. GBV prevalence studies may either focus exclusively on one or several forms of GBV, or have a broader focus on issues such as demographic and health issues, poverty, crime or reproductive health and include questions or modules on GBV (UN Secretary-General 2006).

A study published by the World Health Organization (WHO) in 2013 on global and regional prevalence of two forms of GBV (physical and sexual intimate partner violence as well as sexual violence committed by non-partners)⁵ concludes that “[v]iolence against women is a public health problem of epidemic proportions. It pervades all corners of the globe, puts women’s health at risk, limits their participation in society, and causes great human suffering” (WHO 2013). Table 3 presents select findings from this study.

Table 3 – Global and Regional Prevalence Data on GBV – Select Findings

	Global estimate	Regional estimate for Europe ⁶
% women who have experienced IPV or sexual violence from a non-partner (lifetime prevalence)	35%	27,2%
% women who have been in a relationship and who have experienced IPV (lifetime prevalence)	30%	25,4%
% women who have experienced sexual violence from a non-partner (lifetime prevalence)	7,2%	5,2%

Source: WHO et al 2013

As of February 2014, in at least 13 countries in the region of EECA, prevalence studies on intimate partner and other forms of domestic violence have been published. While these studies are not necessarily comparable due to differences in methodologies (e.g. sample size, geographical coverage, forms of violence covered, formulation and

1 Female and Feminist NGOs Initiatives on CEDAW - Kazakhstan 2014; HRW 2006; UN Country Team Kyrgyz Republic/UNFPA 2008, CEDAW 2010.

2 UNFPA 2014.

3 CoE PA 2011.

4 CEDAW 2010, CEDAW 2010a.

5 The total number of countries included in IPV estimates is 81 (including 10 countries from the WHO region in Europe). Non-partner sexual violence estimates include 58 countries (including 7 countries from the WHO region in Europe).

6 The European region encompasses low- and middle-income countries in Europe and Central Asia.

focus of questions), they clearly illustrate that there is high GBV prevalence in the EECA region. The findings of these studies which are summarized in table 4 can provide actors involved in decision making and implementing interventions with a baseline for efforts to strengthen the health system response to GBV in the region. For instance, trainers may want to use them for the purpose of tailoring capacity building activities to a given country context.

Table 4: Prevalence studies on intimate partner violence and domestic violence in the EECA region⁷

ALBANIA																
Albanian Institute of Statistics, UNDP (2013), Domestic Violence in Albania: National Population Based Survey																
Findings																
Intimate partner violence								Violence committed by other family members (non-partners)								
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence		
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	
14,70%	23,70%	5,00%	7,90%	52,80%	58,20%	4,30%	7,40%	-	-	-	-	-	-	-	-	
Background information																
Sample			Year(s) of the survey				Violence perpetrated by			Forms of violence			Data disaggregated by			
Scope: national Size: 3.598 women between 15-55 years old			2013				Intimate partners			Physical Psychological Economic Sexual			Gender, age and relationship			
Albanian Institute of Statistics, UNDP (2009), Domestic Violence in Albania: National Population Based Survey																
Findings																
Intimate partner violence								Violence committed by other family members (non-partners)								
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence		
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	
-	39,10%	-	12,70%	-	31,20%	-	-	-	0,2-13,8%	-	-	-	-	-	-	
Background information																
Sample			Year(s) of the survey				Violence perpetrated by			Forms of violence			Data disaggregated by			
Scope: national Size: 2.590 households. 2.590 women between 15-49 years old			2007-2008				Intimate partners Other family members			Physical Psychological Sexual			Gender, age and relationship			
ARMENIA																
UNFPA, National Statistical Service (2011), Nationwide Survey on Domestic Violence Against Women in Armenia 2008-2010																
Findings																
Intimate partner violence								Violence committed by other family members (non-partners)								
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence		
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	
-	8,90%	-	3,30%	-	25,00%	-	-	-	2,30%	-	0,10%	-	-	-	-	
Background information																
Sample			Year(s) of the survey				Violence perpetrated by			Forms of violence			Data disaggregated by			
Scope: Urban areas Size: 2.763 women between 15-59 years old			2008-2010				Intimate partners Other / non partner			Physical Economic Psychological Sexual			Gender, age and relationship			

⁷ The structure of this table was prepared based on examples from UN Women 2012a and WAVE 2013. The data stems from the original prevalence studies indicated in the table (in some cases, only summaries were publically available). Cells with a “-“ indicate that this aspect is not covered by the respective study. Life-time prevalence is defined differently in the different studies: Most surveys define life-time prevalence as prevalence of violence occurred after the age of 15; some take 16 or 18 years as threshold. Some surveys do not specify life-time prevalence by using age limits.

AZERBAIJAN

UNFPA (2011), National Survey Report on Violence Against Women in Azerbaijan

Findings

Intimate partner violence								Violence committed by others							
Physical violence		Sexual violence		Emotional*		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
5,00%	15,00%	3,00%	7,00%	-	25,00%	-	-		11,00%	-	5,00%	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: 9 regions Size: 4.760 households. 3.000 women between 15-49 years old	2008	Intimate partners Others	Physical Emotional Sexual	Gender, age, region and relationship

*81% of all ever-partnered women covered in the survey reported being exposed to some form of controlling behaviour

BELARUS

UN Office in Belarus, Sociological and Political Research Center of the Belarusian State University (2008), Main Outcomes of the Survey on Domestic Violence Assessment in the Republic of Belarus in 2008

Findings*

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	24,20%	-	13,10%	-	83,20%	-	22,50%	-	-	-	-	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 512 women between 18-60 years old and 488 men	2008	Intimate partners Other family members	Physical Psychological Economic Sexual	Gender, age and relationship

*Information provided by UNFPA Country Office in Belarus, July 2014

BOSNIA AND HERZEGOVINA

Gender Equality Agency of Bosnia and Herzegovina (2013), Prevalence and Characteristic of Violence Against Women in BiH

Findings

Violence against women by their current partner*								Violence committed by other family members or relatives (non-partners)							
Physical violence		Sexual**		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
2,10%	7,70%	-	5,10%	10,20%	25,70%	-	-	13,90%	0,70%	-	-	2,80%	14,90%	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 3.300 women over 18 years old	2012	Intimate partners Other family members or relatives Others	Physical Psychological Economic Sexual	Gender, age and relationship

* Calculated for women who had partners at the time the survey was conducted

**For sexual violence, the figure is for current and former partners.

GEORGIA

UNFPA (2010), National Research on Domestic Violence Against Women in Georgia

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
3,90%	6,90%	1,95%	3,90%	-	14,30%	-	-	-	2,00%	-	0,20%	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 2.385 women between 15-49 years old	2009	Intimate partners Other domestic relationships	Physical Psychological Sexual	Gender, age and relationship

KAZAKHSTAN

The Agency of Statistics, RK, UNICEF, UNFPA (2012), Multiple Indicator Cluster Survey in the Republic of Kazakhstan, 2011-2012

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
7,10%	15,40%	1,30%	3,70%	8,50%	13,70%	-	7,00%	-	-	-	-	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national (urban and rural area) Size: 10.581 women between 15-49 years old	2010-2011	Intimate partners Other / non partner*	Physical Economic Psychological Sexual	Gender, age, relationship, place of residence (urban/rural), region, education, wellbeing

* From the report it is not possible to extract data on violence committed by other family members (non-partners).

KOSOVO (UNSCR 1244)

Agency for Gender Equality (2008), Security Begins at Home: Research to Inform the First National Strategy and Action Plan Against Domestic Violence in Kosovo

Findings

Intimate partner violence								Violence committed by family members (including partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	1,30%	18,00%	-	3,50%	10,30%	30,00%	-	15,00%

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 1.256 households. 636 women and 620 men over 18 years old	2008	Intimate partners Other family members	Physical Psychological Economic Sexual	Gender, age and relationship

KYRGYZSTAN

National Statistical Committee of the Kyrgyz Republic, Ministry of Health Kyrgyz Republic, ICF International (2012), Kyrgyz Republic Demographic and Health Survey

Findings

Violence against women								Spousal violence							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
13,00%	23,00%	-	3,00%	-	-	-	-	17,00%	25,00%	3,00%	4,00%	10,00%	14,00%	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 8.208 women and 2.413 men between 15-49 years old	2012	Intimate partners Other family members	Physical Psychological Sexual	Gender, age, region, education, marital status and relationship

FORMER YUGOSLAV REPUBLIC OF MACEDONIA

Government of the Republic of Macedonia (2012), Report on the National Survey of Domestic Violence

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological* violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	6,1%	-	1,5%	-	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 2.100 women and men over 15 years old	2012	Family members	Physical Sexual Psychological including economic	Gender, age, employment status and income levels, educational level, ethnicity, location, number of household members/ children

* Prevalence rate for psychological violence: 36,86% (not disaggregated by gender).

** The study addresses economic violence as part of psychological violence.

MOLDOVA

National Bureau of Statistics of the Republic of Moldova, UNDP, UN Women, UNFPA (2011), Violence Against Women in the Family in the Republic of Moldova

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
9,00%	40,00%	4,00%	19,00%	26,00%	60,00%	4,20%	10,00%	1,00%	5,90%	-	-	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 1.575 women between 15-65 years old	2010	Intimate partners Other family members	Physical Psychological Sexual Economic	Gender, age and relationship

ROMANIA

Centrul de Sociologie Urbana si Regionala (2008), Violenta Domestica in Romania, Ancheta Sociologica la Nivel National

Findings

Intimate partner violence								Violence committed by family members (including partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	4,70%	13,50%	0,50%	2,50%	10,40%	18,50%	2,40%	5,30%

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 854 women and 450 men above 18 years old	2008	Intimate partners Other family members	Physical Economic Psychological Sexual	Gender, region and age

SERBIA

SeConS - Group (2010), The Mapping on Domestic Violence Against Women in Central Serbia

Findings

Intimate partner violence								Violence committed by family members (including partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	10,10%	21,60%	1,20%	3,80%	31,80%	48,70%	15,80%	11,40%

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national (except Vojvodina and Kososvo) Size: 2.500 women between 18-75 years old	2010	Intimate partners Other family members	Physical Psychological Sexual Economic	Gender, age, region, employment status, and urban/rural areas

TAJIKISTAN

Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health Tajikistan, ICF International (2013), Tajikistan Demographic and Health Survey 2012

Findings

Violence against women								Spousal violence							
Physical violence*		Sexual violence**		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
13,00%	19,00%	-	4,00%	-	-	-	-	15,00%	20,00%	3,00%	4,00%	10,00%	11,00%	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 9.656 women between 15-49 year old	2012	Intimate partners Other family members	Physical Psychological Sexual	Gender, age, region, education, marital status and relationship

* In 69% of cases, physical violence was perpetrated by the current husband or partner and 13% by the former husband/partner.

**Concerning sexual violence, 90% of these cases were perpetrated by the current or former husband/partner.

TURKEY

Turkish Republic Prime Ministry Directorate General on the Status of Women (2009), National Research on Domestic Violence Against Women in Turkey

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
10,00%	39,00%	7,00%	15,00%	25,00%	44,00%	-	-	-	18,00%	4,00%	3,00%	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 12.795 women between 15-59 years old	2008	Intimate partners Other family members	Physical Psychological Sexual	Gender, age and relationship

UKRAINE

UNDP (2010), Prevalence of Violence in Ukrainian Families

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	-	21,00%	-	1,00%	-	35,00%		

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 1.800 men and women over 18 years old	2009-2010	Intimate partners Other family members	Physical Psychological Sexual	Gender, age and relationship

Ukrainian Center for Social Reforms, State Statistical Committee Ukraine, Ministry of Health Ukraine, Macro International Inc. (2008), Ukraine Demographic and Health Survey 2007

Findings

Intimate partner violence								Violence committed by others (including partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
10,40%	12,70%	2,20%	3,30%	-	22,40%	-	-	8,80%	16,90%	-	5,40%	-	-	-	-

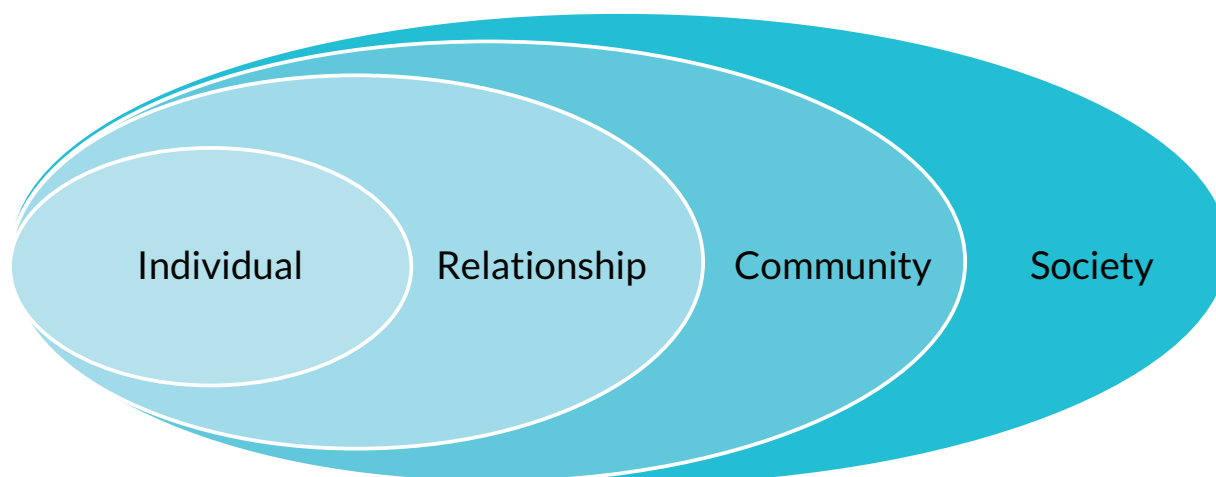
Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 6.842 women and 3.178 men between 15-59 years old	2007	Intimate partners Other family members	Physical Psychological Economic Sexual	Gender, age and relationship

1.3. CAUSES OF GENDER-BASED VIOLENCE

It is widely understood that GBV - be it in the form of isolated acts or systematic patterns of violence - is not caused by any single factor. Rather, it is a combination of several factors that increase the risk of a man committing violence and the risk of a woman experiencing violence.

Figure 1: Ecological Framework for Understanding Violence against Women



Source: Heise 1998

The “**ecological framework**” developed by Heise distinguishes risk factors at four levels: the individual, the relationship, the community and the structural level (Heise 1998, cited in WHO 2005). These factors are associated with an increased likelihood that an individual will become a victim or a perpetrator of violence. This model offers a comprehensive framework for understanding the risk factors of GBV and their interplay, and may therefore be used as a guide for designing interventions in the fields of prevention and response (WHO/LSHTM 2010).

□ **Individual-level factors** are biological and personal history factors that increase the risk of violence. For example, a low level of education, young age (early marriage) and low-economic status/income have been associated as risk factors for both experiencing and perpetrating intimate partner violence. Past experiences of violence also play a role; exposure to sexual abuse and intra-parental violence during childhood as well as a history of experiencing (for women) or perpetrating (for men) violence in previous intimate relationships increases the likelihood of violence in future relationships. Pregnant women are also at high risk of experiencing violence by an intimate partner. While several studies point to a strong association between harmful use of alcohol and the perpetration of intimate partner violence and sexual violence, there is only weak evidence for a truly causal relationship between the use of alcohol and the perpetration of violence. Attitudes also play an important role; there is a strong correlation between women and men perceiving violence as acceptable behaviour and their exposure to intimate partner and sexual violence (as both, survivors and perpetrators (WHO/LSHTM 2010 with multiple references).

□ **Relationship-level factors** contribute to the risk of GBV at the level of relationships with peers, intimate partners and family members. For instance, men having multiple partners are more likely to perpetrate intimate partner violence or sexual violence. Such men are also more likely to engage in risky behaviours with multiple sexual partners by refusing condoms, exposing themselves and their intimate partners to a higher risk of HIV infection. Other factors associated with an increased risk of intimate partner violence include partnerships with low marital satisfaction and continuous disagreements as well as disparities in education status between the partners. Furthermore, family responses to sexual violence that blame women and concentrate on restoring “lost” family honour, rather than punishing men, create an environment in which rape can occur with impunity (WHO/LSHTM 2010 with multiple references).

□ **Community-level factors** refer to the extent of tolerance towards GBV in contexts at which social relationships are embedded, such as schools, workplace or the neighbourhood. Research found that societies that had community sanctions against violence, including moral pressure for neighbours to intervene, in place and where women had access to shelter or family support had the lowest levels of intimate partner and sexual violence. While intimate partner and sexual violence do cut across all socio-economic groups, several studies found women living in poverty to be disproportionately affected; however, it has not been clearly established whether it is poverty as such that increases the risk of violence or rather other factors accompanying poverty. Rather, poverty can be seen as a “marker” for a variety of social conditions that combine to increase the risk faced by women. For instance, rural women living in poverty who work in the fields or collect firewood alone may be at a higher risk of rape. Poverty may also put women under pressure to find or maintain jobs and in turn render them vulnerable to sexual coercion, or push them in to occupations that carry a high risk of sexual violence, such as sex work (WHO/LSHTM 2010).

□ **Society-level factors** include the cultural and social norms that shape gender roles and the unequal distribution of power between women and men. Intimate partner violence occurs more often in societies where men have economic and decision-making powers in the household and where women do not have easy access to divorce and where adults routinely resort to violence to resolve their conflicts. Further, ideologies of male sexual entitlement that are common in many cultures exclude the possibility that a woman is entitled to make autonomous decisions about participating in sex and to refuse a man’s sexual advances and are used to legitimize the use of sexual violence. Social breakdown due to conflicts or disasters further increase the risk of rape in conflict and post-conflict situations (WHO/LSHTM 2010 with multiple references).

Table 5 provides an overview of common risk factors for both, intimate partner violence and sexual violence associated with the ecological model. For information on further risk factors contributing to an increased risk of either intimate partner or sexual violence, see WHO/LSHTM 2010.

Table 5: Common risk factors for intimate partner violence and sexual violence

	Perpetration by men	Victimization of women
Individual level	Demographics: <ul style="list-style-type: none"> • Low income • Low education 	Demographics: <ul style="list-style-type: none"> • Young age • Low education • Separated/ divorced marital status
	Child maltreatment: <ul style="list-style-type: none"> • Sexual abuse • Intra-parental violence 	Child maltreatment: <ul style="list-style-type: none"> • Intra-parental violence
	Mental disorder: <ul style="list-style-type: none"> • Anti-social personality disorders 	Mental disorder: <ul style="list-style-type: none"> • Depression
	Substance abuse: <ul style="list-style-type: none"> • Harmful use of alcohol • Illicit drug use 	Substance abuse: <ul style="list-style-type: none"> • Harmful use of alcohol • Illicit drug use
	Acceptance of violence	Acceptance of violence
Relationship level	Multiple partners/infidelity <ul style="list-style-type: none"> • Low resistance to peer pressure 	
Community level	<ul style="list-style-type: none"> • Weak community sanctions • Poverty 	<ul style="list-style-type: none"> • Weak community sanctions • Poverty
Societal level	<ul style="list-style-type: none"> • Traditional gender norms and social norms supportive of violence 	<ul style="list-style-type: none"> • Traditional gender norms and social norms supportive of violence

Source: WHO/LSHTM (2010)

1.4. UNDERSTANDING THE DYNAMICS OF VIOLENCE IN INTIMATE PARTNER RELATIONSHIPS

Women survivors of violence presenting in a health care setting often do not disclose their experiences. Even in case a patient discloses that she has experienced violence from an intimate partner, health professionals might find out that she is seeking medical help but not willing to leave the abusive relationship.

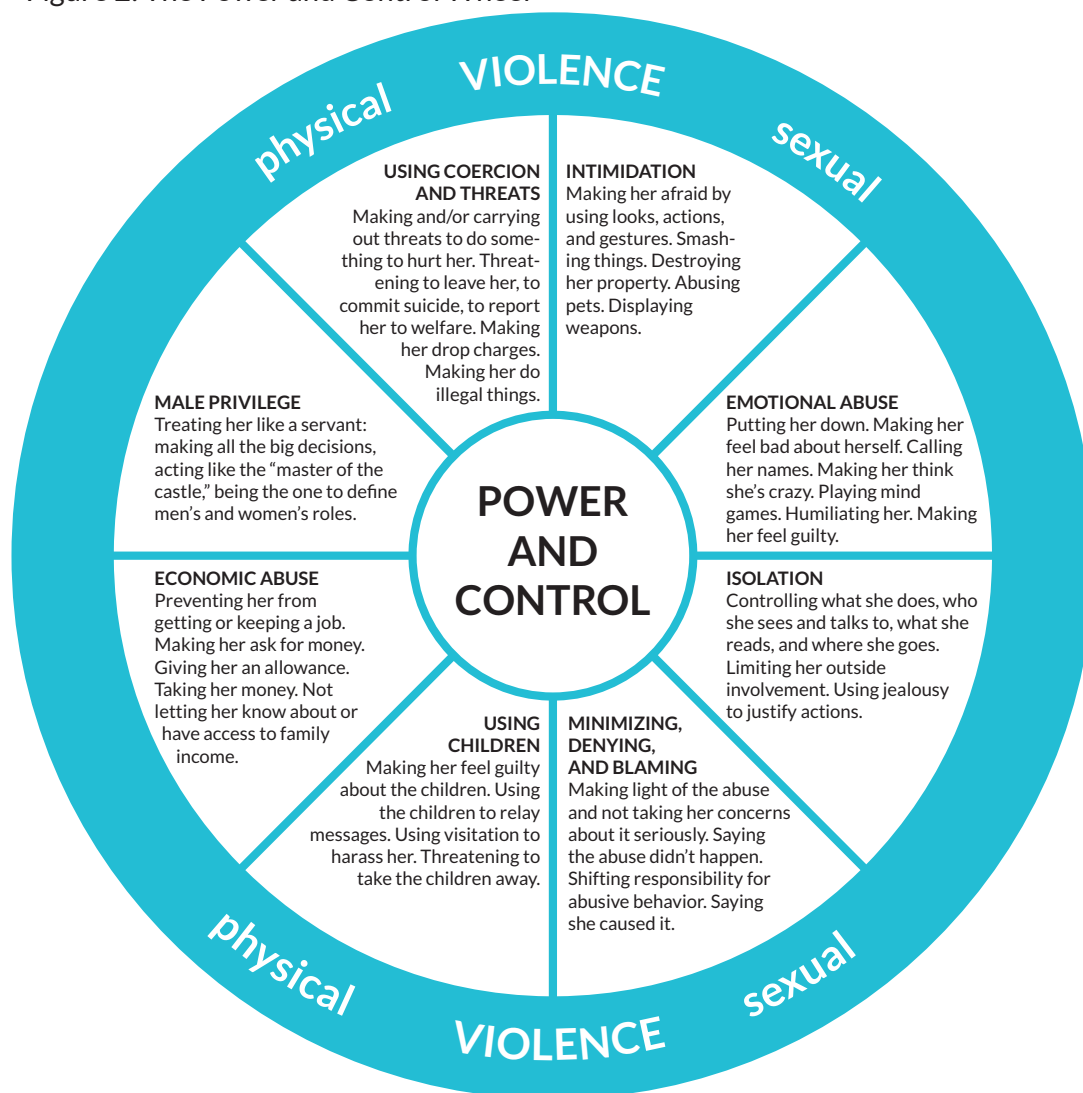
Many health professionals share the norms, beliefs and attitudes of the broader society in which they live. Negative attitudes towards women in general and towards survivors of violence in particular can inflict additional harm upon women who experienced violence and may prevent health professionals from providing adequate medical care. Not understanding the dynamics of violence may leave well-meaning health professionals frustrated and lead them to think that this woman does not need or even deserve help, wondering “why doesn’t she accept help and leave the abusive relationship?” The survivor might even be blamed for her situation. Understanding the dynamics of violent intimate relationships can help health professionals to maintain a supportive, non-judgemental and validating attitude vis-à-vis survivors of violence, which is an important prerequisite of an effective health system response to GBV. For further information refer to chapter 2.3 on the role of health professionals and to chapter 3.1.4 on communication with survivors.

Improving provider attitudes and beliefs about gender-based violence should therefore be considered a central responsibility of every health facility; however, this is a challenging task that requires a long-term approach. This sub-chapter provides a selection of models and theories commonly used to illustrate the dynamics of violent intimate relationships. These models show how power and control are used to maintain women in a position of subordination and control that in turn perpetuates the violence.

1.4.1. THE 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 (WHO 2005). This model was developed by the Domestic Abuse Intervention Programs in Minnesota, US, weaving in the experiences of women survivors of intimate partner violence who had participated in focus groups. The wheel consists of eight spokes that summarize the patterns of behaviours used by an individual to intentionally control or dominate his intimate partner: using intimidation; using emotional abuse; using isolation; minimizing, denying and blaming; using children; using male privilege; using economic abuse; and using coercion and threats. These actions serve to exercise “power and control” – these words are in the centre of the wheel. The rim of the wheel is made of physical and sexual violence – this violence holds it all together (see figure 2; Domestic Abuse Intervention Programs undated).

Figure 2: The Power and Control Wheel



Source: Adapted from Domestic Abuse Intervention Center Duluth, MN 218/722-4134

1.4.2. THE CYCLE OF VIOLENCE

The model of the “cycle of violence” was developed by the American psychologist Lenore E. Walker in 1979. It describes the course of a violent relationship in three phases or cycles:

- 1 In the first phase, tensions gradually build up. The woman tries to appease her partner, generating a false sense of being able to control his aggression and prevent violence.
- 2 This is followed by the second phase, an episode of physical, sexual and psychological violence which ends when the perpetrator stops the abuse temporarily.
- 3 In the third phase (“honeymoon” phase), the perpetrator apologizes and promises to change his violent behaviour. He may show especially loving and gentle behaviour; this makes the woman believe that there is a “good” side to her violent partner, which she can retain through adjusting to his behaviour by modifying her own (Walker 1979, cited in Stark 2000, WHO 2005).

The cycle of violence is being repeated; over time, the phases of aggression increase in regard to both, severity and duration, while the “honeymoon” phases become shorter (BMWVJ 2010). In this situation, women develop a strategy for survival that may include extreme passivity - denying the abuse, refusing help offered and even defending the aggressor (Walker 1979, cited in Stark 2000).

1.4.3. THE STOCKHOLM SYNDROME

The so-called Stockholm syndrome is used to explain why women remain in violent relationships. It was first observed in 1973, when bank robbers in Stockholm took four people hostage and held them for six days. During this period, the captives developed a close relationship with the robbers and regarded the police as enemies. In a survey of over 400 women survivors of intimate partner violence, Graham and Rawlings identified a similar response pattern among women who experienced violence by an intimate partner. These women tend to develop close bonds and even identify with the perpetrator as a coping strategy in order to survive. If the violent partner is willing to make even small concessions or shows some degree of friendliness, the woman has new hopes and is ready to give the abuser another chance. The Stockholm syndrome may develop under four conditions:

- 1 The life of the survivor is threatened.
- 2 The survivor cannot escape or thinks that escape is impossible.
- 3 The survivor is isolated from persons outside.
- 4 The captor(s) show(s) some degree of kindness to the survivor(s).

Graham and Rawlings discovered the Stockholm syndrome is a common experience of persons who experienced severe trauma and violence and do not see a way out of their situation, such as abused children, sect members or prisoners of war. After a certain time, they begin to identify with the aggressors – in order to survive. Thus, women survivors of violence do not develop specific psychological coping patterns; rather, they react like other people in a similar situation (Graham et al 1988, cited in WAVE 2006).

1.4.4. THE CONCEPT OF NORMALIZATION OF VIOLENCE

The concept of normalization of violence developed by the Swedish sociologist Eva Lundgren explains why women living with a violent intimate partner find it difficult to name and define their own experiences as violence because living in a violent relationship changes their interpretation and understanding of the violence experienced; they adopt the violent partner’s understanding of violence. As a consequence, women might perceive an attack which an outsider would regard as violence as manifestation of their own failure. Furthermore, women survivors are reluctant to identify themselves as “battered women” and their partners as “abusers,” as this would imply acknowledging that they and their partners are deviants from the norm of an equal relationship. It is also important to understand that defining the violence as something else than violence or playing it down can be a coping strategy while living in a violent relationship. Research has shown that only after the woman has left the violent relationship, when she no longer faces isolation, control and risk of further violence from her former partner, the process of “denormalization” of violence begins, which enables her to name her experiences as violent (Lundgren 1993, cited in Lundgren et al 2001).

1.5. MYTHS SURROUNDING GENDER-BASED VIOLENCE

Myths and stereotypical attitudes about GBV shape the way in which society perceives and responds to violence perpetrated against women. Such myths and attitudes are harmful as they tend to blame the survivors for the violence, rather than holding perpetrators responsible for their behaviour. As stated earlier, myths can inflict additional harm upon women who experience violence and may prevent health professionals from providing adequate medical care. It is therefore essential that health care professionals understand the difference between myth and fact, in order to understand the survivors' situation and needs and to maintain a professional and impartial attitude. Health care providers are responsible for providing medical care and support to the survivor and to avoid any behaviour that can lead to secondary traumatization. By no means is it the role of health care professionals to assess the credibility of the alleged violence or to blame the survivor. The present sub-chapter presents a number of myths about intimate partner violence and sexual violence that can also be found in the EECA region, and contrasts them with facts.

MYTH 1: WOMEN ALLOW INTIMATE PARTNER INTIMATE VIOLENCE TO HAPPEN TO THEM AND IF THEY REALLY WANT TO, THEY CAN LEAVE THEIR ABUSIVE PARTNERS.

Facts: In no case does a woman deserve to be abused. The international community has recognized violence against women as a human rights violation that cannot be justified and requires a comprehensive state response. As explained in several theories on the dynamics of violent relationships, such as the Stockholm Syndrome or the Power and Control Wheel, perpetrators use a combination of tactics of control and abuse that make it very difficult for women to escape the violence. It is also important to understand that women who experienced violence from an intimate partner and seek to leave the relationship in order to ensure their own and their children's safety paradoxically face an increased risk of repeating and even escalating violence. Women are also prevented from leaving violent relationships due to feelings of shame and guilt, lack of safe housing, or the belief that divorce is wrong for children (adapted from Hagemester et al 2003).

MYTH 2: CONFLICTS AND DISCORD ARE A NORMAL PART OF ANY RELATIONSHIP

Facts: "Everybody can lose control," is a commonly used excuse to justify intimate partner violence. However, violence is not about "losing" control – rather, it is about "gaining" control through the use of threats, intimidation, and violence, as demonstrated by the Power and Control Wheel. Violence in a relationship is not normal - it is a manifestation of historically unequal power relations between men and women (DEVAW).

MYTH 3: MEN AND WOMEN ARE EQUALLY VIOLENT TO EACH OTHER.

Facts: The majority of those affected by GBV, in particular intimate partner violence, are women and girls. Worldwide, almost half (47%) of all female victims of homicide in 2012 were killed by their intimate partners or family members, compared to less than 6% of male homicide victims (UNODC 2013). According to EU-wide data, 67% of physical violence and 97% of sexual violence perpetrated against women is committed by men (FRA 2014). This fact is also confirmed by research from the region. For example, a study from Moldova shows that the perpetrators of violence against women are often family members, the overwhelming majority being husbands or former husbands (73.4%), followed by fathers or stepfathers (13.7%) (UN Special Rapporteur VAW 2009).

MYTH 4: DOMESTIC VIOLENCE HAPPENS ONLY TO A CERTAIN TYPE OF PERSON.

Facts: GBV is a global problem of pandemic proportions. 35% of all women worldwide have experienced either physical and/or sexual violence from an intimate partner or sexual violence from a non-partner (WHO et al 2013). While a number of factors may increase the risk of women experiencing GBV, domestic violence affects all women, irrespective of socio-economic status, educational achievements, ethnic origin, religion or sexual orientation

(IGWG undated). While some studies have found that women living in poverty are disproportionately affected by intimate partner violence and sexual violence, it has not been clearly established whether it is poverty as such that increases the risk of violence or rather other factors accompanying poverty.

MYTH 5: GENDER-BASED VIOLENCE ONLY INCLUDES PHYSICAL ABUSE (HITTING, PUNCHING, BITING, SLAPPING, PUSHING, ETC.).

Facts: Physical abuse is just one form of violence. International law defines violence against women as “*any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women*” (DEVAW, Article 1). For example, prevalence research from Romania shows that 18,5% of women experienced psychological violence from family members including intimate partners; the percentage for economic violence was 5,3% (Centrul de Sociologie Urbana si Regionala 2008). Some studies show that women often consider psychological abuse and humiliation more devastating than physical assault (Casey 1988, cited in Heise et al 1994).

MYTH 6: GENDER-BASED VIOLENCE IS CAUSED BY SUBSTANCE ABUSE SUCH AS ALCOHOL AND/OR DRUGS.

Facts: While substance abuse is present in many domestic violence cases and may lower inhibitions, it is a contributing factor, not the cause of violence (see also chapter 1.3). Neither should alcohol or drug abuse be used to justify violence (IGWG undated). Not all perpetrators of violence use drugs or alcohol, and not all those who use drugs or alcohol are violent (Roberts 1984, cited in Hagemeister et al 2003).

MYTH 7: WOMEN SHOULD TOLERATE VIOLENCE TO KEEP THE FAMILY TOGETHER.

Facts: Every woman has the right to safety, dignity and a life free of violence. Every woman survivor of GBV has the right of self-determination- she can decide to stay with her abusive partner or to leave him and either way she is entitled to support and protection from the state. The argument that women should stay in an abusive relationship is often justified for the well-being of the children. However, it is well established that the safety and health of children are negatively affected when children experience or witness domestic violence. State support for perpetrator programmes teaching violent men to adopt non-violent behaviour in interpersonal relationships is key for preventing further violence and changing violent behavioural patterns (Article 16 Istanbul Convention). This is of particular importance in situations where women are not willing or able to leave a violent relationship, for instance, due to economic dependence and risk of stigmatization by the community, particularly in rural areas. At the same time, perpetrator interventions should supplement, but not replace, or withdraw resources from, the work of women-specific support services.

MYTH 8: DOMESTIC VIOLENCE IS A PRIVATE FAMILY MATTER, IN WHICH THE STATE HAS NO RIGHT TO INTERVENE. HOW A MAN TREATS HIS WIFE IS A PRIVATE MATTER.

Facts: Violence against women is a human rights violation, no matter whether it occurs in the family or in the public sphere. Under international human rights law such as CEDAW or the Istanbul Convention, states are not only entitled to eliminate all forms of violence against women, they are obligated to do so.

MYTH 9: SEX WORKERS CANNOT EXPERIENCE RAPE.

Facts: International definitions of rape and other forms of sexual assault (WHO 2013) focus on the type of violent acts committed, without consideration of who is the perpetrator or the survivor. Accordingly, any man who forces a woman into a sexual act against her is committing rape, whatever her profession is. A survey from Bosnia and Herzegovina demonstrates the high amount of violence experienced by sex workers- three out of five sex workers surveyed reported experiences of sexual violence (PROI 2011).

MYTH 10: A MAN CANNOT RAPE HIS WIFE.

Facts: As mentioned earlier, rape is defined by an action and not by the identity of the perpetrator or the survivor. Accordingly, any forced sexual intercourse is rape, irrespective of whether the woman survivor is married to the perpetrator or not. This statement is also grounded in international human rights law definitions, which encompasses all forms of physical, sexual, psychological or economic violence against women, no matter if they are committed in the family or in public. Even though international human rights law obliges states to criminalize and prosecute rape, not all jurisdictions recognize marital rape as a criminal offence, resulting in impunity of rape committed by intimate partners.

MYTH 11: MOST GBV IS PERPETRATED BY STRANGERS.

Facts: The majority of women experience GBV at the hands of a person close to them, as confirmed by the 2013 Global Study on Homicide. It is estimated that women make up 79% of all persons killed by their intimate partners. Additionally, 47% of all women killed in 2012 were killed by their family members or intimate partners; for men, the respective percentage totals 6% (UNODC 2014). This statement is confirmed for instance by a study from Kyrgyzstan, of which 3% of the women interviewed have experienced sexual violence, with 98% of the perpetrators being current or former partners or husbands (National Statistical Committee 2012).

1.6. GENDER-BASED VIOLENCE AND MULTIPLE DISCRIMINATION

Forms and manifestations of violence against women are shaped by gender inequalities (see chapters 1.1 and 1.3). At the same time, women are not a homogenous group. A number of additional factors may influence what form of violence women experience, as well as their ability to seek help. This includes for instance class, migrant or refugee status, age, sexual orientation, marital status, disability or HIV status (UN Secretary-General 2006, Department of Health 2004). Health professionals should be aware of the interplay of these factors with gender and understand the specific risk and/or needs of women belonging to one or more marginalized groups. Further, specific strategies may be needed to improve outreach to and access of women belonging to these groups to health care.

This sub-chapter provides an overview of specific groups of women, who, due to their specific situation or status are at greater risk of violence and/or face specific obstacles in accessing medical help and others services.

1.6.1. WOMEN IN CONFLICT AND POST-CONFLICT SITUATIONS

While situations of conflict or post conflict affect civilians due to the overall lack of security and the proliferation of violence and arms, women and girls are at a particular risk of violence, especially sexual violence. This is because conflicts exacerbate existing gender inequalities in society (CEDAW GR 30). Perpetrators of violence against women and girls in conflict and post-conflict are diverse, such as military personnel, paramilitaries, border guards, resistance units, male refugees and others with whom women and girls come in contact with (CEDAW GR 30, UN Secretary-General 2006). Women and girls are exposed to various forms of violence, such as sexual violence, torture and mutilation, abduction, trafficking, forced marriage, forced prostitution, and forced sterilization. Sexual violence against women is also being used against women and girls as a weapon of war in order to destabilize and demoralize the enemy (Gender-based Violence Area of Responsibility Working Group 2010, CEDAW GR 30). Refugee and displaced women are at a particular risk of violence during all stages of displacement- during flight, in refugee camps and in countries where they seek asylum (CEDAW GR 30, UN Secretary-General 2006). For women and girls, violence does not stop with the official end of the conflict. During the post-conflict phase, women can experience even more violence due to the absence of rule of law, states' failure to prevent, investigate

and punish all forms of GBV, as well as ineffective disarmament and demobilization and reintegration processes. As a consequence, women and girls in conflict and post conflict areas are at greater risk of unwanted pregnancies, STIs, including HIV, and severe sexual and reproductive injuries.

Factors such as inadequate infrastructure, lack of professionals, lack of basic medicines and health care supplies, the destruction of health services, and restrictions on women's mobility and freedom of movement, all impede women and girls' access to appropriate services during conflict and post-conflict (CEDAW GR 30). They are also less likely to report in these circumstances due to fear of reprisals, the high level of stigma associated especially with sexual violence and fear of exclusion from their communities (UN Secretary-General 2006, Gender-based Violence Area of Responsibility Working Group 2010).

1.6.2. WOMEN WITH DISABILITIES

Women with disabilities experience discrimination and stereotypical attitudes because they are both women and persons with disabilities (UN Special Rapporteur VAW 2012). Some factors expose both men and women with disabilities to a greater risk of violence, compared to persons without disabilities, such as stereotypes regarding them as recipients of charity or objects of others' decisions, rather than holders of rights; or isolation faced by individuals with intellectual and psychosocial disabilities, particularly those living in institutionalized settings (OHCHR 2012). In addition, women experience disability different than men and this difference is largely shaped and determined by gender (Habib 1995, cited in OHCHR 2012).

As a consequence, women with disabilities are more likely to experience violence and/or less able to come for support and escape situations of violence, compared to both, men with disabilities and women without disabilities (OHCHR 2012). For example, stereotypes wrongly portraying women and girls with disabilities as non-sexual beings, being compliant and timid contribute not only to sexual violence against them, but also to a lack of credibility when abuse is reported, resulting in impunity of the perpetrators. Further, women with disabilities experience other forms of violence, such as withholding of medication or communication aids; refusal of caregivers to assist with daily living such as bathing, dressing or eating; or controlling behaviours to restrict access to family, friends or phone calls (Habib 1995 cited in OHCHR 2012). Women with disabilities are often denied control of their sexual and reproductive choices, which may lead to forced sterilization or forced termination of wanted pregnancies, under the paternalistic guide that it is for "their own good" (UN Special Rapporteur VAW 2012).

1.6.3. MIGRANT WOMEN

Due to their double status as migrants and as women, migrant women are at a high risk of GBV (UN DESA 2004, cited in UN Secretary-General 2006). Limited options for women's legal employment in countries of destination as well as gendered notions of what constitutes appropriate work for women leads to an overrepresentation of women in the informal sector (e.g. domestic work, agricultural work, or sex work), which lacks legal protection and puts women at an increased risk of violence (UN Women Virtual Knowledge Centre, CEDAW GR 26). Access to justice and health care may be limited by factors such as language barriers, lack of information on rights and available options, or lack of coverage by national health insurance schemes (CEDAW GR 26).

In addition, fear of losing residency status may prevent migrant women who experience violence by an employer or an intimate partner from accessing justice and leaving an abusive work or intimate relationship, which perpetuates the violence. Undocumented migrant women are at a particular risk of exploitation and abuse. Their irregular residence status may prevent them from accessing support and protection services, which may be due to fear of deportation or restrictive policies of government donors in several countries limiting reimbursement of costs incurred by shelters to clients with regular resident status, thereby excluding undocumented migrant women who experienced violence (PICUM 2012). A qualitative research study undertaken by the University Hospital Geneva,

Switzerland, documents the intersection of undocumented status and women's sexual and reproductive health-undocumented pregnant women were found more likely to have unintended pregnancy, to access prenatal care at a later stage and to experience violence during pregnancy, compared to legal residents (Wolff et al 2008, cited in PICUM 2012).

1.6.4. ADOLESCENT GIRLS

Adolescents are in a difficult transitional period between childhood and adulthood that puts them particularly at risk of several forms of violence, such as child marriage, incest, sexual violence, trafficking or intimate partner violence (UN Women Virtual Knowledge Centre). Adolescents in most cases know the perpetrators and may often depend on them (CAADA 2011). Adolescent survivors of GBV face additional barriers compared to adult survivors. Often, they are less aware of existing services, lack financial resources to access services and are hesitant to seek services due to lack of confidentiality. Adolescents are also less likely to report violence, because they might not recognize the behaviour of perpetrators as violence, or are afraid of not being believed or taken seriously (CAADA 2011, UN Women Virtual Knowledge Centre).

Due to their age and stage of development, adolescent girls face particular consequences of GBV, compared to adults. Adolescent pregnancy, which may result from sexual violence is associated with the risk of low birth-weight for new-borns, higher pre-natal, neonatal and infant mortality and morbidity (WHO undated, cited in UNFPA 2013). Furthermore, adolescent girls who become pregnant, due to lack of physical maturity, at a high risk of pregnancy-related complications, which is a leading cause of death among girls age 15-19 in developing countries (WHO 2011a, cited in UNFPA 2014). In some countries of EECA, nearly 30% of maternal deaths are caused by unsafe abortion (WHO undated, cited in UNFPA 2013). Adolescent girls in most countries of the EECA region are affected by early marriage, a practice with severe physical, intellectual, psychological and emotional impacts on women and girls. Child brides experience a total lack of control over their bodies, they are traumatised by adult sex and forced to bear children before their bodies are fully mature, in addition to reproductive health problems like fistula. They typically move in with the husband's family, which implies taking on a large burden of unpaid domestic work and care responsibilities and exposure to domestic violence from husbands and in-laws. Child marriage also deprives girls from accessing educational opportunities, which leaves them without any qualifications or professional skills (adapted from UNFPA 2014).

1.6.5. OLDER WOMEN

Older women may suffer multiple forms of discriminations, on the basis of gender and age (CEDAW GR 27). Age-specific factors such as their physical vulnerability, possible illness, isolation, dementia or dependence to the family or social care workers put older women at greater risk of violence compared with women of younger age. Older women who experience violence are more likely to have severe consequences such as fear, anger, depression, exacerbation of existing illness, confusion and distress and life-threatening injuries (WHO 2011a, Department of Health 2004). Further, they are especially vulnerable to economic abuse especially in case of deferment of their legal capacity to somebody else (CEDAW GR 27).

Older women are more likely to know their perpetrators and to depend on them, which limits their access to appropriate services. Other barriers include lack of information about services, their age, lack of resources (CAADA 2011, WHO 2011a), as well as fear that they will not be believed and that their claims are dismissed as illness or amnesia. Older women can also be accustomed to the abuse with the time, or not recognize abusive behaviour like domestic violence (CAADA 2011).

1.6.6. RURAL WOMEN

As a result of social isolation, a lower level of education and literacy and less access to services and resources, rural women are at higher risk of GBV. Another root cause is the traditional perceptions regarding the subordinate role of women, which persist in most rural regions. Consequentially, rural women have greater difficulties to access services, compared to women living in non-rural regions. First of all, services may not exist, be limited or inaccessible due to long distance or the lack of transportation (CAADA 2011, CEDAW 2011). Even when services exist, the lack of confidentiality in small villages, rural women may be deterred from accessing these services (CAADA 2011). Where women decide to leave the rural communities to find a job in a city, she may be at risk of violence and sexual exploitation. Due to poverty and the lack of opportunities in rural regions, women who stay in the village may also be at risk of GBV, including trafficking, sexual exploitation and forced labour (CEDAW 2011).

1.7. CONSEQUENCES OF GENDER-BASED VIOLENCE

1.7.1. THE IMPACT OF GENDER-BASED VIOLENCE ON WOMEN'S HEALTH

GBV seriously affects all aspects of women's health- physical, sexual and reproductive, mental and behavioural health. Health consequences of GBV can be both, immediate and acute as well as long lasting and chronic; indeed, negative health consequences may persist long after the violence has stopped. The more severe the level of violence, the greater the impact will be on women's health. Furthermore, exposure to more than one type of violence (e.g. physical and sexual) and/or multiple incidents of violence over time tends to lead to more severe health consequences (WHO 2002, Johnson/Leone 2005, both cited in WHO/PAHO 2012a).

GBV can result in women's deaths. Fatal outcomes may be the immediate result of a woman being killed by the perpetrator, or in the long-term, as consequence of other adverse health outcomes. For example, mental health problems resulting from trauma can lead to suicidality, or to conditions such as alcohol abuse or cardiovascular diseases that can in turn result in death. HIV infection as a result of sexual violence can cause AIDS and ultimately lead to death (Heise et al 1999, WHO 2013).⁸

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.⁹ Every year lost due to premature death is counted as one disability-adjusted life year (DALY) and every year spent sick or incapacitated is counted as a fraction of DALY, depending on the severity of the disability. At the global level, the number of disability-adjusted life years (DALY) lost by women in this age group is estimated at 9,5 million years, comparable to other risk factors and diseases such as tuberculosis, HIV, cardiovascular diseases or cancer (World Bank 1993 cited in Heise et al 1994).

A recent study published by the WHO in 2013 systematically reviewed studies providing data on health effects of physical and sexual intimate partner violence and non-partner sexual violence against women. The review identified, among others, the following consequences of violence against women:

- » Globally, 38% of all murders of women are reportedly committed by intimate partners.
- » Out of all women who experienced physical and/or sexual violence by an intimate partner, 42% experienced injuries, as a result

⁸ For a diagram showing pathways and health effects of intimate partner violence, see WHO 2013, figure 1.

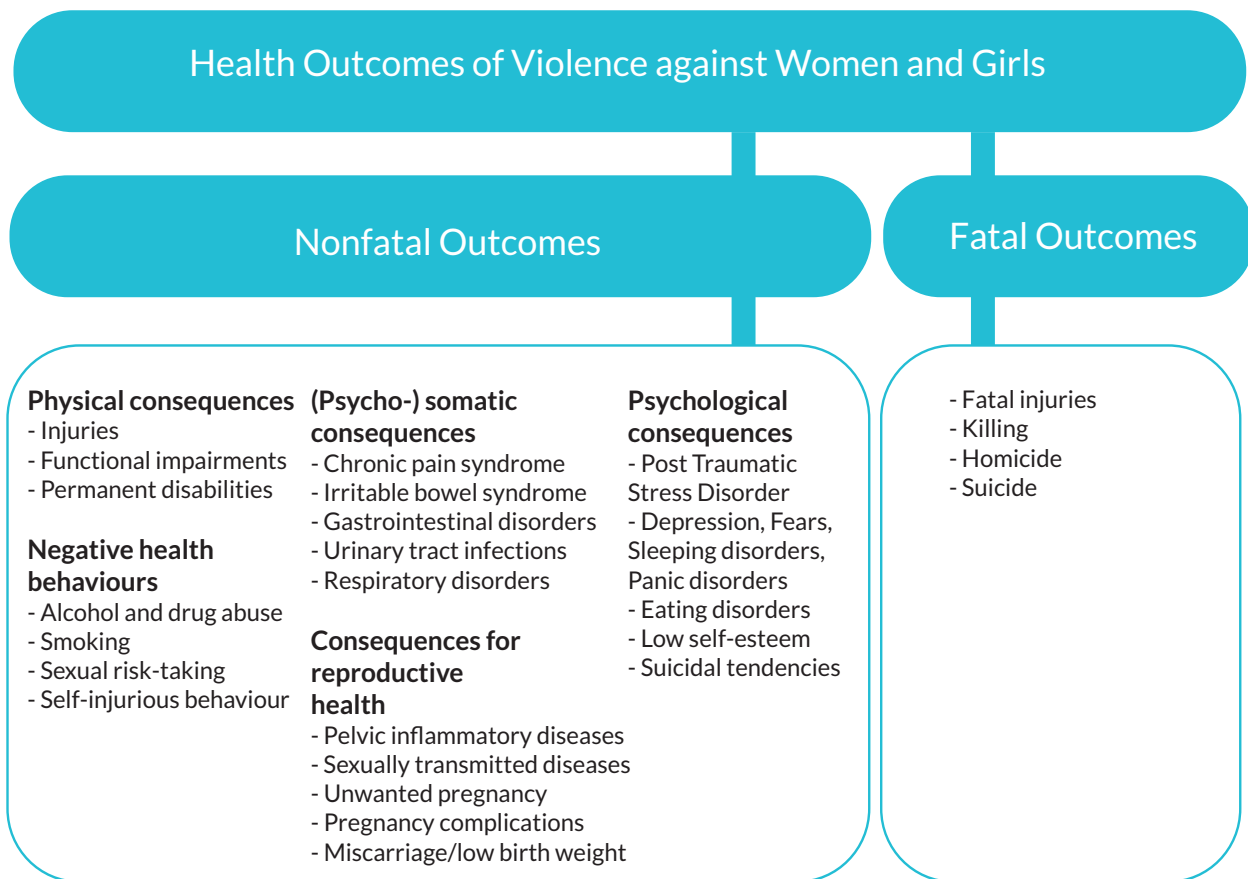
⁹ This methodology estimates the healthy life years of life lost to men and women due to different causes (World Bank 1993 quoted in Heise et al 1994).

- » Compared to women who have not experienced partner violence, women survivors of such violence face a 16% higher risk of having a low-birth weight baby, are more than twice as likely to have an induced abortion, and are more than twice as likely to experience depression.
- » In some regions, women who experienced sexual intimate partner violence are 1,5 times more likely to acquire HIV and 1,6 times more likely to have syphilis, compared to women have not experienced such violence.
- » Women who have experienced non-partner sexual violence are 2,3 times more likely to have alcohol use disorders and 2,6 more likely to have depression or anxiety, compared to women have not experienced such violence (WHO et al 2013).

While health consequences of GBV are similar across low-, middle- and high-income countries, the nature or severity of the effects of such violence may vary according to context-specific factors, such as poverty; gender inequality; cultural or religious practices; access to health, legal and other support services; conflict or natural disaster; HIV prevalence; and legal and policy environments (WHO PAHO 2012a).

Figure 3 summarizes the consequences of gender-based violence on women’s physical, sexual and reproductive, mental and behavioural health.

Figure 3: Health consequences of violence against women and girls



Source: Hellbernd et al 2004, CHANGE 1999, all cited in PRO TRAIN 2009

1.7.2. THE LIFE-CYCLE APPROACH TO GENDER-BASED VIOLENCE

Violence can occur during any phase of women and girl's lives. Many women experience multiple episodes of violence that may start in the prenatal period and continue through childhood to adulthood and old age (see table 6).

A global synthesis of lifetime prevalence data on intimate partner violence reveals high prevalence rates among young women, indicating that violence starts early in women's relationships. Among ever-partnered women aged 15-19 years, 29% have experienced physical and/or sexual violence by an intimate partner. Prevalence reaches its peak in the age group of 40-44 years (37,8%) and declines for women aged 50 years and older. However, this fact does not necessarily imply that older women experience lower levels of IPV. Rather, it is assumed that less is known about patterns of violence affecting women in this age group, especially in low- and middle income countries (WHO et al 2013).

Understanding GBV through a life-cycle approach can help health professionals to understand the cumulative impact of violence, especially in terms of its long-term effects on the lives and health of women and girls. Violence experienced in one phase can have long-term effects that predispose the survivor to severe secondary health risks, such as suicide, depression, and substance abuse (Heise et al 1994). Evidence suggests that the earlier in a woman's life violence occurs, especially sexual violence, the deeper and more enduring its effects are (Burnam et al 1988, cited in Heise et al 1994).

Table 6: The life-cycle approach to gender-based violence

Pre-birth	Sex-selective abortions, battering during pregnancy (emotional and physical effects on the woman; effects on birth outcome); coerced pregnancy (for example, mass rape in war)
Infancy	Female infanticide; emotional and physical abuse; differential access to food and medical care for girl infants
Girlhood	Child marriage; genital mutilation; sexual abuse by family members and strangers; differential access to food and medical care; child prostitution; child labour; neglect of girl child
Adolescence	Early and forced marriage; dating and courtship violence (e.g. date rape); economically coerced sex; sexual abuse in the workplace; rape; sexual harassment; forced prostitution; trafficking in women; limitations in access to education; dowry/kalim" and other marriage related practices
Reproductive age	Marital rape, partner femicide, psychological abuse, battering during pregnancy and other forms of intimate partner violence; abuse by in-laws and other relatives; dowry abuse and age murders; sexual abuse or harassment at the workplace; rape; extreme exploitation of household labour; kidnapping; forced abortion
Old age	Abuse of widows; against older women

Source: adapted from Heise et al 1994

1.7.3. THE IMPACT OF VIOLENCE ON CHILDREN

Like violence against women, violence against children is a global problem. It takes a variety of forms and happens in many settings: the home and family, in schools and educational settings, in institutions such as orphanages, children's homes or detention facilities, places where children work, or in the community. Children experience violence most commonly from people who are parts of their lives - parents, school mates, teachers, employers, boyfriends/girlfriends, spouses or partners (UN Secretary General 2006a).

Much violence against children remains hidden. Many children are afraid to report incidents of violence they experience. This fear is closely related to the stigma attached to reporting violence, especially in cases of rape or other forms of sexual violence. Another factor is the social acceptance of physical, sexual or psychological violence by both, perpetrators and children as normal. Further, there is a lack of safe or trusted ways for children to report violence (UN Secretary General 2006a).

Violence against children in the family frequently takes place in the context of discipline, in the form of physical, cruel or humiliating punishment. It is often accompanied by psychological violence, such as insults, belittling, name calling or rejection (UN Secretary-General 2006b, Durrant 2005, both cited in UN Secretary-General 2006a). Furthermore, there is increasing acknowledgement of the occurrence of sexual violence in the home (Finkelhor 1994, WHO 2005a, both cited in UN Secretary-General 2006a).

Children are also directly or indirectly affected by intimate partner violence committed against their mothers, in the following ways (Walker/Edwall 1987, cited in Warshaw/Ganley 1996):

- » intentionally injuring children in order to threaten or control the survivor (e.g. using a child as a physical weapon by throwing her/him against the woman) or physically or sexually abusing a child as a way to coerce the woman into doing something;
- » unintentionally injuring the children during an attack on the survivor (e.g. injuring a child when the mother is pushed against the wall when holding the child or kicking a child who is trying to stop the attack against her/his mother);
- » creating an environment where children witness the abuse or its effects, through directly watching the assault, overhearing it or seeing the aftermath of the injuries; and
- » using the children to coercively control the survivor while the partners live together or after separation.

Violence against children in its different forms has a negative impact on children's physical, psychological and sexual health. Further, witnessing intimate partner violence against their mothers – even when the child is not physically targeted – has shown negative social and health consequences for children, including anxiety, depression, poor school performance and negative health outcomes (WHO 2002, cited in WHO/PAHO 2012b). For example, prevalence research in Armenia shows that the rate of children who have frequent nightmares is nearly two times higher for children whose mothers experienced partner violence, compared to those children whose mothers did not. Similarly, the percentage of children who are aggressive and who wet their bed often is almost three and 1.5 times higher, respectively, among children who were exposed to intimate partner violence against their mothers compared to those who were not (UNFPA 2010). Furthermore, it is well-established that exposure to intimate partner violence against the mother increases the risk of boys perpetrating and girls experiencing intimate partner violence later in life (see chapter 1.3).

Box 5: Consequences of intimate partner violence on children – research from Serbia

In 2013, the Autonomous Women's Center conducted a qualitative study among 170 women from 12 towns/municipalities in Serbia, to assess the impact of intimate partner violence on children (Ignjatovic 2013). The sample included women survivors of intimate partner violence who are mothers of at least one minor child and have addressed women's organizations for support. The study revealed, among others:

- In more than two thirds of the cases, the children witnessed violence committed by their father against their mother; in almost half of the cases, children experienced violence themselves.
- In more than 40% of the cases, children tried to protect the mother from violence or prevent the father from acting violent, which put them at major risk of harm.
- Mothers report the existence of physical injuries to children, sleep disturbances and loss of appetite (in every fourth case, respectively), as well as night urination in every fifth case.
- The following changes in behaviour were reported: children being quiet and withdrawn (50%), restless, disobedient or irritable and prone to shouting (every third case), or showing physical and verbal aggression (every fourth child).
- Most commonly reported reactions of children to their violent fathers included fear, avoidance of any contact or unconditional obedience. It was observed that obedience decreased over time, as a result of age and increasing independence. In some cases, however, children insisted on contacts with the father, due to authentic emotions for him but also as a result of manipulative behaviours on the part of the perpetrator.

CHAPTER 2

The role of health systems in the response to gender-based violence

Health care professionals play a key role in the multi-sectoral response to GBV. This chapter provides an overview of key international standards and documents guiding the work of health care professionals (chapter 2.1). It explains why health systems play an important role in addressing GBV (chapter 2.2) and what this role entails (chapter 2.3), and lists barriers to an effective health care response to GBV (chapter 2.4). Further, it lists key principles and quality standards for providing health services to survivors of GBV (chapter 2.5).

2.1. INTERNATIONAL STANDARDS TO STRENGTHEN HEALTH SYSTEM RESPONSES TO GENDER-BASED VIOLENCE

2.1.1. STATES OBLIGATIONS UNDER INTERNATIONAL HUMAN RIGHTS LAW

Gender-based violence is a violation of women's human rights. According to international human rights law, states are therefore obliged to prevent, investigate and prosecute violations and to provide women survivors with redress, which includes protection, support and compensation. This obligation also involves a duty to improve the response of the health sector to GBV. The content of state obligations is specified in a number of international human rights conventions and declarations. This sub-chapter provides an overview of select human rights documents guiding the health system's response to GBV in the region of Eastern Europe and Central Asia.

UNITED NATIONS CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted by the United Nations (UN) General Assembly in 1979. It provides a legally binding framework for state measures to end discrimination against women in all spheres of life: the political, economic, social, cultural, civil or any other field. All states in Eastern Europe and Central Asia have ratified CEDAW and are therefore obliged to implement its provisions in their countries.

Interestingly, the Convention does not explicitly mention violence against women. The reason for this omission is that in the 1970s, when the text of CEDAW was drafted, GBV, in particular violence committed in the home, was not yet regarded as a human rights issue. The CEDAW Committee closed this gap in 1992, when it adopted General Recommendation No. 19 on violence against women. This document clarifies that GBV against women constitutes a form of “discrimination,” and is therefore covered by the Convention (for the Committee’s definition on GBV, see chapter 1.1). In 1994, the CEDAW Committee adopted another important document, General Recommendation No. 24 on women and health, which specifies the obligations of states to end discrimination against women in the field of health care and to ensure women’s equal access to health care services. Importantly, General Recommendation No. 24 also addresses the health sector’s role in responding to GBV. Both General Recommendations specify the obligations of state parties to CEDAW to eliminate GBV, including through strengthening the response of the health care system:

CEDAW standards for an effective state response to GBV (General Recommendation No. 19):

- » Ensure that **laws** against GBV give **adequate protection** to all women. Effective legal measures include penal sanctions, civil remedies and compensatory provisions.
- » Implementing gender-sensitive **training** of public officials including judges and police.
- » Provide women survivors with **effective complaint procedures and remedies**, including compensation.
- » Establish or supporting appropriate **protective and support services** for women who have experienced or are at risk of violence, rape, sexual assault and other forms of GBV. This includes an obligation to provide shelters, specially trained health workers, rehabilitation and counselling services, and to ensure that such services are accessible to rural women.
- » Undertak **preventive** measures, including public information and education programmes to **overcome attitudes, customs and practices that perpetuate GBV**.
- » **Compile statistics and research** on the extent, causes and effects of GBV, and on the effectiveness of measures to prevent and respond to violence.

CEDAW standards for strengthening the health system’s response to GBV (General Recommendation No. 24):

- » Enact and implementing **laws, policies, protocols and procedures** to address violence against women and girls and to provide appropriate health services.
- » Implement a **comprehensive national strategy to promote women’s health throughout their lifespan, including interventions responding to GBV** and ensuring access to high quality and affordable health care, including sexual and reproductive health services.
- » **Remove all barriers to women’s access** to health services, education and information.
- » Ensure women’s **access to health services** in line with women’s human rights, including their right to **autonomy, privacy, confidentiality, informed consent and choice**. Further, services should be delivered in a way that they respect women’s **dignity** and are sensitive to **women’s needs and perspectives**. This implies, among others, prohibiting coercive practices such as non-consensual sterilization or mandatory testing for sexually transmitted diseases.

- » Gender-sensitive **training** to enable health-care workers to detect and manage the health consequences of GBV. Training curricula should include comprehensive, mandatory, gender-sensitive courses on health and women's human rights, in particular GBV.
- » Ensure **adequate protection and health services**, including trauma treatment and counselling, for women in **especially difficult circumstances**, such as women trapped in armed conflict and refugee women.
- » Ensure **complaint procedures and sanctions** against health care professionals guilty of sexual abuse of women patients.

PROGRAMME OF ACTION OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

The Programme of Action adopted at the 1994 International Conference on Population and Development (ICPD) in Cairo underlined the inextricable linkages between population and development as well as the important contribution of women's empowerment and people's access to education and health, including reproductive health to both individual advancement and balanced development. Advancing gender equality, eliminating violence against women and ensuring women's ability to control her own fertility are acknowledged as cornerstones of population and development policies. To this end, countries committed, among others, to eliminate all forms of exploitation, abuse, violence and harassment against women, adolescents and girls. An important aspect of the Platform for Action is its focus on reproductive rights and reproductive health and the expressed commitment of governments to make reproductive health accessible through the primary health care system to all individuals at an appropriate age. The document defines reproductive health as *"a state of complete physical, mental and social well-being in all matters related to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so."* Reproductive health also includes sexual health, which aims at the enhancement of life and personal relations. The concept of reproductive rights includes: the right of individuals and couples to decide freely and responsibly on the number, spacing and timing of their children and to have the means and information to do so; the right to attain the highest standard of sexual and reproductive health; and the right to make decisions concerning reproduction free of discrimination, coercion and violence (UNDPI 1995).

AGREED CONCLUSIONS OF THE 57TH SESSION OF THE COMMISSION ON THE STATUS OF WOMEN

The Commission on the Status of Women (CSW) at its 57th session in 2013 adopted Agreed Conclusions on "Eliminating and Preventing all Forms of Violence against Women and Girls." Section A of the document calls for better implementation of existing laws and policies to end violence against women, by ensuring women's access to justice, the development and implementation of effective multi-sectoral policies and strategies and the allocation of sufficient resources for their implementation. Section B lists measures to tackle discrimination and structural violence as root causes and risk factors for violence against women. Section C contains many detailed provisions for responses to the problem and mentions inter alia the need for independent women's shelters and other services. Such services should be accessible, comprehensive and involve the coordination of all relevant actors, including police, judiciary, legal aid, health care and counseling services. The CSW also encourages the health sector to respond to GBV and to ensure accessible and quality health-care services. It calls upon governments to address the physical, mental and sexual and reproductive health consequences of violence against women and girls by providing accessible health-care services. Such services should be responsive to trauma and include affordable, safe, effective and good-quality medicines, first-line support, treatment of injuries and psychosocial and mental health support, emergency contraception, safe abortion where such services are permitted by national law, post-exposure prophylaxis for HIV infection, diagnosis and treatment for sexually transmitted infections, as well as forensic examinations by appropriately trained professionals. Further, medical professionals should be trained to effectively identify and treat women subjected to violence. Section D points out the need for research and comprehensive collection of data on violence against women, to ensure that the formulation of new laws and policies and the adaptation of existing standards are based on sound evidence. Several provisions of the Agreed Conclusions stress the important role of women's NGOs in the work to end violence against women.

COUNCIL OF EUROPE

COUNCIL OF EUROPE CONVENTION ON PREVENTING AND COMBATING VIOLENCE AGAINST WOMEN AND DOMESTIC VIOLENCE (ISTANBUL CONVENTION)

On 7 April 2011, the Committee of Ministers of the Council of Europe adopted the Convention on preventing and combating violence against women and domestic violence. As it was adopted in Istanbul, this document is often referred to as the “Istanbul Convention”. The Convention will enter into force on 1 August 2014. As of 30 June 2014, eleven countries have ratified it, including the following EECA countries: Albania, Bosnia and Herzegovina, Montenegro, Serbia and Turkey. The Former Yugoslav Republic of Macedonia and Ukraine have signed, but not yet ratified. The Istanbul Convention is also open for accession by non-member states of the Council of Europe. Therefore, countries such as Belarus or the Central Asian states could also accede to the Convention.

The Istanbul Convention provides a detailed, comprehensive and legally binding framework for state measures to eliminate GBV, covering, among others, the following areas:

Integrated policies and data collection: This includes an obligation to adopt and implement comprehensive and coordinated policies to prevent and combat all forms of violence that place the rights of the victim at the centre and are implemented through effective cooperation among all relevant organizations (Article 7); an obligation to support and effectively cooperate with relevant non-governmental organizations (Article 9); and an obligation to collect disaggregated relevant statistical data and support research on violence against women (Article 11).

Prevention: Among others, the Convention establishes a duty to ensure training of relevant professionals dealing with victims of violence on gender equality, the prevention and detection of such violence, the needs and rights of survivors, as well as how to prevent secondary victimization. Such training should also address coordinated multi-agency co-operation to ensure comprehensive and appropriate referrals to services (Article 15).

Protection and support: States shall ensure access of victims to adequate support services to facilitate their recovery from violence. This includes health care and social services that are adequately resourced and staffed with professionals who are trained to assist survivors and refer them to appropriate services (Article 20). Further, the Convention foresees appropriate and easily accessible shelters and rape crisis or sexual violence referral centres that should exist in sufficient numbers (Article 23, 25) and state-wide 24/7 telephone helplines that operate free of charge and provide confidential advice (Article 24). States shall ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand (Article 19). The Convention also specifies a set of basic principles for service provision (Article 18, see chapter 2.5, box 8).

The Convention further establishes state obligations in the areas of legislation; investigation, prosecution and protection measures; migration and asylum; and international cooperation.

ORGANIZATION FOR SECURITY AND COOPERATION IN EUROPE

MINISTERIAL COUNCIL DECISION No. 15/05 “PREVENTING AND COMBATING VIOLENCE AGAINST WOMEN”

All countries in Eastern Europe and Central Asia are participating states of the Organization for Security and Cooperation in Europe (OSCE) and therefore politically bound by the Ministerial Council Decision No. 15/05 “Preventing and Combating Violence against Women,” adopted in 2005.

The declaration addresses violence against women as a violation of human rights and a threat to human security (preamble). It calls upon OSCE participating states to “*take all necessary legislative, policy and programmatic monitoring and evaluation measures to promote and protect the full enjoyment of the human rights of women and to prevent and combat all forms of gender-based violence against women and girls.*” In particular, states should undertake, among others, the following measures:

Protection and support: to ensure that women victims have full, equal and timely *access to justice* and effective remedies, medical and social assistance, confidential counselling and shelter; to adopt and implement legislation that criminalizes GBV and establishes adequate legal protection; to provide in a timely manner physical and psychological protection for victims, including appropriate witness protection measures; and to investigate and prosecute the perpetrators

Collect, analyze and disseminate comparable data on violence against women and provide support to specialized NGOs and research on the issue;

In the context of prevention, the Declaration calls for measures to **strengthen the economic independence of women** with a view of reducing their vulnerability to all forms of violence;

It also addresses GBV against women and girls during and after **armed conflict and emergencies** by calling upon states to bring perpetrators of crimes to justice and to take special measures to address the needs of women and girls in the post-conflict environment.

2.1.2. OTHER GUIDELINES FOR HEALTH PROFESSIONALS

In 2013, the World Health Organization published a set of evidence-based guidelines to improve the health care response to intimate partner violence and sexual violence, titled “Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines.” This document seeks to provide healthcare providers with guidance on how to respond to violence against women. It also addresses policy makers, encouraging better coordination and funding of services, and greater attention to responding to violence against women within training programmes for health care providers. The guidelines cover the following areas:

- » identification and clinical care for intimate partner violence,
- » clinical care for sexual assault,
- » training relating to intimate partner violence and sexual assault against women,
- » policy and programmatic approaches to delivering services, and
- » mandatory reporting of intimate partner violence.

The WHO guidelines provide standards that can form the basis for national guidelines, and for integrating these issues into health-care provider education (WHO 2013). Its recommendations are incorporated in the present publication.

Box 6: Select international guidelines and manuals to strengthen health system responses to GBV

General guidelines

- International Planned Parenthood Federation, Improving the health sector response to gender based violence: A resource manual for health care professionals in developing countries, 2010
- International Rescue Committee. Clinical care for sexual assault survivors. New York, International Rescue Committee, 2008.
- UNFPA, A Practical Approach to Gender-based Violence: A Programme Guide for Health Care Providers & Managers, author: Lynne Stevens (UNFPA 2001)
- WHO, Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. 2013
- WHO, War Trauma Foundation, World Vision International. Psychological first aid: Guide for field workers, 2011.
- WHO, Preventing intimate partner violence and sexual violence against women. Taking action and generating evidence, 2010.
- WHO, mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, 2010.

- WHO, Integrating Poverty and Gender into Health Programmes. A Sourcebook for Health Professionals. Module on Gender-based Violence, 2005.
- WHO, Guidelines for medico-legal care for victims of sexual violence, 2003

Guidelines for humanitarian settings:

- Inter-Agency Standing Committee. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva, Inter-Agency Standing Committee, 2007.
- Inter-Agency Standing Committee Task Force on Gender and Humanitarian Assistance, Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, 2005.
- Inter-Agency Working Group on Reproductive Health in Crises, Gender-based Violence. Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010.
- International Rescue Committee, UNICEF, Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings, 2012

2.2. WHY DO HEALTH CARE PROFESSIONALS PLAY AN IMPORTANT ROLE IN RESPONDING TO GENDER-BASED VIOLENCE?

It is widely recognized that the health system has a crucial role in preventing and responding to GBV. At the same time, when health care professionals do not or inadequately address the issue of GBV, such neglect can cause harm to women.

Gender-based violence is a public health issue, with a significant impact on women's and girls' physical, psychological and sexual health. It affects women throughout the entire life cycle and is a major cause for of injury, disability and death among women (see chapter 1.7.1).

Health care professionals are often the first point of contact for women who have experienced violence. Virtually every woman uses the health care system at some point in her life - whether for routine health care, pregnancy and childbirth, illness, injury, or for caring for children or older people (National Assembly for Wales 2001). For women survivors of intimate partner violence who experience isolation and control by a violent partner, health professionals might even be the only point of contact, particularly in a situation where these women do not want to report the violence to the criminal justice authorities. Health professionals enjoy a great degree of trust among women as professionals to whom they disclose abuse. Besides, statistics show that women who have experienced violence use health care services more often than those who have not (WHO 2013).

Forensic medicine plays an important role in collecting evidence to support the criminal prosecution of a perpetrator, in particular through recording the history of assault, undertaking a medical and psychological examination, performing different laboratory tests and documenting injuries.

Knowing about a woman's situation of violence may help in diagnosing or treating many conditions, such as chronic pain or reoccurring sexually transmitted diseases (IPPF 2010).

Therefore, health care professionals are in a strategic position to identify women who have experienced and/or are at risk of experiencing further violence, to provide them with medical care and to make referrals to other services. While some women may disclose violence experienced, many women do not disclose, or do so only if they are being asked. Therefore, it is important that health professionals are trained on how to recognize signs of gender-based violence and how to communicate with survivors (IPPF 2010). Many different types of health care providers may be confronted with health symptoms of GBV in their daily work and therefore offer a broad range of potential entry points for identifying GBV (see chapter 2.3).

Responding to GBV can improve the overall quality of health care. According to International Planned Parenthood Federation data, strengthening the health service response to GBV leads to overall better quality of care, promotes privacy and confidentiality, increases respect for women's rights and encourages a more integrated and holistic vision of women's health (IPPF 2010).

Health care providers who are knowledgeable and skilled on the appropriate response to GBV can thus make an important contribution to improve the health and wellbeing of the patient. On the other hand, lack of such skills and knowledge can put women at further risk and harm. For instance, when health care professionals do not ask about or do not recognize symptoms of GBV, they may misdiagnose survivors or offer inappropriate care. Furthermore, health professionals who are uninformed or unprepared may put the patient's safety, life and wellbeing at risk. For example, health care professionals can unwittingly cause harm by expressing negative attitudes to patients who have been raped or by discussing women's injuries in a way that can be overheard by a potentially violent spouse waiting outside (IPPF 2010).

Traditionally, medical training and education have perceived the role of the health care provider as "diagnosing and 'fixing' clients" (UNFPA 2001). However, this approach reaches its limits when it comes to providing survivors of GBV the care and support they need. Therefore, health care providers, with institutional support of health facilities, should revisit their role and apply a broader understanding of the practice of medicine which encompasses "*diagnosing, healing, treating, preventing, prescribing or removing any physical, mental or emotional ailment ... of an individual*" (Civic Research Institute 2000, cited in UNFPA 2001). This broader approach to medical care can serve to improve the process of identification of GBV and of assisting survivors in getting the help they need to address the health consequences of violence (UNFPA 2001).

2.3. THE ROLE OF HEALTH PROFESSIONALS IN RESPONDING TO GENDER-BASED VIOLENCE

A wide range of health professionals are likely to come into contact with women who have experienced GBV and therefore provide an important entry point for women's access to health care. These professionals include:

- » General practitioners,
- » Doctors specialized in emergency assistance, accident surgery, intensive care, orthopedics, surgery,
- » Obstetricians and gynecologists, family planning specialists,
- » Assistants in doctor's offices,
- » Hospital nurses, nurses providing at-home care, geriatric nurses,
- » Midwives,
- » Dentists,
- » Psychiatrists, psychotherapists, clinical psychologists, doctors with diploma in psychology,

- » Ear, nose and throat doctors, eye specialists,
- » Company physicians, public health officers,
- » Physiotherapists,
- » STI and HIV/AIDS clinics professionals, and
- » Clinical social workers (adapted from BMWFJ 2010).

It is important to keep in mind that not only doctors have an important role in identifying and responding to GBV. Therefore, trainings and other efforts to strengthen health system responses to GBV should also target nurses and physiotherapists who might spend more time with patients than doctors. Furthermore, survivors may be less reluctant to talk to medical assistants, clinical social workers and reception staff. Reception and administration staff may alert doctors and nurses to concerns if they observe behaviour in the waiting room or around making appointments that makes them suspicious of GBV (Johnson 2010).

In order to be sustainable, efforts to improve the response of the health system to GBV need to target several levels:

- » the level of the actual health care provider (staff level),
- » the level of health facilities, such as hospitals, clinics, health centres or doctor's practices (management level),
- » the level of health policy (policy makers and public administration).

The present guidelines mainly focus on the role of health care staff and management in health care facilities; the level of health policy will be addressed only briefly.

2.3.1. THE LEVEL OF HEALTH CARE STAFF

The following list summarizes key elements of the role of health care staff in responding to GBV. Each element will be addressed in greater detail in chapter 3 as well as in the training package provided in part II – please refer to the respective chapters for further information.

- » Understand the symptoms of GBV
- » Provide the patient with information on GBV and its consequences on women's health
- » Ask questions about GBV in case of clinical symptoms that indicate possible experience of GBV
- » Create a friendly and confidential environment, listen to the patient and give her validating messages
- » Collect the patient's medical history and undertake a medical examination
- » Provide appropriate medical and psychological care,
- » Document the health consequences of GBV
- » Provide the patient with information and referral to other service providers, as needed (such as specialized medical women's shelter, crisis centre)
- » Assist the patient in safety planning
- » Ensure follow-up care

2.3.2. THE LEVEL OF HEALTH FACILITIES

The management of health facilities is responsible for providing the institutional framework enabling health care professionals to perform their role. In particular, this includes the following:

- **Putting in place written guidelines and protocols** on how to handle cases of GBV, and ensuring that all staff members are familiar with them and with the procedures for implementing the guidelines in their everyday work (WAVE 2006).

- **Ensuring top-down management support, including financial support** to ensure the long-term sustainability of efforts to integrate GBV into health system responses (WHO 2013).
- **Ensuring that services provided promote human rights principles and non-discrimination**, and are women and girls-centered. Services must be acceptable, i.e., which implies that *“delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.”* This means that systems, processes and services are developed, implemented and evaluated based on the needs and desires of the woman or girl receiving the care (CEDAW GR 24).
- **Providing an adequate infrastructure to ensure the patient’s privacy, safety and confidentiality**, e.g. through providing a private room for consultations, requiring that consultations are held without presence of a partner, putting in place a system for keeping records confidential or giving instructions to staff on explaining legal limits of confidentiality, if any (UNFPA 2001).
- **Sensitizing staff and building their skills** on how to recognize and respond to GBV, with the aim to create a climate that demonstrates to patients that “GBV can be discussed here.” Training should address the entire staff. Apart from improving practical clinical skills, such as recognizing the signs of GBV or documenting injuries, health care staff also need to understand the issue of GBV as well as the specific local context, for instance the views of the local community on GBV or the words people use when talking about GBV (UNFPA 2001). Training efforts should not be undertaken in an isolated manner, but be implemented alongside other changes in the system of care and referral pathways (Lo Fo Wong et al 2006, Garg et al 2006, all cited in WHO 2013). For WHO guidelines on staff training, see box 7. For further information on how to set up training activities and a comprehensive training package, see part II.
- **Providing staff and patients with information materials**, such as checklists for doctors and nurses summarizing the steps of the intervention, leaflets or small cards informing patients about their legal rights and service providers, posters on GBV to be displayed in waiting rooms, consulting rooms or bathrooms (UNFPA 2001, WHO 2013) or directories of service providers to whom the patient can be referred for further services.
- **Providing support to health care staff delivering care** (WHO 2013). Working with survivors of GBV is emotionally challenging. Health care staff may experience survivors of GBV as difficult patients – being passive and dependent, always returning to the violent partner. Further, common feelings such as worries about the safety and well-being of the patient, fear of a violent perpetrator for oneself and one’s family or having own experiences of violence in the past can lead to exhaustion and even trauma of the health care provider. In order support staff capacities to protect themselves and to cope with difficult situations, health facilities should provide staff with training on the dynamics and consequences of GBV, as well as possibilities for supervision (Perttu et al 2006).
- **Networking and building coalitions with other organizations working on the same issue, with a view to ensuring a multi-sectoral, coordinated response.** As part of an overall referral mechanism, this might include other doctors or hospitals in the same community, government bodies such as police, child welfare or psychosocial services, as well as women’s shelters or crisis centers. Networking and coalition building can contribute in increasing efficiency in service provision. For instance, other organizations may become partners for referring patients (both to and from the health facility) and working together can therefore help to provide the patient with the best possible support without duplicating services. Further, networks and coalitions provide a forum for exchanging knowledge and tools which other partners can pick up for their work. These for a can also be used for joint advocacy for improving existing or creating new laws and policies. Protocols are an effective tool to specify the roles and responsibilities of different organizations involved in a coalition, as well as procedures for interventions and referrals (UNFPA 2001, WHO 2013). For more information on referral systems, please refer to chapter 4.
- **Implementing a system for monitoring and evaluating** to assess the impact of interventions undertaken to improve the facility’s response to GBV (WHO 2013). Monitoring and evaluation is an important aspect of assuring quality in service provision, with a view of ensuring accountability of service providers to service users, to their institution and society in general (WAVE 2006). For more information on monitoring and evaluation, please refer to chapter 5 and IPPF 2010.

Please refer to Annex 1 for a table summarizing key elements of quality health care for women that management in health facilities may wish to consult.

Table 7: Types of clinical policies and protocols recommended for health facilities

Type of policy or protocol	Why this type of policy or protocol is important and what it needs to contain
Sexual harassment policy	<p>Every health care organization should have a written policy that prohibits sexual harassment by staff members against other staff members and against clients. The policy should</p> <ul style="list-style-type: none"> • state the types of actions that are prohibited, • provide a clear definition of sexual harassment, • specify the procedures for reporting a case of sexual harassment, and • specify consequences of violating the policy. <p>Health care organizations cannot adequately address the issue of gender-based violence if they cannot ensure respect for the rights of their own staff members and clients. A sexual harassment policy that has a clear procedure for handling violations is therefore an essential part of this effort.</p>
Policies and protocols about client privacy and confidentiality	<p>Every health care organization should have written policies that explain how staff should protect client privacy and confidentiality. These policies should address issues such as</p> <ul style="list-style-type: none"> • where in the clinic and under what circumstances staff members are allowed to discuss information about clients with other staff or with clients themselves, • the circumstances under which providers are allowed to share information about clients with other people, including family members, • confidentiality of medical records, • whether or not providers are required to get parental consent for certain services, and • whether or not adolescents can keep their personal and medical information confidential from their parents.
Protocols for treating cases of violence against women, including sexual abuse and rape	<p>Ideally, health care organizations should develop protocols for caring for women who experience GBV, including rape. These protocols can help providers know how to respond to a woman's disclosure of violence in a caring and supportive way, that preserves her legal rights. In cases of sexual violence, for example, the protocol should include guidelines about the provision of emergency contraception and testing for STIs. Such protocols may increase the chances that women will receive adequate treatment, especially when health care professionals have misconceptions about issues such as sexual abuse, emergency contraception and STIs/HIV.</p>
Protocols for handling situations of risk and crisis	<p>Health care organizations that want to strengthen their response to the issue of violence against women should develop protocols for caring for women who are in situations of crisis or high risk. This includes clients who appear to be at high risk of suicide, homicide, injury or extreme emotional distress. A protocol for situations of risk and crisis should include a discussion of</p> <ul style="list-style-type: none"> • how to identify risk factors, • how to ensure that women get at least the basic assistance that they need, and • among who the staff can provide emotional counseling and safety planning.

Source: IPPF 2010

Box 7: WHO guidelines on in-service training of health care providers

Health care providers should receive in-service training on intimate partner and sexual violence against women. Such training should:

- enable health care providers to provide first-line support to patients who experienced violence;
- teach appropriate skills, including when and how to inquire about violence, the best way to identify violence and to provide clinical care, and how to conduct forensic evidence collection where appropriate;
- address basic knowledge on violence and relevant laws, knowledge of existing support services, inappropriate attitudes among health-care providers (e.g. blaming women for violence), as well as own experiences of violence;
- integrate both intimate partner violence and sexual violence in the training programme, given thematic overlaps between both issues and the limited resources available; and
- cover different aspects of the response to violence, such as identification, safety assessment and planning, communication and clinical skills, documentation and provision of referral pathways.

2.3.3. THE LEVEL OF HEALTH POLICY MAKERS AND PUBLIC ADMINISTRATION

While health care staff and health facilities play a key role in the daily health system response to GBV and the provision of services to survivors, efforts at these levels will have limited impact unless there is a specific health policy on the issue of GBV that guides the work of staff and facilities to integrate the response to GBV into health care. Without a basis in health policy, there is a risk that efforts to improve the provision of care to survivors of GBV remain ad hoc initiatives of individual providers or particular facilities, rather than being institutionalized within the health sector (WHO 2005). At the same time, adopting policies cannot be an end in itself – in order to be implemented, they need to be widely disseminated among health care providers as well as the public (WHO 2005). Further, health care management and staff need to be trained on existing policies.

Some countries have addressed the role of the health sector as part of **wider GBV policies or action plans**. For example, the Government of Armenia has integrated, among others, the following measures into its 2011-2015 Strategic Action Plan to Combat Gender Based Violence:

- » provision of information by health care institutions to survivors of violence and individuals at risk of violence about GBV and its consequences, HIV/AIDS, about existing services for survivors and the organizations providing them as well as minimum standards for service provision;
- » establishing a 24-hour helpline in health care institutions;
- » elaborating minimum standards for health care and other services provided by shelters;
- » introducing mechanisms to involve social workers and psychologists in the provision of medical aid services by primary health care services and hospitals;
- » elaborating standards for identifying survivors of GBV and for recording, reporting and referral procedures in the field or health care; and
- » organizing training courses for public health specialists in the areas of identification, recording, reporting and referrals (Government of Armenia 2011).

The Turkish Government adopted a National Action Plan on Combating Domestic Violence against Women (2007-2010). Two of its goals focus on improving the provision of health services and on establishing a multi-sectoral response to domestic violence, respectively. Among others, the following measures are foreseen:

- » incorporation of the topic of GBV into the routine work and household visits of the midwives and nurses working at the primary level health institutions;
- » setting up special units within health institutions for provision of health services to women survivors of violence, involving both medical and non-medical experts;
- » preparation and signing of memoranda of understanding amongst relevant institutions that define the cooperation framework, the authorities involved and their responsibilities;
- » establishment of local coordination committees with the participation of governorates, local security forces, gendarmerie, municipalities, universities, professional organizations and the mufti's office, and NGO representatives in order to work on prevention of violence against women (Republic of Turkey 2007).

For guidance on developing National Action Plans on Violence against Women, please refer to UN Women, Handbook for National Action Plans on Violence against Women, 2012 (UN Women 2012).

Another approach to address the health system's response to GBV is the adoption of **special protocols or policies, usually issued by the Ministry of Health**, that specify the role of health care professionals in the response to GBV and provide guidance through defining standards for services provided and steps to be taken as well as providing tools. For instance, the Ministry of Health of the Republic of Serbia has adopted a Special Protocol for the Protection and Treatment of Women Victims of Violence. Following an introduction on basic terms and concepts, the Protocol provides background information and guidelines for the following steps of a health care intervention:

- » acknowledging and identifying violence,
- » responding to the health consequences of violence,
- » risk assessment and safety planning,
- » referrals to other services,
- » ending the interview.

For example, the Protocol lists examples of recommended as well as potentially harmful statements and suggests direct and indirect questions that health care staff can ask to verify the existence of violence. It also provides a template for recommending and documenting violence which includes a checklist for risk assessment and a form for collecting contact information of other service providers that can be compiled in a referral directory (Republic of Serbia 2010).

Please refer to Annex 3 for a table compiling select policies and protocols on the health sector's response to GBV.

2.4. BARRIERS TO AN EFFECTIVE HEALTH CARE RESPONSE TO GENDER-BASED VIOLENCE

Even though it has been widely acknowledged that the health sector plays a key role in the effective response to GBV, a number of barriers persist that prevent women survivors of GBV from receiving appropriate health care. Such barriers exist at the levels of both the patient who experienced GBV and the health care provider.

In order to overcome these barriers, changes in guidelines and policies as well as in the daily work practices of health care professionals are required. To this end, chapters 2.3.2, 2.3.3 and 3 provide guidelines and recommendations.

Barriers faced by women survivors

The following reasons may prevent women who experienced GBV from accessing health care and disclosing violence to health professionals (adapted from Ganley 1998 and Hellbernd 2006 cited in PRO TRAIN 2009):

- » Shame, guilt, and the feeling to be solely or partly responsible for the violence suffered: A woman who experienced violence from an intimate partner may be convinced that she can stop the violence if she obeys the perpetrator's wishes and "betters" herself.
- » Fear of reprisals from the perpetrator: Women who live in violent relationships may fear an escalation of violence and further threats, as violent partners usually forbid women to talk about the violence with any other person and threaten with further violence.
- » Fear of stigma and social exclusion by their families and communities.
- » Social isolation and the feeling of having to deal with the experienced violence all by themselves.
- » Long-term experiences of mistreatment that can damage women'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 to irregular immigration status or of losing status following separation from a violent spouse.
- » Lack of realistic options, e.g. for financial resources, housing, employment or safety.

Even though these barriers operate at the levels of partner relationships, families and the wider community and therefore require interventions beyond the health care system, health professionals nevertheless need to be aware of them, in order to be able to provide effective care and referrals to relevant service providers, such as shelters, crisis centres or counselling centres. These organizations may assist women in addressing some of these barriers, for instance through providing accommodation, legal counselling or other support.

Other barriers faced by women can and should be addressed by health care systems, including the following:

- » Lack of physical access to health care services for women living in remote areas.
- » Fear of negative responses from service providers and of being blamed for not separating from the abusive partner, in particular when the woman has received inappropriate and victim-blaming responses from other service providers in the past.
- » Not knowing which steps health care professionals will take, for instance whether police will be informed or whether the perpetrator will be approached.
- » Language and cultural barriers faced by migrant women and women belonging to ethnic minorities.
- » Situational aspects of the counselling and treatment situation, such as inappropriate physical conditions of the facility or insensitive behaviour of doctors and nursing staff.

Provider barriers to an effective health care response to GBV

The following barriers prevent health care professionals from identifying GBV as a cause of medical symptoms, from asking patients about violence and/or from providing effective care and support (adapted from Ganley 1998 and Hellbernd 2006 cited in PRO TRAIN 2009, IPPF 2010, Warsaw/Ganley 1996):

- » Insufficient knowledge about causes, consequences and dynamics of GBV: If health professionals do not ask about or do not recognize symptoms of GBV, they may misdiagnose survivors or offer inappropriate care.
- » Own attitudes and misconceptions about GBV that may result in perceiving intimate partner violence as a private matter or blaming the survivor for the violence.
- » Own experiences of GBV in the past.
- » Lack of clinical skills in responding to GBV. As a consequence, health care professionals may be reluctant to ask about GBV, so as to avoid “opening Pandora’s box” (McCauley et al 1998, cited in PRO TRAIN 2009). Lack of knowledge and skills may also put the patient’s safety, life and wellbeing at risk, for instance when health professionals express negative attitudes to a patient who has been raped or by discussing a woman’s injuries in a way that can be overheard by a potentially violent spouse waiting outside.
- » Lack of information about existing support services and appropriate professional contacts, which could serve as a basis for referral.
- » Lack of time for medical care, as well as inadequate funding of counselling. It may be difficult to estimate how time-consuming a conversation would be and health care professionals are worried about having to cut back on the time needed for other patients.
- » Missing intra-institutional support such as standardized protocols, documentation forms or staff training on dealing with survivors of GBV.
- » 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 GBV follow standards of good clinical care.

2.5. PRINCIPLES AND STANDARDS FOR SERVICE PROVISION

Women survivors of violence have different needs, depending on their individual situation, the severity of the violence experienced and the consequences. At the same time, there are a number of minimum standards and principles to guide the provision of health services to all women of violence, regardless of the type or setting of the violence experienced (WHO 2013).

Box 8: Standards for GBV support services according to the Istanbul Convention

Services are based on a **gendered understanding of violence against women** and focus on the human rights and safety of the victims.

Services are based on an **integrated approach**, which takes into account the relationship between victims, perpetrators, children and their wider social environment.

Services aim at **avoiding secondary victimization**.

Services aim at the **empowerment and economic indepen-**

dence of women victims of violence.

Services allow, where appropriate, for **a range of protection and support services** to be located on the same premises.

Services address the **specific needs of vulnerable persons**, including child victims, and services are made available to them.

Source: Article 18 Istanbul Convention

The following sub-chapters detail the principles and standards that should guide the health care response to GBV (please note that some of them may overlap).

2.5.1. GENDER-SENSITIVE APPROACH

Health-care providers need to have an understanding of the gender-based nature of violence against women (WHO 2013, Article 18 Istanbul Convention), the root causes of which are “*a manifestation of historically unequal power relations between women and men, which have led to domination over, and discrimination against, women by men*” (preamble Istanbul Convention). Services therefore need to demonstrate an approach which recognizes the gender dynamics, impacts and consequences of violence against women (WAVE 2011).

Health services should take into account the needs of specific groups of women and girls, including those belonging to marginalized groups. This includes women with physical or mental disabilities; women living in rural or remote areas; pregnant women and women with young children; women with a national or ethnic minority background; migrant women, including undocumented migrants and asylum seeking and refugees; lesbian and bi-sexual women; transgender persons; sex workers; HIV positive women; substance abusing women; homeless women; older women; girls and adolescent women (Article 12, 18 Istanbul Convention and Explanatory Report, WAVE 2011, UN Women Virtual Knowledge Centre) and girls involved in early/forced/child marriage. Women belonging to these groups may face an increased risk of experiencing violence: Perpetrators often choose them as targets because they know that these women are less likely to be able to defend themselves, or seek prosecution of the perpetrator and other forms of reparation, because of their situation (Article 12 Istanbul Convention - Explanatory Report).

Health service providers need to respect the diversity of service users and apply a non-discriminatory approach (WAVE 2011). This implies that all women survivors, regardless of the characteristics listed above, have equal and full access to health care and receive care at the same level of quality. Furthermore, health services need to be appropriate and tailored to the particular needs and specifics of service users (Article 18 Istanbul Convention, UN Women Virtual Knowledge Centre). Providers need to identify and address any barriers faced by women belonging to specific groups in accessing health services.

When women experience intimate partner violence, children are always affected too, either directly (being subject to violent acts) or indirectly (witnessing violence against their mother). Therefore, health service providers contacted by women survivors should be able to understand the impact of violence on children (for more information, see chapter 1.7.3). They should be equipped to help them access adequate care and support, according to their age and their needs (WAVE 2010) – if needed, through providing referrals to other service providers in the same facility or externally, as appropriate.

Box 9: How to incorporate a gender and human rights perspective into the work of a health facility

Management can work towards incorporating a gender and human rights perspective into the organization's work in many ways, for example, by

- Collecting, reading and distributing educational material about gender and human rights.
- Encouraging staff in the institution to attend workshops on gender and human rights.
- Building alliances with local organizations and individuals working on issues of health, gender and human rights.
- Evaluating whether the organization incorporates a gender and human rights perspective into its work.
- Identifying ways to strengthen the institution's commitment to gender equity and human rights.
- Carrying out an organization-wide exercise such as "Evaluating Quality of Care from a Gender Perspective," a methodology developed by IPPF/WHO (2000).
- Ensuring that anyone hired to educate or train staff about violence against women has a grasp of gender and human rights issues.
- Ensuring that your organization's approach to violence is based on a gender and human rights framework.
- Developing or strengthening policies that acknowledge patient rights and prohibit sexual harassment.

Source: IPPF 2010

2.5.2. SURVIVOR-/WOMEN-CENTRED APPROACH

A survivor- or women-centred approach implies that those who develop and deliver health care to survivors of GBV prioritize the survivor's rights, needs, and wishes, with a view to

- » creating a supportive environment in which the survivor treated with respect and dignity,
- » promoting the survivor's recovery, and
- » promoting the survivor's ability to identify and express her needs and wishes and reinforcing her capacity to make decisions about possible interventions (UNICEF 2010, cited in UN Women Virtual Knowledge Centre).

In order to implement this approach, management of health care facilities need to make sure that care providers have the necessary resources and tools at their disposal (UN Women Virtual Knowledge Centre).

Box 10 summarizes the elements of a women-/survivor-centred approach to health care (see below).

Box 10: Elements of women-centred care and first-line response

Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support.

Health-care providers should, as a minimum, offer first-line support when women disclose violence. First-line support includes:

- being non-judgmental and supportive and validating what the woman is saying;
- providing practical care and support that responds to her concerns, but does not intrude;
- asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved);
- helping her access information about resources, including legal and other services that she might think helpful;

- assisting her to increase safety for herself and her children, where needed; and
- providing or mobilizing social support

Providers should ensure:

- that the consultation is conducted in private and
- confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting).

If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.

Source: WHO 2013 Recommendation 1

ENSURING THE PATIENT'S SAFETY

Any health care intervention must prioritize the safety of women survivors and their children as the highest concern (WHO 2013, WAVE 2006).

This means first, that health care services need to *refrain from any action*, even well-intentioned, *that might put women survivors at risk* of experiencing further violence. As underlined in the WHO Guidelines, “*any intervention must be guided by the principal to “do no harm”, ensuring the balance between benefits and harms*” (WHO 2013). For example, a health professional trying to convince a patient to return to her violent partner or asking her about violence in the presence of a potentially violent partner can increase the risk of experiencing further violence.

Additionally, health care professionals need to *assist female patients who experienced GBV to increase safety* for herself and her children, where needed (WHO 2013). This includes assisting the patient in assessing potential safety risks and developing a safety plan.

In practice, health facilities and other institutions not specialized on working with women survivors of violence are often not adequately equipped to provide comprehensive protection and support to women survivors of violence and their children. Therefore, referral pathways linking health care providers to specialized services, such as women's shelters that provide women survivors of violence with anonymity, keep their whereabouts secret and do not allow men to enter, should be established (WAVE 2011).

Furthermore, health service providers need to be familiar with any available protection measures under their country's legislation, such as protection orders and the legal requirements and procedures for their application.

For more information on principles for communicating with survivors, please refer to chapter 3.1.4. For more information on risk assessment and safety planning, please refer to chapter 3.4. For more information on referrals, please refer to chapter 4.

ENSURING THE PATIENT'S DIGNITY AND PROVIDING A SUPPORTIVE AND VALIDATING ENVIRONMENT

Health services should aim at avoiding secondary victimization (Article 18 Istanbul Convention), thus, a situation in which service providers, rather than supporting the healing process, may further add to the suffering to the victim, for instance through inappropriate communication or behaviour. To this end, health care professionals should be supportive and non-judgmental and validate what the patient is saying. When asking about the patient's history of violence, they should listen carefully, without pressuring the survivor to talk. Care should be taken when discussing sensitive topics and interpreters are involved (WHO 2013).

Health service providers need to take a clear stance against GBV and condemn violence in all its forms. Trying to remain neutral about what has happened means running the risk of tolerating violence. Health care professionals should convey the message that there is no excuse for violence, they believe the patient's story and that it is the perpetrator, not the survivor, who is responsible for the violent behaviour. By no means should health professionals blame a survivor for violence; also, they should respect a patient's decision not to separate from a violent partner (WAVE 2006, WAVE 2011).

Health care providers also need to ensure that all interventions respect the dignity of the survivor (WAVE 2006, WAVE 2011). To this end, health care facilities should ensure the availability of female examiners where requested and promote the patient's bodily integrity in examinations (UN Women Virtual Knowledge Centre). Furthermore services should ensure access to family planning, contraception, and where legal, safe abortions (WHO 2008 cited in UN Women Virtual Knowledge Centre). Safeguarding women's dignity is closely linked to measures aiming at ensuring privacy, such as private waiting areas, a private toilet and washing facility, and a private examination room (Jewkes 2006, cited in UN Women Virtual Knowledge Centre).

For more information on principles for communicating with survivors and working with interpreters, please refer to chapter 3.1.4, box 7, and table 10. For more information on the medical examination of survivors, please refer to chapter 3.2.

ENSURING PRIVACY AND CONFIDENTIALITY

Privacy and confidentiality of the consultation should be a priority for health professionals as stipulated in a number of internationally respected guidelines and policies (WHO 2013). To this end, providers should ensure that consultations are held in private so that no one in the waiting room or in adjoining areas can overhear the conversation (WHO 2013, UN Women Virtual Knowledge Centre).

Furthermore, health service providers should not share any information regarding a survivor without her informed consent. Staff should only discuss cases with other providers when strictly necessary and in a manner that cannot be overheard. In addition, health facilities should ensure that patient files are stored in a confidential manner. These and other measures should be regulated in a confidentiality policy for the facility and all health care staff should be trained on this policy (UN Women Virtual Knowledge Centre)

According to WHO, mandatory reporting of violence to the police is not recommended. If a country's legislation does establish mandatory reporting, health care providers should inform patients of this obligation, as well as of any other limits of confidentiality (see box 11). It is therefore important that health care providers understand their legal obligations, as well as their professional codes of practice (WHO 2013).

Box 11: WHO guidelines on mandatory reporting

Mandatory reporting of intimate partner violence to the police is not recommended, however, health-care providers should offer to report the incident to the appropriate authorities (including the police) if the women wants this and is aware of her rights.

Child maltreatment and life-threatening incidents must be reported to the relevant authorities by the health-care provider, where there is a legal requirement to do so.

Health care providers need to understand their legal obligations (if any), as well as their professional codes of practice, to ensure that women are informed fully about their choices and limitations of confidentiality.

Source: WHO 2013 Recommendations 37, 38

The WHO based its recommendations on a review of evidence on the impact of mandatory reporting laws (see table 8 for a list of the advantages and disadvantages identified). It concluded that evidence did not support mandatory reporting of violence to the police because it can infringe upon women's autonomy and decision-making. *“While a number of women supported mandatory reporting, there appears to be an equally large number who do not. In particular, abused women appear to be against mandatory reporting, especially if it involves the police. Women in these studies suggested that the decision about reporting should be up to the woman; and that the safety of the woman and her children should be the first priority. Furthermore, recovery should focus on healing for the victims, including through counselling”* (WHO 2013).

Table 8: Mandatory reporting – advantages and concern

	Advantages	Concerns
Perspective of health care providers	<ul style="list-style-type: none"> • Improved collection of statistics • Prosecution of the perpetrator • Improved responsiveness of the physician 	<ul style="list-style-type: none"> • Time and resource requirements • Women may be discouraged from disclosing information • Confidentiality and women's autonomy being compromised • Risk of retaliation • Consequences of unsuccessful prosecutions
Perspective of women survivors	<ul style="list-style-type: none"> • Enabling them to get help while taking away the responsibility to report violence themselves • Making them feel less alone and less to blame • Teaching partners the seriousness of abuse • Potentially positive interaction with police, with the incident being on record if needed in the future 	<ul style="list-style-type: none"> • Risk of retaliation • Fear that their children would be taken away • Anxiety about interacting with a social worker or other people in authority • Being victimized by the health system • Being left with bills to pay as a the result of reporting • Worries over autonomy and confidentiality

Source: WHO 2013

Good communications skills on the part of the health professionals contribute essentially to ensuring privacy and confidentiality of services (WHO 2013).

For more information on principles for communicating with survivors, please refer to chapter 3.1.4. For more information on the medical examination and documentation, please refer to chapters 3.2 -3.3.

ENSURING THE PATIENT'S EMPOWERMENT, AUTONOMY AND PARTICIPATION

All services provided to women survivors of violence should aim at supporting women's empowerment (WAVE 2011). Empowerment of GBV survivor is the process of "helping women to feel more in control of their lives and able to take decisions about their future" (Dutton 1992, cited in WHO 2013). Intrinsically linked to empowerment is the principle of supporting women's autonomy. Often, relatives, friends and professionals in service providing organizations try to tell the survivor what to do. However, such advice can create even more pressure on her and is rarely helpful (WAVE 2006).

Providing women with information on their rights and on legal and other services is a key strategy for empowerment, as it enables them to take informed decisions and to instill in them a sense of control of their lives (WHO 2013, Article 19 Istanbul Convention and Explanatory Report). Health professionals can contribute to empowering survivors of GBV, for instance, through providing them with leaflets or brochures entailing information of their legal rights and of existing shelters, helplines, as well as socio-economic and other support services.

Health-care providers should support survivors in their decision-making. This can be done through presenting and discussing options and providing practical care and support that responds to the patient's concerns, while respecting the patient's autonomy; the woman should always be the one to make the decisions (WHO 2013). This requires that health professionals make themselves aware of the needs and wishes of patient with respect to both her treatment and her interaction with police, the legal system or other referrals. They should seek the patient's informed consent, through informing her about the examination to be performed and medication to be given, including side effects (UN Women Virtual Knowledge Centre). Health professionals should refrain from passing on the survivor's name or any other personal information about her to family members, other service providers, governmental bodies or researchers, unless she gives her informed consent. Exceptions should and must be made if the life and health of women or children are at stake (i.e., suicide attempts, acute danger from the violent partner, or women committing violence against their children) (WAVE 2006). Another exception is mandatory reporting, in which case health providers should inform survivors of their obligation to report (WHO 2013, see chapter 2.5.2).

Finally, health care providers should promote the participation of women survivors in the development and evaluation of the services provided. Survivors should be regularly invited to participate in the evaluation of services and have the right to file a complaint to an independent body (for instance, the ombudsperson) if they are not satisfied with the quality of the service (WAVE 2011).

Box 12 – Participation of service users in the development and evaluation of services

Example from Serbia: In 2006, the Belgrade-based Women's Health Promotion Centre (WHPC) interviewed 240 women users of health centers to identify their needs for support and to identify gaps in existing health services. WHPC used the results of these interviews, together with the findings of focus group discussions among health care providers held in the same year, to develop education programmes for health care providers, which included the preparation of a training manual for health care providers titled "Violence against women – My professional responsibility." The survey results were also used to inform the orga-

nization's work to lobby the government for improved services and training of health care providers (Bacchus et al 2012).

For an example of an evaluation of maternity and sexual health intervention to improve the health professionals response to identify domestic violence and to refer survivors to a specialized service provider that took into account the perspective of both patients and health care professionals, see box 27 in chapter 5.2.

2.5.3. HUMAN RIGHTS-BASED APPROACH

A human rights-based approach (HRBA) to GBV seeks to redress the human rights violations that are both the root causes and the consequences of violence. A HRBA seeks to strengthen the capacities of rights holders (patients who experienced GBV) to understand, claim and enjoy their human rights, while at the same time building the capacity of duty bearers (including policy makers, hospital management, health professionals) to fulfill their obligations to encourage, empower and assist rights holders (UNFPA 2010b, UN Women Virtual Knowledge Centre, OHCHR/WHO undated).

ADDED VALUE OF APPLYING A HUMAN-RIGHTS-BASED APPROACH

- » A HRBA adds legitimacy to an intervention as it is based on universal human rights principles and standards as defined in international conventions and declarations (see chapter 2.1.1) and moves it from the optional realm of benevolence (charity) to the mandatory realm of law.
- » It establishes human rights of individuals (“rights holders”), as well as corresponding duties of state and non-state service providers, including health service providers (“duty bearers”) to respect, protect and fulfill these rights.
- » It underscores the importance of creating accountability mechanisms at all levels for duty bearers and ensures that service users are not passive beneficiaries, but active participants of their own development.
- » Being grounded in the full spectrum of civil, political, economic, cultural and social rights, it provides a holistic lens through which to address development challenges (UNFPA 2010b).

IMPLICATIONS OF A HUMAN-RIGHTS BASED APPROACH

A HRBA to strengthen the health system’s response to GBV requires that:

- » any policies, protocols, programmes or interventions to end are in line with human rights standards and
- » health services aim at empowering survivors and are delivered through a multi-sectoral and comprehensive response that involves both governmental and non-governmental stakeholders.

Further, it implies that those who develop and deliver health services:

- » assess the capacities of women survivors to access health care services, identify any immediate, underlying, and structural barriers and address them, for instance, through improving legislation or implementing information campaigns to inform survivors on available services to ensure that services are accessible to women survivors;
- » assess the capacities of health service providers to fulfill their obligations vis-à-vis survivors according to international and national laws, identify any barriers and design and implement strategies to overcome them, e.g. through development of policies and protocol, staff training or supervision;
- » monitor and evaluate the processes and outcomes of health system interventions to GBV, in accordance with human rights standards and principles; and
- » ensure national accountability of duty bearers for non-compliance with international or national standards or laws (UN Women Virtual Knowledge Centre, UNFPA 2010b).

The HRBA is closely linked to the principles of gender-sensitivity, diversity and non-discrimination, participation and inclusion, as well as empowerment (see chapter 2.5). Please refer to box 9 (chapter 2.5.1) for suggested steps for incorporating a gender and human rights perspective into the work of a health facility. For more information on designing and implementing a HRBA to programming, please refer to UNFPA 2010b.

2.5.4. INTEGRATING THE RESPONSE TO GENDER-BASED VIOLENCE INTO EXISTING HEALTH SERVICES

It is widely acknowledged that medical care for survivors of GBV should be integrated into existing services, rather than offered as stand-alone services (see box 13). This is because stand-alone health services for survivors of GBV may be difficult to sustain and may have a potential harmful effect. For example, an already under-staffed mental health service might run the risk of being further weakened, if had to provide services specifically for survivors of violence, rather than ensuring that all patients (including survivors of GBV) get the best possible care (WHO 2013).

Integrating medical care for survivors of GBV into existing services is also advisable as it may facilitate women's easy access to a range of care and support services offered in one premise.

Box 13: WHO guidelines for policy makers on integration of GBV services

- Rather than offering care for survivors of intimate partner violence and sexual violence as stand-alone services, such care should, as much as possible, be integrated into existing health services.
- While a country needs multiple models of care for survivors of IPV and SV, at different levels of the health system (see box 7), priority should be given to training and service delivery at primary level of care.
- A health-care professional (nurse, doctor or equivalent) who is trained in gender-sensitive sexual assault care and examination should be available at all times of the day or night (either on location or on-call) at a district/area level.

Source: WHO 2013 Recommendations 34-36

When considering a model of integrating GBV into existing health services, it is important to keep in mind that there is nothing like a “one size fits all” model: A model that might work in one setting may turn out not be effective in another setting. Therefore, policy makers should take into account the specificities of the given context in which an intervention is operating and consider different models and their advantages and disadvantages (see table 9). To this end, they should promote evaluation of health system interventions to GBV to identify what works best and what is most cost-effective in a given setting (WHO 2013). For further information on evaluation, see chapter 5 and IPPF 2010. Whatever model is chosen, the overall aim should be to reduce the number of services and providers a women has to contact and to facilitate her access to needed services in a manner respecting her dignity and confidentiality and prioritizing her safety (WHO 2013).

Table 9: A comparison of different models of delivering care for survivors of violence against women;

Site	Advantages	Disadvantages
Health centres and clinics	<ul style="list-style-type: none"> • Located close to the community • Can provide some core services • Improves access for follow-up services • If a good network is established, it can improve access to an intersectoral network of services, including legal, social, other 	<ul style="list-style-type: none"> • May not be able to treat serious injuries or complications • May not have laboratory or specialized services • In services in small communities, where providers are members of the community, confidentiality and providers' fear of retaliation may be a challenge
District and regional hospitals	<ul style="list-style-type: none"> • Equipped to provide 24-hour services • Have specialized services • Can be centralized in one department (emergency department, gynecology, reproductive health, HIV/STI) or distributed throughout the hospital 	<ul style="list-style-type: none"> • Can reduce accessibility • If services are split across departments, can hamper services, especially if some services are only available during working hours
One-stop centres	<ul style="list-style-type: none"> • More efficient and coordinated services • Provide a full range of services (sometimes including police, prosecutors, social worker, counsellors, psychological support, etc.) 	<ul style="list-style-type: none"> • More space and resources required • Client load may be small (e.g. in rural areas), raising concerns on cost effectiveness • May draw staff and resources out of other services • May not be fully integrated into general health services • If administered by the judicial system, may focus too much on prosecution and not on women's health • Costly to sustain

Source: WHO 2013

Box 14 provides an example from Austria of integrating GBV services into a hospital setting.

Box 14: Example from Austria – Setting up victim support groups in hospitals

In 2011, a new provision was introduced into the Austrian Health Facilities Act, establishing so-called “victim protection groups” in hospitals¹⁰. The law specifies that separate groups are to be set up for children survivors of violence and adult survivors of domestic violence, respectively. In exceptional situations, hospitals may also establish one group providing support to both adult and minor survivors, or establish joint groups with other hospitals. The law defines two main purposes of the victim protection groups (early identification of violence and sensitization of health care providers on domestic violence) and specifies the composition of the groups (at least two doctors specialized in accident surgery and gynaecology/obstetrics, as well as nurses and health care professionals specialized in psychological and psychotherapeutic care). This law built on practice that already existed earlier in some hospitals in the country and transformed it into a legal obligation. To date several hospitals have set up victim support groups, including for example the General Hospital of the City of Vienna (AKH), Austria's largest hospital. AKH set up a victim protection group in

2011 and adopted rules of procedure to further specify the group's aims and tasks, as follows: providing advice to health care professionals in contact with survivors of domestic violence, sensitization of health care professionals, development of standardized procedures and guidelines for interventions, organization of trainings, and coordination of the different departments and case conferences. While the creation of victim protection groups has been widely welcomed, practice shows that a number of challenges still exist. Practitioners involved have identified the following prerequisites for the effective operation of the victim support groups: the creation of specific country-wide standards to guide the operation of the groups, the provision of adequate human and financial resources, making trainings on GBV mandatory for all health care professionals, ensuring stronger institutional support to avoid that an improved response rests on the responsibility of committed individuals, as well as effective co-operation both internally and with external stakeholders, such as shelters, police or general practice doctors.

Sources: Austrian Health Facilities Act; Rules of Procedure of the Victim Protection Group at the General Hospital of the City of Vienna; information provided by Anneliese Erdemgil-Brandstätter, Training project “Domestic violence – the role of the health sector”, 2014

¹⁰ More specifically, the law establishes an obligation of parliaments of Austria's nine provinces to adopt laws for their province in order to set up such groups. This is because Austria is a federal state, with health care being part of the provinces (Länder).

CHAPTER 3

Steps of an effective intervention of health professionals to gender-based violence

This chapter explains the different steps of an effective intervention of health professionals vis-a-vis a female patient who is a potential survivor of GBV: identifying GBV (3.1), undertaking a medical examination and providing medical care (3.2), documenting GBV (3.3), and risk assessment and safety planning (3.4). Referrals to other services needed are addressed in chapter 4.

Annex 2 provides a flowchart illustrating a possible sequence of the different intervention steps in the health system response to GBV, based on international examples and as outlined in the present chapter. In their daily practice, health care professionals will need to follow any protocols, guidelines and guidelines existing in their countries and specific clinical settings.

For each step of the intervention, health care providers should observe the key principles and standards for service provision (human-rights based approach, gender-specific approach, women-centred approach), as specified in chapter 2.5. In particular, all actions taken should be guided by the respect of choices, wishes, rights and dignity of the survivor.

3.1. IDENTIFYING GENDER-BASED VIOLENCE

Even though survivors of GBV are more likely than the general population to use health services, they are not likely to spontaneously disclose. Research has shown that when health care professionals sensitively enquire if a woman presents with symptoms that can indicate GBV, this can increase the chances of disclosure (NHS 2010, Feder et al 2011); for an example of a UK-based intervention in a general practice setting, see chapter 4, box 24). Therefore, facilitating a positive disclosure of GBV is an important starting point for any health care intervention. Asking about GBV, when done in a professional and supportive manner, can help to break the feelings of isolation, guilt and shame that survivors of violence may experience and to convey the message that help is available and that she may use it, if she feels ready (Warshaw/Ganley 1996).

This sub-chapter introduces the concepts of routine enquiry and clinical enquiry (chapter 3.1). It aims to support health care professionals in understanding clinical conditions associated with GBV (chapter 3.2), in setting up a safe space to ask the patient about GBV (chapter 3.3) and in asking questions to a woman who presents with conditions that may be caused by GBV (chapter 3.4). Chapter 3.5 presents resources that health facilities can provide to assist health care providers in asking about GBV, as well as to encourage survivors to disclose GBV to the health care provider.

3.1.1. ROUTINE ENQUIRY VERSUS CLINICAL ENQUIRY

In health care settings, two approaches can be distinguished in facilitating the disclosure of intimate partner violence:

- » Routine enquiry (also referred to as screening or universal screening), i.e. routinely asking women presenting in health care settings about exposure to intimate partner violence.
- » Clinical enquiry (or case-finding), i.e. asking women presenting in health care settings based on clinical conditions, the history and the examination of the patient (WHO 2013)

Routine enquiry is not recommended (WHO 2013 Recommendation 2). This is because even though this method has shown to increase rates of identification, it has neither reduced intimate partner violence nor led to any notable benefit for women's health. Instead, clinical enquiry is advised; health professionals should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by violence, in order to improve diagnosis/identification and subsequent care (WHO 2013 Recommendation 3). See chapter 3.1.3 for minimum conditions that should be observed when asking about GBV.

However, routine enquiry might be considered in specific circumstances:

- » Women presenting with mental health symptoms and disorders (depression, anxiety, PTSD, self-harm/suicide attempts) due to the strong correlation between mental health disorders among women and intimate partner violence.
- » HIV testing and counseling- since intimate partner violence may affect the disclosure of HIV status, or jeopardize the safety of women who disclose, as well as their ability to implement risk-reduction strategies.
- » Antenatal care- because of the dual vulnerability of pregnancy and also taking into account the possibility of follow-up in antenatal care (WHO 2013).

3.1.2. UNDERSTANDING THE SIGNS OF GENDER-BASED VIOLENCE

The following list presents symptoms that should make health professionals consider asking about GBV, in particular intimate partner violence.

Box 15: Examples of clinical conditions associated with intimate partner violence

- Symptoms of depression, anxiety, 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)
- 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

Source: Adapted from Black 2011, cited in WHO 2013

Apart from clinical symptoms, health care professionals should also be aware that certain types of behaviours observed with female patients can be indicators of exposure to intimate partner violence.

Box 16: Examples of behaviours that may indicate intimate partner violence

- Frequent appointments for vague symptoms
- Injuries inconsistent with explanation of cause
- Woman tries to hide injuries or minimize their extent
- Partner always attends unnecessarily
- Woman is reluctant to speak in front of partner
- Non-compliance with treatment
- Frequently missed appointments
- Multiple injuries at different stages of healing
- Patient appears frightened, overly anxious or depressed
- Woman is submissive or afraid to speak in front of her partner
- Partner is aggressive or dominant, talks for the woman or refuses to leave the room
- Poor or non-attendance at antenatal clinics
- Early self-discharge from hospital

Source: Department of Health 2005

It is important to keep in mind that none of the above signs automatically indicate that a patient has experienced GBV. However, they should raise suspicion and prompt health professionals to try to see the woman in private to ask her if she has experienced violence. Even if she chooses not to disclose at this time, she will know that the health care provider is aware of the issue and she might choose to approach the care provider at a later time (Department of Health 2005).

3.1.3. MINIMUM REQUIREMENTS FOR ASKING ABOUT GENDER-BASED VIOLENCE

When enquiring about GBV, health care facilities and providers need to ensure that a number of minimum requirements are in place. In particular, this requires that (WHO 2013):

- » A protocol or standard operating procedure is in place to guide the intervention.
- » Health care providers are trained on the correct way to ask and how to respond to women who disclose.
- » Health care providers have ensured that it is safe to ask about GBV (see figure 4), including privacy and confidentiality of the consultation.
- » A system for referral is in place.
- » Health care providers are aware and knowledgeable about resources to refer women to.

Health care professionals may use the following criteria to determine whether is safe to ask about GBV (see also figure 4):

- Ensuring a private and confidential space is an important first step to consider, especially in the context of hospital-based health care providers who may be seeing a patient behind a fabric curtain. While curtains offer a visual barrier, it may still be possible for third persons to overhear the conversation.
- Health care providers should avoid asking a woman about GBV in the presence of a family member, friend, or child over 2 years. While health care staff may feel that it is positive that the patients get support from a family member or friend, they should keep in mind that intimate partners, other family members or friends can be partaking in the abuse. Perpetrators may also use children accompanying the patient to obtain information.
- For women who are migrants, refugees or belong to an ethnic minority and do not speak the local language, health care providers should ensure the presence of a professional translator (see box 17).

Box 17: Recommendations for working with interpreters in health care settings

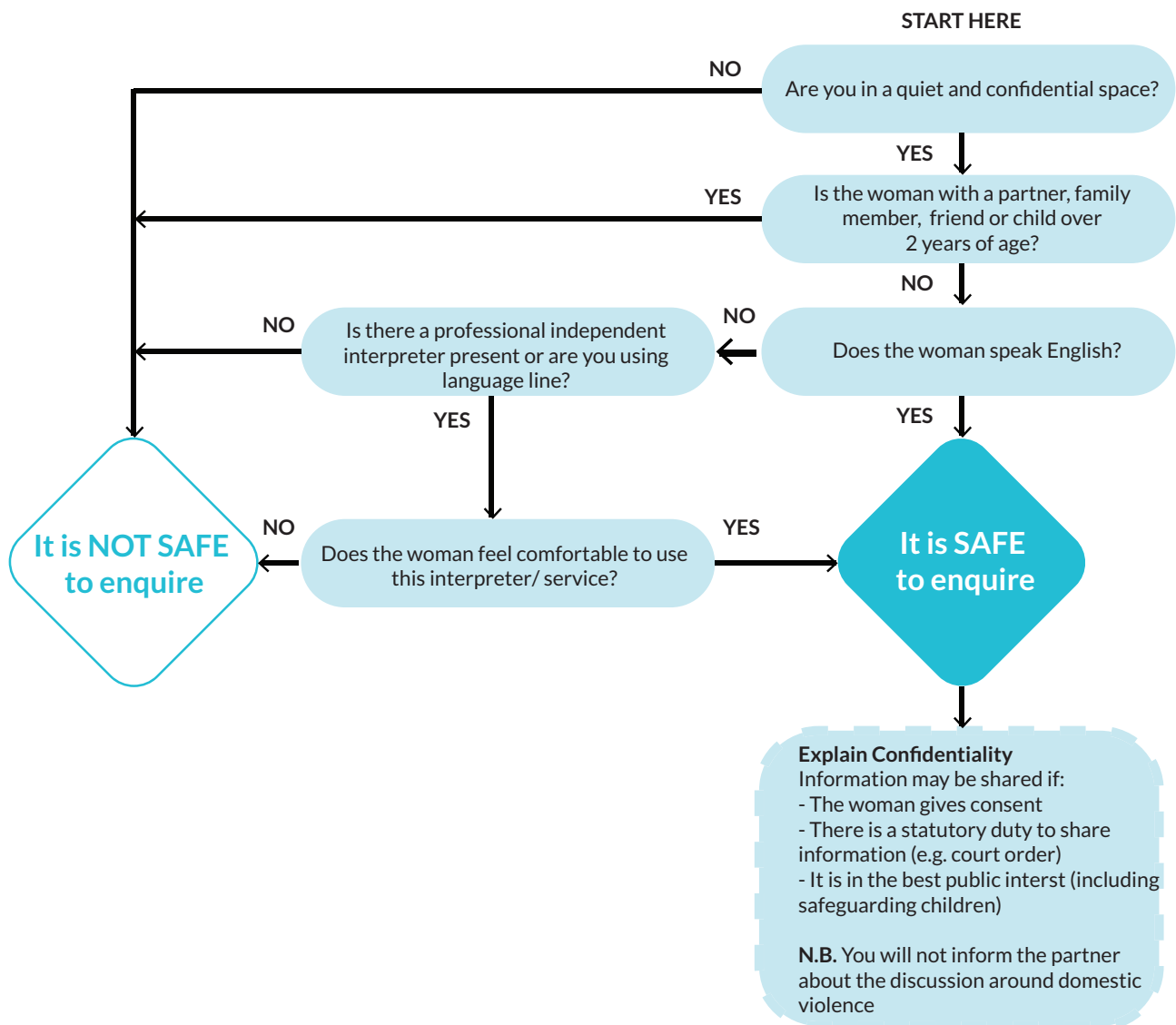
Avoid using family members as interpreters. While this might seem to be an option because of limited financial resources or unavailability of professional interpreters in a certain language, it can put women at risk and should therefore be avoided. When using a family member as the interpreter is the only option, health care staff should not enquire about GBV. Health facilities could consider preparing a list of multilingual staff that can help with interpretations.

Ensure that patient is comfortable with using the interpreter. Health care professionals should keep in mind that in small communities (e.g. among deaf women or groups using minority language) the translator might be able to identify the woman through providing interpretation services and then pass on the information to the perpetrator.

Ensure that the interpreter is trained to interpret around issues of GBV. This will not only help to ensure a non-judgmental and professional approach, but also accuracy of terms used, keeping in mind that in some languages, terms like abuse, risk or counsellor can have different meanings. The NGO Standing Together against Domestic Violence shared the following example: A health professional asked a woman if she wanted to be referred to a “counsellor” (i.e. psychological therapist). This was translated as “counsellor” in the meaning of local government official – a difference in meaning that may easily lead to irritation and lack of confidence in the support provided on the part of the patient.

Source: Standing Together against Domestic Violence 2008

Figure 4: Is it safe to enquire about intimate partner violence?



Source: Standing Together Against Domestic Violence, UK

3.1.4. HOW TO ASK ABOUT GENDER-BASED VIOLENCE

Asking a woman if she has experienced GBV is a difficult task. Health care professionals may be reluctant to ask because they are afraid of offending the patient, lack knowledge or confidence to bring up the issue of violence or do not know what to do next, after having opened “Pandora’s box”. At the same time, asking about GBV is very important. Research has shown that most women, even though they would not themselves start talking about violence, react positively to being asked (Stenson et al 2001, Bacchus et al 2002, Perttu 2005, all cited in Perttu/Kaselitz 2006).

Training health care professionals is crucial in order to increase their knowledge and confidence on asking about GBV and on the next steps of the intervention following, as shown in the following quote from a health care professional working at a hospital in Austria: *“(Back) in 1997, I (...) attended a training programme on responses to violence against women. Until then, working as a nurse in the accident surgery outpatient clinic of Wilhelminen Hospital, I had not questioned statements by patients but simply accepted what they said: that they had fallen from a ladder or down the stairs, etc. During the training, I became aware for the first time that a number of injuries might have another cause and that it could be a good idea to ask further questions. (...) In one case, when I suspected that the patient had been abused I said on an impulse that her injuries were not consistent with what she had told us about her accident but that I rather thought she had been abused. The patient answered: ‘You are the first one to ask. I have often been to (two other hospitals in town) but nobody has ever shown any further interest in my case. I just received treatment. But you are the first one to ask me directly.’ Following this ‘success’ I have gradually become less reluctant to ask women directly whether they have experienced violence”* (Federal Chancellery 2008).

Table 10: Tips for communicating with survivors of GBV – do’s and don’ts

Do’s	Don’ts
<ul style="list-style-type: none"> ○ Take the initiative to ask about violence – do not wait for the woman to bring it up. This shows that you take a professional responsibility for her situation, and it helps to build trust. ○ Explain that the information will remain confidential and inform her about any limitations to confidentiality. ○ Use eye contact and focus all her attention on her. Avoid doing paper work at the same time. ○ Be aware of your body language. How you stand and hold your arms and head, the nature of your expression and tone of voice all convey a clear message to the woman about how you perceive the situation. ○ Show a non-judgemental and supportive attitude and validate what she is saying. ○ Use a sympathetic voice to reassure the survivor. ○ Carefully listen to her experience and assure her that her feelings are justified. ○ Show her that you believe her story. ○ Be patient with women and girls survivors of GBV, keeping in mind that they are in a state of crisis and may have contradictory feelings. ○ Emphasize that violence is not her fault and that the perpetrator is responsible for his behaviour. ○ Use supportive statements, such as “I am sorry that this happened to you” or “You really have been through a lot,” which may encourage the woman to disclose more information. ○ Underline that there are options and resources available. Try to find adequate services together with her. Leave “the door” open for her to come back to you. 	<ul style="list-style-type: none"> ○ Don’t ask about violence in the presence of a partner, family member or friend. Remember that the patient’s safety is paramount. ○ Avoid passive listening and non-commenting. This may make her think that you do not believe her and that she is wrong, and the perpetrator is right. ○ Don’t blame the woman. Avoid questions such as “Why do you stay with him?”, “Did you have an argument before violence happened?”, “What were you doing out alone?”, “What were you wearing?” Instead, reinforce that GBV cannot be tolerated. ○ Avoid body language conveying the message of irritation, disbelief, dislike or anger toward the survivor. ○ Do not judge a survivor’s behaviour based on culture or religion. ○ Don’t pressure her to disclose. If she does not disclose, tell her what made you think about violence. Document your doubts and the evidence they are based on. Explain her that she can come back for further assistance. Bring up the issue at the next appointment.

Sources: Adapted from Perttu/Kaselitz et al 2006, Warshaw/Ganley 1996, WHO 2003, WHO 2013

When asking about GBV, it is advisable to begin the enquiry with an introductory question, explaining the patient that GBV affects many women and underlining the impact of violence on women's health, before continuing with direct and more specific questions.

Examples of introductory questions:

- » “From my experience, I know that abuse and violence at home is a problem for many women. Is it a problem for you in any way?”
- » “We know that many women experience abuse and violence at home and that it impairs their health. I wonder if you have ever experienced violence at home?”
- » “We know that violence against women is a very common problem. About 30% of women in this country are abused by their partners. Has that ever happened to you?”
- » “Some women think they deserve abuse because they have not lived up to their partners' expectations, but no matter what someone has or hasn't done, no one deserves to be beaten. Have you ever been hit or threatened because of something you did or didn't do?”
- » “Many of the women I see as patients are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves. Have you ever experienced violence from your partner?” (adapted from Perttu/Kaselitz 2006, Warshaw/Ganley 1996).

Examples of direct questions:

- » “I am concerned that your symptoms may have been caused by someone hitting you. Has someone been hurting you?”
- » “According to our experience, women get these kinds of injuries when assaulted. Has someone assaulted you?”
- » “Did someone hit you? Who was it? Was it your partner/husband?”
- » “Has your partner or ex-partner ever hit you or physically hurt you or someone close to you?”
- » “Has your partner ever forced you to have sex when you did not want to? Has he ever refused to practice safer sex?”
- » “Does your partner frequently belittle you, insult you and blame you?”
- » “Has your partner ever tried to restrict your freedom or keep you from doing things that were important to you (like going to school, working, seeing your friends or family)?” (adapted from Perttu/Kaselitz 2006, Warshaw/Ganley 1996).

Health care professionals should be sure to raise questions and provide explanations in a manner appropriate to the survivors' age, education, culture and level of tranquillity at the time. Depending on the local context, it may be advisable to avoid legal or technical terms like “domestic violence,” as the meaning might not be clear and some women might not identify with it, and instead circumscribe the violence, using commonly used terms.

3.1.5. RESOURCES TO FACILITATE A POSITIVE DISCLOSURE OF GENDER-BASED VIOLENCE

Displaying written information materials on GBV in health care settings can help to encourage women to speak about violence. This may be achieved through displaying posters in waiting or consultation rooms, containing a message encouraging survivors to raise violence in the medical consultation. Further, health facilities should make pamphlets or leaflets available in private areas such as women's washrooms, to provide information on available services, such as shelters, helplines or legal advice, with appropriate warnings about taking them home if an abusive partner is there (WHO 2013 Recommendation 4).

Figure 5: Desk organizer – “You can talk to me about violence.”

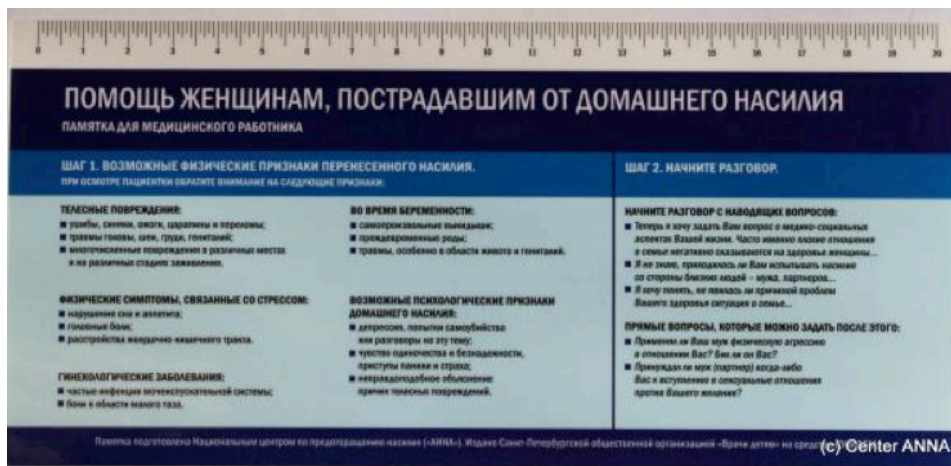


Source: ANNA – National Center for the Prevention of Violence, Russian Federation

Translation from Russian: “There is NO Excuse for Domestic Violence! You can talk to me about violence.”

Health facilities should also provide health care staff with information resources to help them memorize clinical indicators of GBV, tips for asking questions and other steps in the intervention chain. This may include laminated handouts or cards displaying simple flowcharts or stationary such as the ruler designed and produced by ANNA – National Center for the Prevention of Violence, which lists five key steps in identifying GBV and providing care for survivors (figure 7)

Figure 6: Reference card - Helping woman survivors of domestic violence



Summary translation from Russian:
HELPING WOMEN SURVIVORS OF DOMESTIC VIOLENCE
 A quick reference card for health care professionals

Step 1. Observe the indicators of domestic violence. This step includes a brief description of body injuries, physical symptoms related to stress, and gynaecological problems.

Step 2. Start the conversation. This step includes indirect and direct questions to be asked to patients.

Step 3. If you have observed that a patient is a victim of violence: This step presents basic principles of communication with survivors of GBV.

Step 4. Description (documentation) of body injuries. This step lists key principles for documenting injuries.

Step 5. Assistance and information: This step provides contact information of services

3.2. UNDERTAKING A MEDICAL EXAMINATION AND PROVIDING MEDICAL CARE

Following disclosure of GBV, health care professionals should undertake a medical examination and provide medical care. Even if a woman does not reveal GBV, health care providers should ensure examination and care, as required by the clinical symptoms observed.

Throughout the entire process of medical examination and care, health care providers need to take into account that survivors of sexual violence are often in a heightened state of awareness and very emotional after an assault, due to the circulation of stress hormones. While kindness of service providers may support the process of emotional recovery from sexual assault, conversely, inappropriate comments by police, doctors or other persons may contribute to patient distress during the examination and hinder long-term recovery. Please refer to chapter 3.1.4, table 10 for a list of “do’s and don’ts” in communicating with survivors of GBV that should be observed throughout the entire medical consultation.

3.2.1. FIRST-LINE SUPPORT

When a woman discloses violence, health care providers should offer immediate first-line support. If they are unable to do so, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to provide first-line support (WHO 2013 Recommendation 1).

Box 18: Guidelines for women-centred care - elements of first-line response

First-line support includes:

- being non-judgemental and supportive and validating what the woman is saying;
- providing practical care and support that responds to her concerns, but does not intrude;
- asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved),
- helping her access information about resources, including legal and other services that she might think helpful;

- assisting her to increase safety for herself and her children, where needed, and
- providing or mobilizing social support.

Providers should ensure:

- that the consultation is conducted in private, and
- confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting).

Source: WHO 2013 Recommendations. 1, 10, 12, 24

3.2.2. MEDICAL HISTORY AND EXAMINATION

Health care professionals first need to obtain **informed consent** from the patient on all aspects of the consultation. This means explaining all aspects of the consultation to the patient, so that she understands all her options and is able to make informed decisions about her medical care. In particular, health care professionals need to point out any limitations of confidentiality, such as any legal obligations to report GBV to the police or other authorities. If required by national legislation, the health care professional needs to ask the patient to sign or mark the consent form. Examining a person without her consent may result in criminal prosecution of health care professionals. Further, in some jurisdictions, the results of an examination conducted without the consent of the patient cannot be used in legal proceedings (WHO 2003).

The next step is to take a complete **medical history**, recording events to determine what interventions are appropriate. This should include a detailed description of the assault, its duration, whether any weapons were used (such as belts, household objects, knives or guns, as well as date and time of the assault (BMFWJ 2010). In cases of sexual violence, the following information should be added:

- » the time since assault and type of assault,
- » the risk of pregnancy,
- » the risk of HIV and other sexually transmitted infections (STIs), and
- » the woman's mental health status (WHO 2013 Rec. 11).

For more information on taking the patient's general medical history and gynaecological history, refer to the WHO 2003 chapter 4.3).

When interviewing the patient about the assault, health care professionals should

- » ask her to tell in her own words what happened;
- » avoid unnecessary interruptions and ask questions for clarification only after she has completed her account;
- » be thorough, bearing in mind that some patients may intentionally avoid particularly embarrassing details of the assault, such as details of oral sexual contact or anal penetration;
- » use open-ended questions and avoid questions starting with “why”, which tends to imply blame; and
- » address patient questions and concerns in a non-judgemental, empathic manner, for instance through using a very calm tone of voice, maintaining eye contact as culturally appropriate and avoiding expressing shock or disbelief.

After taking the history, health care professionals should conduct a **complete physical examination (head-to-toe; for sexual violence also including the patient’s genitalia)** (WHO 2013 Recommendation 11), observing the following *general principles* (Perttu/Kaselitz 2006, Warshaw/Ganley 1996, WHO 2003):

- Explain the medical examination, what it includes, why it is done and how, to avoid the exam itself becoming another traumatic experience. Also, give the patient a chance to ask questions.
- Ask the patient if she wishes a female doctor (especially in cases of sexual violence).
- Do not leave the patient alone (e.g. when she is waiting for the examination).
- Ask her to disrobe completely and to put on a hospital gown, so that hidden injuries can be seen.
- Examine especially areas covered by clothes and hair.
- If she has experienced sexual violence, examine her whole body – not just the genitals or the abdominal area.
- Examine both serious and minor injuries.
- Note emotional and psychological symptoms as well.
- Throughout the physical examination inform the patient what you plan do next and ask permission. Always let her know when and where touching will occur. Show and explain instruments and collection materials.
- Patients may refuse all or part of the physical examination. Allowing her a degree of control over the examination is important to her recovery.
- Both medical and forensic specimens should be collected during the course of the examination. This should be done by a health care professional trained in forensic medicine. Providing medical and legal (forensic) services at the same time, in the same place and by the same person reduces the number of examinations that the patient has to undergo and can ensure the needs of the patient are addressed more comprehensively.

For more information on the different steps to follow in the “top-to-toe” physical examination and the genito-anal examination of survivors of sexual violence, refer to WHO 2003, chapter 4.4.

3.2.3. TREATMENT AND FOLLOW-UP CARE

TREATMENT OF INJURIES

Patients with severe, life-threatening conditions should be referred for emergency treatment immediately. Patients with less severe injuries, for example, cuts, bruises and superficial wounds can usually be treated in situ by the examining health care worker or other nursing staff. Any wounds should be cleaned and treated as necessary. The following medications may be indicated:

- » antibiotics to prevent wounds from becoming infected;
- » a tetanus booster or vaccination (according to local protocols);
- » medications for the relief of pain, anxiety or insomnia (WHO 2003).

PREVENTION OF UNWANTED PREGNANCIES, HIV AND SEXUALLY TRANSMITTED INFECTIONS

Health care professionals should offer **emergency contraception** to survivors of sexual assault, based on the following guidelines:

- Emergency contraception should be initiated as soon as possible after the assault. It is more effective if given within 3 days but can be given up to 5 days (120 hours).
- Health-care providers should offer levonorgestrel (recommended: single dose of 1.5 mg).
- If levonorgestrel is not available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics to prevent nausea, if available.
- If oral emergency contraception is not available and it is feasible, copper-bearing intrauterine devices (IUDs) may be offered to women seeking ongoing pregnancy prevention. Taking into account the risk of STIs, the IUD may be inserted up to 5 days after sexual assault for those who are medically eligible, in line with the WHO medical eligibility criteria (WHO 2010a, cited in WHO 2013; WHO 2013 Recommendations 12, 13).

Availability of drugs may depend on existing country-specific regulations and thus vary in the region.

Safe abortion should be offered in accordance with national law, if:

- » a woman presents after the time required for emergency contraception (5 days),
- » emergency contraception fails, or
- » the woman is pregnant as a result of rape (WHO 2013 Recommendation 14).

Health care professionals should consider offering HIV post-exposure prophylaxis (HIV PEP) for women presenting within 72 hours of a sexual assault. Health professionals and the survivor should use shared decision-making in order to determine whether HIV PEP is appropriate (WHO 2013 Recommendations 15). When discussing the HIV risk, the following factors should be taken into account:

- » HIV prevalence in the geographic area,
- » limitations of PEP,
- » the HIV status and characteristics of the perpetrator if known,
- » assault characteristics, including the number of perpetrators,
- » side-effects of the antiretroviral drugs used in the PEP regimen, and
- » the likelihood of HIV transmission (WHO 2013 Recommendations 15, WHO 2007 cited in WHO 2013).

If HIV PEP is used, health care professionals should:

- » start the regimen as soon as possible and before 72 hours,
- » provide HIV testing and counselling at the initial consultation,
- » ensure patient follow-up at regular intervals, and
- » provide adherence counselling (WHO 2013 Recommendation 16). The latter is important, keeping in mind that many women survivors of sexual violence do not successfully complete the 28 days of the preventive regime required in order to be effective. This is because HIV PEP causes nausea and vomiting, may trigger painful thoughts of the rape and may be overtaken by other issues in the lives of the survivors.

Two-drug regimens (using a fixed dose combination) are generally preferred over three-drug regimens, prioritizing drugs with fewer side-effects. The choice of drug and regimens should follow national guidance. It is recommended that survivors of sexual violence undergo HIV testing prior to giving PEP, but should not preclude PEP from being offered. Persons with HIV infection should not use PEP; rather, they should receive care and antiretroviral therapy (WHO 2013 Recommendations 17, 18).

Health care professionals should offer women survivors of sexual assault **post-exposure prophylaxis for the following sexually transmitted infections:**

- chlamydia,
- gonorrhoea,
- trichomonas, and
- syphilis, depending on the prevalence.

The choice of drug and regimens should follow national guidance. In order to avoid unnecessary delays, presumptive treatment is preferable to testing for STIs; therefore, testing prior to treatment is not recommended (WHO 2013 Recommendations 19).

Hepatitis B vaccination without hepatitis B immune globulin should be offered according to national guidelines. Health care professionals should take blood for hepatitis B status prior to administering the first vaccine dose. If immune, no further course of vaccination is required (WHO 2013 Recommendations 20).

PSYCHOLOGICAL/MENTAL HEALTH INTERVENTIONS

Where referral possibilities are available, primary health care professionals should **refer survivors with pre-existing diagnosed or intimate partner violence-related mental disorders to specialist health care providers** for psychological/mental healthcare interventions. Some of the interventions may also be performed by **primary health care providers** themselves, in accordance with the WHO mhGAP guidelines that apply to non-specialized health care settings. In health care settings with limited or no referral possibilities, psychological first aid provides a very basic form of psychological support that is suitable for primary care level. Psychological first aid involves the following elements: providing practical care and support, which does not intrude; assessing needs and concerns; helping people to address basic needs (for example, food and water, information); listening to people, but not pressuring them to talk; comforting people and helping them to feel calm; helping people connect to information, services and social supports; and protecting people from further harm (WHO et al 2011, WHO 2013).

The following WHO recommendations refer to **survivors of intimate partner violence**; however, they may also be used as guidance when addressing psychological/mental health outcomes of non-partner violence.

- Survivors of intimate partner violence with **pre-existing diagnosed or intimate partner violence-related mental disorder** (such as depressive disorder, alcohol use disorder) should receive mental health care in accordance with the WHO mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings (WHO 2010a), delivered by a health professional with a good understanding of GBV. For women who are either breastfeeding or pregnant, the use of psychotropic medicine requires specialist knowledge and should be provided in consultation with a specialist (WHO 2013 Recommendation 5).
- Women who **no longer experience intimate partner violence but are suffering from post-traumatic stress disorder (PTSD)**, should receive cognitive behavioural therapy or eye movement desensitization and reprocessing interventions (see glossary), delivered by a health professional with a good understanding of GBV (WHO 2013 Recommendation 6). According to WHO, there is insufficient evidence for providing such interventions to women who are still experiencing intimate partner violence (WHO 2013).
- Mother-child intervention: Children who are exposed to intimate partner violence** should be offered a psychotherapeutic intervention, including sessions with and sessions without the presence of their mother. The WHO observes that the extent to which this applies to low- and middle-income countries is unclear, given the cost of this type of intensive intervention, the lack of resources, and lack of trained providers in these countries (WHO 2013 Recommendation 9).

For **survivors of sexual violence**, health professionals need to observe three main stages after the assault when setting appropriate interventions:

1 During the first days of the assault, health care providers should

- » continue to provide first-line support (WHO 2013 Recommendation 21),
- » provide survivors with written information on coping strategies for dealing with severe stress (with appropriate warnings about taking printed material home if an abusive partner is there) (WHO 2013 Recommendation 22),
- » and not use psychological debriefing¹¹ (WHO 2013 Recommendation 23).

2 Up to three months post-trauma, health care providers should

- » continue to provide first-line support (WHO 2013 Recommendation 24);
- » apply “watchful waiting” for 1-3 months after the event (i.e. explaining the woman that she is likely to improve over time and offering her the option to come back for further support by making regular follow-up appointments), However, “watchful waiting” should not be applied if the woman is depressed, has alcohol or drug use problems, is suicidal or self-harming or has difficulties functioning in day-to-day tasks (WHO 2013 Recommendation 25);
- » arrange cognitive behavioural therapy or eye movement desensitization and reprocessing interventions in case the woman is incapacitated by the post-rape symptoms (i.e. she cannot function on a day-to-day basis), to be provided by a health care provider with a good understanding of violence (WHO 2013 Recommendation 26); and
- » provide care in line with the WHO mhGAP Intervention Guide if the person has any other mental health problems, such as symptoms of depression, alcohol or drug use problems, suicide or self-harm (WHO 2013 Recommendation 27).

3 After three months post-trauma, health care providers should

- » assess for mental health problems (symptoms of acute stress/PTSD, depression, alcohol and drug use problems, suicidality or self-harm) and treat depression, alcohol use disorder and other mental health disorders using the WHO mhGAP intervention guide (WHO 2013 Recommendation 28); and
- » if the survivor is suffering from PTSD, arrange for PTSD treatment with cognitive behavioural therapy or eye movement desensitization and reprocessing (WHO 2013 Recommendation 29).

When delivering psychosocial/mental health care, it is essential for health professionals to ensure the patients' informed consent and her safety. Therapies should be implemented by a trained health care provider with a good understanding of sexual violence. Further, health care providers should consider pre-existing mental health conditions, keeping in mind that women with mental health and substance abuse problems may be at greater risk of rape than other women. Therefore, there is likely to be a disproportionate burden of pre-existing mental health and substance abuse problems among rape survivors. Pre-existing traumatic events such as sexual abuse in childhood, intimate partner violence or war-related trauma should also be considered (WHO 2013).

11 Psychological debriefing involves promoting ventilation by asking a person to briefly, but systematically recount their perceptions (WHO 2010a and Sphere 2011, all cited in WHO 2011).

3.3. DOCUMENTING GENDER-BASED VIOLENCE

3.3.1. WHY SHOULD HEALTH CARE PROVIDERS DOCUMENT GENDER-BASED VIOLENCE?

- **For the health professional's legal issues:** Health care providers have a professional obligation to record the details of any consultation with a patient. The notes should reflect what was said (by the patient) and what was seen and done (by the health care provider) and be kept in confidentiality.
- **For the patient's legal issues:** Medical records can be used in court as evidence, for example in criminal proceedings or child custody proceedings. Documenting the health consequences may help the court with its decision-making as well as provide information about past and present violence. Lack of coordination between health care providers and police/prosecutors can result in evidence getting lost. To this end, it is critical that health care providers understand the links between forensic medicine and criminal justice in order to facilitate women's access to the criminal justice system.
- **For good clinical care:** Documentation can alert other health care providers who later attend the patient to her experiences of GBV and thereby assist them in providing appropriate follow-up care (adapted from Warshaw/Ganley 1996, WHO 2003).

3.3.2. RECORDING AND CLASSIFYING INJURIES

Health care professionals should carefully describe any injuries assessed. The description should include the type and number of injuries, as well as their location, using a body map. In case a survivor does not disclose, health care professionals should note whether the injuries are compatible with her explanations. This may help clarifying the situation at a future visit and provide documentation in case she decides to pursue legal action (Warshaw/Ganley 1996).

Interpretation of injuries for medico-legal purposes is a complex and challenging matter. In practice, clinicians and pathologists are often being asked by police, courts or lawyers to determine the age of an injury, how it was produced or the amount of force required to produce the injury. This requires proven expertise on the part of the practitioners performing it, based on continuing education, exposure to peer review, and quality assurance. Without accurate documentation and expert interpretation of injuries, conclusions on how injuries occurred might be seriously flawed. Therefore, health care professionals who are not trained in the interpretation of injuries should

- » document injuries, using standard terminology as provided in WHO 2003 (i.e. abrasions, bruises, lacerations, incisions, stab wounds or gunshot wounds) and
- » refer the task of injury interpretation to a forensic specialist (WHO 2003)

Refer to WHO 2003 for more information on the standard terminology for classifying wounds and the main features of each category (chapter 4.5.2), as well as for a list of violent acts and their most probable associated pattern of injury (chapter 4.5.4).

3.3.3. HOW AND WHAT SHOULD BE DOCUMENTED?

Mechanisms for documenting consultations include hand-written notes, diagrams, body charts and photography (WHO 2003). Through the entire process of documentation, health care professionals should ensure the patient's informed consent.

In some countries, health care authorities provide standard documentation forms, the use of which may be obligatory. A WHO sample form for recording consultations with survivors of sexual violence, which may be used as it stands, or can be adapted to meet local needs and circumstances is included in Annex 8. Refer to the training package (part II, module 7) for an example of a documentation form from Austria.

In cases of sexual violence, documentation should include the following (WHO 2003):

- » demographic information (i.e. name, age, sex);
- » consents obtained;
- » history (i.e. general medical and gynaecological history);
- » an account of the assault;
- » results of the physical examination;
- » tests and their results;
- » treatment plan;
- » medications given or prescribed; and
- » patient education;
- » referrals given.

Photography is an important tool that should be used by all health care providers – specialized and non-specialized in forensic medicine - to document injuries resulting from GBV, as photos are important evidence in possible future criminal proceedings instituted against the perpetrator. When using photography, it is however important to keep in mind that photos may supplement, not replace, the other methods of recording findings mentioned above (WHO 2003). For more information on the use of photography, see box 19.

Box 19: Checklist for using photography to document findings

Consider the patient and obtain informed consent:

Many survivors will be uncomfortable, unhappy, tired or embarrassed. Communicate the role of photography and obtain informed consent for the procedure.

Identification: Each photograph must identify the subject, the date and the time that the photograph was taken. The photographs should be bound with a note stating how many photographs make up the set. Ideally, a new roll of film should be used for each subject; alternatively, there should be a clear indication of where a new series commences.

Scales: A photograph of the colour chart should commence the sequence of photographs. Scales are vital to demonstrate the size of the injury. They may be placed in the horizontal or vertical plane. Photographs should be taken with and without a scale.

Orientation: The first photograph should be a facial shot for identification purposes; this may not be required if the photographs have been adequately identified (see above). Subsequent shots should include an overall shot of the region

of interest followed by close-up shots of the specific injury or injuries.

Chain of custody: This should be logged as for other forensic evidence.

Security: Photographs form part of a patient record and as such should be accorded the same degree of confidentiality. Legitimate requests for photographs include those from investigators and the court. If, however, a copy is made for teaching purposes, the consent of the subject or his/her parents/guardian should be obtained.

Sensitivity: The taking of photographs (of any region of the body) is considered to be inappropriate behaviour in some cultures and specific consent for photography (and the release of photographs) may be required. Consent to photography can only be obtained once the patient has been fully informed about how, and why, the photographs will be taken. The briefing should also explain how this material may be used (e.g. released to police or courts and cited as evidence).

Source: WHO 2003

Box 20: Documenting cases of sexual abuse: a check-list for health workers

The following check-list is intended to assist health workers develop their documentation skills:

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

Source: WHO 2003, Warshaw et al 1996

3.3.4. FORENSIC EXAMINATIONS

A forensic examination is defined as “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 (WHO 2003).

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

- » collect carefully, avoiding contamination;
- » collect specimens as early as possible; 72 hours after the assault the value of evidentiary material decreases dramatically;
- » label all specimens accurately;
- » dry all wet specimens;
- » ensure specimens are secure and tamper proof;
- » maintain continuity; and
- » document details of all collection and handling procedures. (WHO 2003).

Health care workers should be aware of the capabilities and requirements of their forensic laboratory; there is no point collecting specimens that cannot be tested (WHO 2003).

For a list of forensic specimens that are typically of interest in cases of sexual violence, together with notes on appropriate collection techniques and comments on their relevance, refer to WHO 2003, chapter 5.2.

3.3.5. PROVIDING EVIDENCE IN COURT

Health care professionals may be called upon to give evidence, either in the form of a written report or as an expert witness in a court of law. Therefore, they would be expected to (WHO 1999, cited in WHO 2003):

- » be readily available;
- » be familiar with the basic principles and practice of the legal system and obligations of those within the system, especially their own and those of the police, as it applies to their jurisdiction;
- » make sound clinical observations, which will form the basis of reasonable assessment and measured expert opinion; and
- » reliably collect samples from victims of crime (the proper analysis of forensic samples will provide results which may be used as evidence in an investigation and prosecution).

At the same time, health care practitioners should be aware of the following pitfalls and potential problem areas:

- » providing opinions which are at the edge of, or beyond, the expertise of the witness;
- » providing opinions that are based on false assumptions or incomplete facts;
- » providing opinions based on incomplete or inadequate scientific or medical analysis; and
- » providing opinions which are biased, consciously or unconsciously, in favour of one side or the other in proceedings (WHO 2003).

When writing reports or giving evidence in court, it is paramount that health care professionals should aim to convey the truth of what they saw and concluded in an impartial way, and ensure that a balanced interpretation of the findings is given (WHO 2003). Refer to table 11 for guiding principles for writing reports and giving evidence.

Table 11: Providing evidence in sexual violence cases: guiding principles for health professionals

Writing reports	Giving evidence
1. Explain what you were told and observed.	1. Be prepared.
2. Use precise terminology.	2. Listen carefully.
3. Maintain objectivity.	3. Speak clearly.
4. Stay within your field of expertise.	4. Use simple and precise language.
5. Distinguish findings and opinions.	5. Stay within your field of expertise.
6. Detail all specimens collected.	6. Separate facts and opinion.
7. Only say or write what you would be prepared to repeat under oath in court.	7. Remain impartial.

Source: WHO 2003

Health care professionals providing medico-legal services to survivors of GBV should undergo training in such matters. In the absence of specific training in medico legal aspects of service provision, health professionals are advised to confine their service delivery to the health component and defer from offering an opinion. Under such circumstances, the court can seek the assistance of an expert to provide the necessary interpretation of the observations (WHO 2003).

3.3.6. STORAGE AND ACCESS TO PATIENT RECORDS AND INFORMATION

Patient records and information are strictly confidential. All health care providers have a professional, legal and ethical duty to maintain and respect patient confidentiality and autonomy. Records and information should not be disclosed to anyone except those directly involved in the case or as required by local, state and national statutes (American College of Emergency Physicians 1999, cited in WHO 2003).

All patient records (and any specimens) should be stored in a safe place. Biological evidence usually needs to be refrigerated or frozen; check with your laboratory regarding the specific storage requirements for biological specimens (WHO 2003).

3.4. RISK ASSESSMENT AND SAFETY PLANNING

The safety of patients who experienced GBV must be at the centre of any health sector intervention to GBV. In case of intimate partner violence, isolated occurrences of violence are rare; the danger of repeated offences is very high. In times of separation and divorce, the risk of violence even increases: The majority of murders, attempted murders and acts of serious violence are committed when survivor attempt to leave violent partners. Ironically speaking, it may thus be safer for women to stay in a violent relationship than to end it (WAVE 2006).

Health care professionals have an important role to play in supporting a survivor through jointly assessing potential risks of further violence, supporting her in her safety planning, as well as offering referrals to a shelter (for more information on referrals, see chapter 4). As a first step, health professionals need to understand risk factors for repeating or escalating violence.

3.4.1. UNDERSTANDING RISK FACTORS FOR REPEATING OR ESCALATING VIOLENCE

The following list of risk factors has been identified in international studies as risk factors for a high degree of dangerousness in instances of intimate partner violence (Gondolf 2001, Robinson 2004, Humphreys et al 2005, all cited in WAVE 2006). As a general principle, the more factors that apply in a specific case, the higher the risk is that acts of violence will be repeated or that the violence may increase or even escalate (WAVE 2006).

Risk factors for a high degree of dangerousness in case of intimate partner violence (adapted from WAVE 2006):

- Previous acts of violence against the woman, the children or other family members, as well as former partners:** Look at the history of abuse, forms and patterns of violence used as well as former convictions or reports to police. Perpetrators who have committed frequent, severe acts of violence (such as using a weapon or strangling the survivor) are particularly dangerous.
- Previous acts of violence outside the family**, e.g. against the staff of service providers or authorities, indicate a general tendency to use violence also within the home.
- Separation and divorce** are times of high risk.
- Acts of violence committed by other family members** of the perpetrator may be used to control the survivor and result in making it impossible for her to flee.
- Possession and/or use of weapons:** Legal or illegal possession of weapons increases the risk of armed violence, especially when the perpetrator has used, or threatened to use weapons in the context of earlier episodes of violence.
- Abuse of alcohol or drugs** does not in itself cause violence, but may lower the threshold and thus contribute to an escalation of violence.

- **Threats** should always be taken serious. It is wrong to assume that person who “only” use threats are not dangerous – in fact, severe violence is often preceded by threats. In particular, threats of murder must be taken serious: In many cases of women being killed by intimate partners, they had been repeatedly threatened with murder before being killed.t
- **Extreme jealousy and possessiveness:** Perpetrators who kill or severely injure their partners are often possessed by the desire to own and control their partners, sometimes regarding every man around their partner as rival and constantly accusing her of infidelity.
- **Extremely patriarchal concepts and attitudes,** such as that a woman or girl must obey her husband or father who is the head of the family or comply with rigid concepts of honour and sexuality.
- **Persecution and psychological terror (stalking):** Many perpetrators are not willing to accept a separation from their partner and try to prevent it by all means, including violence. This may lead to acts of violence and threats committed even many years after a separation.
- **Danger for children:** Children are also at particular risk during separation and divorce. Abuser’s aggression against the partner may also extend to the children, and he may take revenge by abusing or killing them. Therefore, safety planning must always include the children.
- **Non-compliance with restraining orders by courts or police** indicate a high-risk situation because it shows that the perpetrator is not willing to change his behaviour.
- **Possible triggers** that may lead to a sudden escalation of violence include changes in the relationship, for instance when the woman takes a job against the partner’s will, seeks help or files for divorce.

3.4.2. UNDERTAKING A RISK ASSESSMENT

Risk assessment enables criminal justice authorities to decide on actions against the perpetrator. It also enables health care professionals and other service providers to support the patient in identifying measures to increase her safety and to raise her awareness of the risk (WAVE 2013).

A number of standardized risk assessment tools have been developed to assess the risk of repeating or escalating violence. One of the most commonly used tools to assess the danger of a woman being killed by a current or former partner used is Danger Assessment by Campbell (2004). It consists of two elements: 1) a calendar, on which the woman should mark frequency and severity (on a scale from 1-5) of violent incidents that happened in the past year; and 2) a list of 20 questions, to be answered with yes or no. Questions address significant risk factors, such as separation, use of a gun, or abuse during pregnancy, as well as factors that point to a lower risk (such as having never lived together or having never been pregnant by the perpetrator). For a copy of the Danger Assessment Tool, refer to the training package (part II, module 8).

Considerations for undertaking risk assessment (WAVE 2013):

- » Health care professionals should undergo training on applying risk assessment tools.
- » It is of utmost importance to ask the survivor about her own assessment of the situation. Any risk assessment tools should not be a substitute for listening to her assessment of the situation.
- » Many existing risk assessment tools focus on high-risk cases. A lower level of risk should not be used as basis to deny survivors access to services.
- » Most existing risk assessment tools were adopted in North America and Western Europe. When applying them in EECA or other regions, adapting them to local contexts may be advisable.

Health professionals may find acronyms useful to memorize key factors or steps in assessing risks. An example used in the UK is “S P E C S S”, which stands for Separation, Pregnancy, Escalation of Violence, Cultural Factors, Stalking and Sexual Assault (Department of Health undated, see 21). This list of risk factors is non-exhaustive. Health facilities in the EECA region may want to consider creating localized acronyms, suitable to local languages and regional contexts.

Box 21: Example of an acronym to remember risk factors: S P E C S S

Separation/child contact: Leaving a violent partner is extremely risky; in London 76% of domestic abuse murder victims had recently ended the relationship.

Pregnancy (pre-birth and under 1s): 30% of domestic violence and abuse starts in pregnancy.

Escalation of violence: Previous domestic violence is the most effective indicator that further domestic violence will occur. 35% of households have a second incident within five weeks of the first.

Cultural factors, such as language barriers, immigration status, and isolation.

Stalking: Research finds that intimate relationship stalkers use more dangerous stalking behaviours than non-intimate relationship stalkers.

Sexual assault: Where abusers use both physical and sexual violence, victims are at an elevated risk.

Source: Department of Health undated

3.4.3. SUPPORTING THE PATIENT IN DEVELOPING A SAFETY PLAN

Safety planning is part of the overall process of risk management, which aims at preventing violence by influencing risk factors and protective factors. Safety planning seeks to improve the survivor's resources – both dynamic (i.e. the social environment) and static (i.e. the physical environment, such as locks, video cameras, etc.) (WAVE 2013).

Developing a safety plan may help the woman prepare to leave the relationship safely in case the violence escalates. The health provider should help the woman find out if there are affordable safe places that she can go to, such as homes of friends or relatives. They may be referred to women's shelters or women's organizations that can help them, in places where such facilities exist. Developing such a safety plan may prove difficult in the case of low-income women, especially those from rural or ethnic minority communities, who may not have the resources to leave the abuser and, in the absence of shelters, may not have access to or even be able to afford temporary stays in hotels or guest houses. Health facilities should take the initiative to network with such groups and establish referral pathways to facilitate further support to help women experiencing intimate partner violence (WHO 2005; for more information on referrals see chapter 4). In the absence of shelters, health facilities should consider practical solutions, such as offering women short-term stays in the facility.

The check list provided in box 22 provides further guidance to health professionals when developing a safety plan together with the patient.

Box 22: Check list for developing a safety plan with the survivor

- Identify one or more neighbours you can tell about the violence, and ask them to help if they hear a disturbance in your house.
- Are there any friends or relatives you can trust and who could give you and your children shelter for a few days?
- Decide where you will go if you have to leave home and have a plan to go there, even if you do not think you will need to leave.
- If an argument seems unavoidable, try to have it in a room or an area that you can leave easily.
- Stay away from any room where weapons may be available. If possible, get the weapons outside your home.
- Practice how to get out of your home safely. Identify which doors, windows, elevator or stairwell would be best.
- Have a packed bag ready, containing spare keys, money, important documents and clothes. Keep it at the home of a relative or friend, in case you need to leave your home in a hurry.
- Devise a code word to use with your children, family, friends and neighbors when you need emergency help or want them to call the police.
- Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he wants to calm him down. You have the right to protect yourself and your children.
- Remember, you do not deserve to be hit or threatened.

Source: adapted from Heise et al 1999

Please refer to the training package (part II, module 8) for a template for a simple safety plan that health professionals may go over together with the patient and help her to spell out resources and steps to increase her safety, such as packing a safety bag and noting where she keeps it, or identifying a code word that she can use with her children or neighbours so that they can call for help. Attention should also be paid to identifying a place where she can keep the safety plan without endangering her or her children's safety.

CHAPTER 4

Creating referral pathways integrated into health care

Health care professionals are often the first point of contact for survivors of GBV. Therefore, they are well positioned not only to identify GBV and provide survivors with medical care, but also to refer them to other necessary services. This may include referrals to other health care professionals within the same or at another health facility, for example, to mental health care providers or HIV specialists, and referrals to other services, such as shelters or organizations providing psychosocial or legal counselling. In turn, health care professionals may also receive referrals of women survivors, for instance from police, shelters or other health care professionals.

Chapter 4 defines what is meant by a referral system and explains why referrals are important in the context of the health sector's response to GBV (chapter 4.1). It lists key actors and service providers typically involved in referrals (chapter 4.2), and suggests practical steps and recommendations to guide the establishment and implementation of a referral system (chapter 4.3). Further, it suggests what health professionals can do in the absence of a formal referral mechanism (chapter 4.5).

4.1. THE DEFINITION OF A REFERRAL SYSTEM

Women who have experienced GBV have multiple and complex needs. This includes medical care, safe accommodation, psychosocial counselling, police protection and/or legal advice. Therefore, an effective response to GBV requires a comprehensive set of services. Since it is virtually impossible for a single organization to provide all services in the required quality and specialization, a multi-sectoral response that coordinates the services by all relevant service providers helps to ensure the availability of comprehensive support for survivors of GBV. Referrals are an important step in case management as part of multi-sectoral work, besides case review, monitoring and after-case/follow-up support. An important prerequisite for the design and implementation of effective referrals is the existence of an institutionalized referral mechanism.

Referrals in general describe the processes of how a woman gets in touch with an individual professional or institution about her case and how professionals and institutions communicate and work together to provide her with comprehensive support. Partners in a referral network usually include different government departments, women's organizations, community organizations, medical institutions and others. There is also the possibility of self-referral, where a woman approaches an agency herself, which is low in case of restricted mobility. As a principle of good clinical practice, referrals should happen with the consent of the woman concerned. However, in some cases, it may be justified that referrals by a family member or an agency occur without the woman's consent, in cases where her life is at risk, like high risk of suicide, threat of being killed or child marriage.

A referral system can be defined as a comprehensive institutional framework that connects various entities with well-defined and delineated (albeit in some cases overlapping) mandates, responsibilities and powers into a network of cooperation, with the overall aim of ensuring the protection and assistance of survivors, to aid in their full recovery and empowerment, the prevention of GBV and the prosecution of perpetrators (the so-called 3 p's). Referral mechanisms work on the basis of efficient lines of communication and establish clearly outlined referral pathways and procedures, with clear and simple sequential steps (UNFPA 2010).

Box 23: Establishing a referral mechanism to prevent and respond to domestic violence at the local level, Kyrgyzstan

Since 2010, UNFPA has been partnering with NGOs, the government of Kyrgyzstan to set up a system of multi-sectoral cooperation for the prevention of and response to GBV at the municipal level. At the outset, the following steps were undertaken:

- **A Coordinating Council** was set up by the mayors' office in capital city Bishkek; it approved local level work plans for the prevention of and response to domestic violence.
- **Models for inter-agency cooperation** were developed and tested in specified pilot districts/sub-districts in Bishkek. The pilot was coordinated by the municipal administration in the respective pilot district/sub-district.
- **Sector-specific action plans** and departmental instructions for health care and the municipality administration (including police, health, education and local self-governance including social services) on how to work with survivors of domestic violence were adopted.
- **All involved professionals were trained** on understanding GBV, relevant local and international laws, and how to effectively respond to GBV. Training of health care providers targeted both, doctors and nurses.
- **Standard forms** for reporting and tracking domestic violence for use by health care institutions and municipal administration were adopted.
- **Quarterly coordination meetings** of all sectors involved have been organized and facilitated by the deputy mayor and UNFPA. These meetings served to register identified cases of women and children survivors of domestic violence; further, service providers discussed and agreed on further support measures.
- **A number of public awareness** raising activities were held. For example, health facilities organized information stands to inform patients and health care professionals on available services for survivors and contact information of organizations providing support. Education departments organized a series of activities in schools among students

and children, those who have experienced domestic violence were provided with psychosocial support.

- **Local self-governance bodies** worked on identification and prevention of domestic violence in their respective communities.

In 2012, this model cooperation framework developed at the capital city level was then translated into action at the sub-national level, through a pilot in the cities of Osh and Jalal-Abad:

- **Participating organizations** formalized their cooperation based on a Memorandum of Understanding (MoU) which also includes implementation of GBV Standard Operating Procedures at the national level. The MoU was initiated under the IASC GBV sub-cluster¹² during the interethnic conflict that occurred in June 2010, in order to set up a national network to respond to and prevent GBV in the aftermath of the conflict. The MoU was signed by the Ministries for Labour, Employment and Migration; Social Protection; Internal Affairs; Justice; and Health, as well as UNICEF, UNFPA and UN Women.
- In both cities, the mayor's offices set up **Multi-sectoral Coordinating Councils**; they approved local level work plans for the prevention of and response to domestic violence. Members include the deputy mayors, representatives of women crisis centres, women's NGOs, NGOs providing legal support, health departments, local self-governance bodies, and municipal law enforcement bodies.
- **Municipal workers and service providers** underwent training on the implementation of the MoU and the SOPs, based on the 2003 Law on Social and Legal Protection against Domestic Violence.

(continued on page 93)

¹² The Inter-Agency Standing Committee (IASC) is a global mechanism to coordinate the efforts of international organizations working to provide humanitarian assistance to people in need as a result of natural disasters, conflict-related emergencies, global food crises and pandemics. Its work is organized by thematic clusters; GBV is included as sub-cluster in the Protection Cluster.

These efforts have resulted in identification and referrals of survivors of GBV, as follows:

- In 2012, 500 cases of domestic violence were registered at the Emergency Medical Care Center (Osh), which included 329 women and 171 men.
- 117 complaints of instances of physical domestic violence were registered in 2012 at the trauma unit of the City Hospital (Osh) and received medical support.
- From August 2012 to March 2013, three women survivors of domestic violence sought help at the emergency room of Family Medical Center No1 (Osh). Two of them were referred to the Police Department of Osh. While some progress has been made, more work still needs to be done to ensure that GBV survivors have access to comprehensive support. It is necessary to continue strengthening the capacity of local providers of health, psychosocial, legal and protection services, with a view to setting up a sustained and well-functioning referral pathway. For the health sector, emphasis should be put on sensitizing doctors to address GBV as a public health issue, rather than a family/private matter, in order to improve the identification of survivors. Further, improvements in the infrastructure of health facilities are urgently needed. Currently, many health facilities lack separate rooms for psychosocial consultations provided to patients who experienced GBV. This prevents doctors from asking confidential questions, and survivors from disclosing GBV due to shame and fear. Furthermore, sector-specific instructions on the response to GBV should be institutionalized through capacity building of ministerial workers on gender equality and GBV.

Lessons learned:

- Political will on the part of central-level authorities that ensure accountability of local governments are important prerequisites to ensure that laws, policies and action plans documents are actually implemented and that appropriate financial and human resources are in place at the local level.
- Political and financial support from the municipal administration not only helped to secure funds needed for the implementation of action plans but also serve to create a sense of ownership among those responsible for implementation.
- Coordinating bodies need to meet regularly, in order to ensure ongoing implementation and monitoring of action plans and to enable them to address emerging issues in a timely manner. Ensuring broad-based membership of governmental, non-governmental and international organizations in coordination structures is desirable.

The added value of setting up a multi-sectoral cooperation mechanism and getting to know each other's counter parts in the partner organizations is illustrated in the following statement from a district police inspector in Osh: *"After we started working together, I realized that we are all doing the same job. Not only us, but others also work on resolving domestic violence. Now that we know each other, it's easier. You can't just send someone off to another agency without that."*

(continued from page 92)

Source: UNFPA 2013, information provided by UNFPA Country Office Kyrgyzstan, June 2014

Referral systems should involve governmental, non-governmental and, as appropriate, relevant international organizations (see chapter 4.2 for an overview of relevant services and providing organizations). Their work, at the levels of both the multi-sectoral structure and individual agencies, should be normatively based on international human rights principles and standards (see chapters 2.1 and 2.5). In order to ensure that cooperation among stake

holders is grounded in sustainable structures, rather than relying on the contributions of committed individuals, the operation of referral mechanisms should be grounded in legislation or standardized protocols that define the roles and responsibilities of all organizations involved (see also chapter 2.3.2).

Referral mechanisms may operate at different levels - national, regional and/or municipal/community. Local and/or regional referral mechanisms should be grounded in national laws and/or policies. See box 23 for an example from Kyrgyzstan, illustrating a step-by-step-approach for setting up a referral mechanism for cases of domestic violence at the local level.

REFERRAL SYSTEMS BENEFIT BOTH THE PATIENT WHO EXPERIENCED GBV AND THE HEALTH CARE PROVIDER.

Guiding a survivor through a referral system enables her to access comprehensive and specialized care and support, tailored to her individual needs. From the perspective of health care professionals, the establishment of clear and simple referral routes

- » **can offer relief to their daily work load**, as they can count on support provided by other referral partner agencies;
- » **can increase the confidence of health care professionals to ask about violence**, as shown in following quote from a general practitioner : “[I]t has really made a huge difference being able to [refer patients to a specialized domestic violence support service]. We are all much more willing to ask the question which might open a can of worms knowing that there’s help if we do – and our patients have benefitted enormously.” (Johnson 2010); and
- » **enables them to adequately act upon the identification of a survivor of GBV**, keeping in mind that the existence of a system of referring survivors to further services constitutes a minimum requirement for health care professionals inquiring about GBV (see chapter 3.1.3); “[i]ndeed, what is the point of asking a woman whether she has been subjected to gender-based violence if no appropriate help is available?” (UNFPA 2010).

In practice, health care professionals, confronted with the reality of limited time and resources in busy clinical settings, might be inclined to perceive the referral process for patients who experienced GBV as complicated and time-consuming. In this situation, it may help to approach GBV like any other health symptom that they would enquire, diagnose and refer for specialist treatment, as they do in their regular clinical work.

EFFECTIVE REFERRALS REQUIRE THAT HEALTH CARE PROFESSIONALS:

- » **Are able to recognize and facilitate the disclosure of GBV** (see chapter 3.1) **and provide first-line support** (see chapter 3.2.1).
- » **Are able to assess the individual situation and needs of the patient**, in particular the risk of further or escalating violence (for more information on risk assessment, see chapter 3.4), and tailor the type of referral accordingly. If the assessed risk is high, 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 the existing referral system and services and support the patient in identifying the best options**. To this end, health care professionals should have at hand the contact details from relevant service providing institutions, in particular shelters and police. A useful tool is a referral directory (see chapter 4.3.2 and Annex 7), which should also specify any protocols on acceptance to shelters. In some countries, shelters accept survivors only upon referral via specific state bodies only. Seemingly small details may matter a lot in actual referral. Health care professionals also should keep in mind that survivors might have limited opportunities for visiting several locations, due to lack of money, time and freedom to travel. Therefore, they should try to offer the most efficient route and give very clear directions, so as to minimize the number of contacts and enable the patient to receive as much as care and support as possible on the first contact.
- » **Are knowledgeable about national laws** on GBV, including definitions of relevant criminal offences, about available protection measures and any reporting obligations on their part. For more information in mandatory reporting, refer to chapter 2.5.2.
- » **Obtain the consent of the survivor before sharing information** about her case with other agencies or service providers and follow the procedure that protects the woman’s confidentiality.

AT THE LEVEL OF HEALTH FACILITIES, EFFECTIVE REFERRALS BENEFIT FROM:

- » **Ongoing capacity building** of health care staff to ensure effective referrals and service delivery, Multi-sectoral trainings can serve as a first step towards establishing a working partnership as well as to develop and maintain capacities to deliver services and provide effective referrals.

» **A coordinated monitoring mechanism**, such as a joint database for monitoring the system of response and improving the quality of services provided to women. The analysis of the data will allow to track the use of different services by individual survivors, to identify women who need support over a long period of time and those who drop out and to obtain critical information to improve management and planning of services. Particular emphasis should be put on collecting feedback from survivors who use the services provided and on ensuring safety and confidentiality of personal data of the survivor. For more information on setting up a monitoring and evaluation system, please refer to chapter 5 and IPPF 2010.

Box 24: Capacity building improves the effectiveness of referrals – an example from UK (IRIS intervention)

As demonstrated in the case of the IRIS (Identification & Referral to Improve Safety) intervention, training of health care professionals in general practices combined with the provision of technical support to practice teams and the establishment of a simple referral pathway to a specialist domestic violence support organization led to improvements in the clinical response to domestic violence. The intervention was implemented from 2007-2010 and targeted doctors, nurses and reception staff in 24 general practices in

London and Bristol, UK. The evaluation compared the performance of this group of health care professionals (intervention practices) with 24 control practices who did not participate in the training and support programme. Following the intervention, the number of referrals recorded in intervention practices was 21 times larger than that recorded in control practices. Further, intervention practices recorded 3 times more identifications than control practices.

Source: Feder et al 2011

4.2. KEY ACTORS INVOLVED IN THE REFERRAL SYSTEM

A referral system for GBV should involve a broad range of different stakeholders, including representatives from governmental and non-governmental organizations, including specialized women's organizations. In countries with field presence of international organizations in the area of development or peace building/peacekeeping, relevant organizations should also be involved. Multi-sectoral initiatives work best at the local level, with agencies actually working together on a day-to-day basis (WAVE 2006).

The following sub-chapters provide an overview of key sectors and actors that should be involved in a referral system.

4.2.1. SPECIALIZED WOMEN SUPPORT SERVICES

Participation of women's organizations in the multi-sectoral response to GBV is of particular importance. These organizations often possess long-standing experience in the response to GBV. Further, because of their mandates as direct and specialized service providers they are well positioned not only to provide many services themselves, but also to accompany survivors throughout the entire process. They complement, but cannot be replaced by, general support services offered by public authorities (see chapter 4.2.2).

Specialized women's support services for survivors of GBV may provide a broad range of services, including in particular women's shelters, women's helplines, women's centres, providing various types of non-residential support, as well as services specialized for survivors of sexual violence. These organizations might serve survivors of GBV more broadly, or concentrate on survivors who have experienced specific forms of violence (such as intimate partner violence, trafficking or sexual violence) or belong to specific groups (such as migrant women, adolescent girls or sex workers).

Box 25: Minimum standards for specialized women's services

Specialized women's services should:

- Be sufficiently spread throughout the country.
- Be run by independent women's organizations that are committed exclusively to the interests of women.
- Be specialized in two ways 1) especially targeted at women survivors and their children, and 2) specialized on violence against women as a gender specific form of violence.
- Receive adequate financial support from the state.
- Be specialized in two ways 1) especially targeted at women survivors and their children, and 2) specialized on violence against women as a gender specific form of violence.
- Work alongside the principles of a woman-/survivor-centred, gender-sensitive and human rights-based approach.
- Be run and provided by women, so as to support survivors' empowerment and to enable them to overcome experiences of discrimination and subordination by men.
- Be provided by professional staff trained on working with survivors of GBV, such as social workers, pedagogues, psychologists or therapists.
- Be provided by properly employed and paid staff. Volunteers can be a necessary and valuable resource, but should be adequately trained and supported by employed staff.

Sources: Article 18 Istanbul Convention and Explanatory Report, WAVE 2013

□ **Women's helplines** may be the first contact point for survivors to receive information about available services and legal options. Therefore, helplines, which are widely-advertised public numbers that provide support, crisis interventions and referrals to face-to-face services such as shelters or the police provide an important cornerstone of a multi-sectoral response to GBV. Women's helpline should operate 24/7, be free of charge and anonymous, and serve survivors of all forms of GBV. All women in the country should have access to a helpline, so at least one national helpline should exist and provide support in all the main languages spoken in country, at least for a considerable amount of hours per week (WAVE 2013, CoE 2008, Article 24 Istanbul Convention and Explanatory Report).

□ **Women's shelters** are specialized in providing immediate and safe accommodation to women survivors of violence and their children. Furthermore, they provide comprehensive support and empowerment to help survivors to deal with their traumatic experience, to regain their self-esteem and to lay the foundations for a self-determined life. Shelters should be accessible 24/7. They need to apply special safety precautions, which includes risk assessment and safety planning in each individual case, keeping locations secret and technical security of the building in order to protect clients and staff, but also neighbours from violent attacks by perpetrators. Shelters should be available in a sufficient number in the country (Article 23 Istanbul Convention and Explanatory Report, WAVE 2013). A commonly referred benchmark is one family place per 10 000 inhabitants (CoE 2008). An important part of the work provided by shelters is follow-up or after-case support, in order to assist women and girls in their reintegration after leaving the shelter. This requires consideration of existing risks, the client's income generation and livelihood skills, alongside other factors. The reintegration process should be well managed, ensure safety to the woman and her children, and subsequently monitored by the caseworker.

□ **Women's centres** (in some countries, also referred to as "women's crisis centres" or "women's counseling centres") encompass all women's services that provide non-residential support of any kind (psychosocial counseling, legal or other information and advice, practical support, court accompaniment, etc.) to women survivors of GBV and their children. These organizations play an important role in countries or regions where women's shelters do not exist. Moreover, they provide advocacy and counselling to women that might not need accommodation but require other specialist support and advocacy (WAVE 2013).

□ **Specialized support services for survivors of sexual violence** are necessary in light of the traumatic nature of sexual violence, requiring a particularly sensitive response by trained and specialized staff. These services include immediate medical care and trauma support, complemented by medium- and long-term psychological counselling, as well as immediate forensic examinations to collect evidence needed for prosecution. It is good a practice to carry out forensic examinations regardless of whether the matter will be reported to the police and to offer the survivor the possibility to have the samples taken and stored, so that the decision as to whether or not to report the rape can be taken at a later date.

Service providing organizations typically include (Article 25 Istanbul Convention and Explanatory Report):

» Sexual violence referral centres specialized in immediate medical care, forensic practice and crisis intervention. These centres can be part of a hospital setting to respond to recent sexual violence and refer the survivor to specialized organizations for further support or specialist care.

» Rape crisis centres offering long-term help. Services may take the form of face-to-face counseling, support groups and contact with other services. They also accompany support during court proceedings.

A commonly referred benchmark is one specialized support centre per every 200 000 inhabitants (CoE 2008, cited in Istanbul Convention - Explanatory Report).

Specialized support services for survivors of sexual violence might not exist in all countries in EECA. Where they do not exist, it is of particular importance that healthcare professionals, particularly gynecologists and forensic doctors, are trained to provide the required immediate medical care and trauma support (see chapter 3.2).

4.2.2. GENERAL SUPPORT SERVICES

General support services refer to help funded and offered by public authorities, which provide long-term help and are not exclusively designed for the benefit of survivors only but serve the public at large. Besides health services, this includes housing, financial support and other social services, employment services, public education or child welfare. These services are complemented by women's support services, which have specialized in providing support and assistance tailored to the needs of survivors of GBV. In particular, health and social services are often the first point of contact for survivors of GBV and therefore should be adequately resourced to respond to their long-term needs. Staff members should be trained on the different forms of GBV, the specific needs of survivors and how to respond to them in a supportive manner (Article 20 Istanbul Convention and Explanatory Report).

4.2.3. POLICE AND JUDICIARY

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

In order to enable survivors of GBV to access justice and to de facto enjoy their legal rights, it is necessary to train police officers, public prosecutors and judges on GBV and the response to violence. Further, survivors should have access to appropriate protection, free legal aid and be treated and interrogated in a sensitive, respectful way to avoid the risk of further traumatization. Separate waiting rooms in court buildings can help to avoid confrontation with the perpetrator.

4.3. STEPS FOR DEVELOPING AND IMPLEMENTING AN EFFECTIVE REFERRAL SYSTEM

4.3.1. UNDERTAKING A SITUATION ANALYSIS AND MAPPING OF EXISTING SERVICES

At the outset, it is recommended to conduct a comprehensive situation analysis to assess the overall legal and institutional environment of a referral system. Also, developing a referral system does not necessarily mean establishing new services, but rather identifying existing services and agencies that will be included into the referral system. Therefore, it is important to obtain a comprehensive picture on services available and gaps, if any. This assessment seeks to identify entry points and potential partners to participate in a referral system. It may also point to gaps in services, capacities and resources that the referral system should address. The following data should be collected and analyzed:

- » the nature, causes and extent of GBV in the region/country;
- » the legislative framework, including criminal law and specific laws on GBV, if any, as well as laws regulating protection measures, and progress and gaps in implementation;
- » the role, capacity and track record of the police, criminal justice system and civil courts in responding to GBV;
- » the overall organization of the health care system;
- » the existence of special policies or protocols regulating the health system's response to GBV;
- » the availability of existing specialized and general services for survivors of GBV in the country, region and/or municipality; and
- » the extent to which survivors access these services and any obstacles preventing them from doing so.

The assessment should not be limited to the national level, but also look into the regional and local situation, for example, to find out if whether regional or local referral systems are already in place and if so, which actors are involved in it.

When doing the analysis, it is advisable to draw on a mix of sources, in order to obtain a picture as complete and objective as possible. While official government reports do include relevant data and information, it is also recommended to take into account the views of NGOs. These organizations often not only have valuable day-to-day experience in working with survivors of GBV, but also might have different perceptions of the availability of quality services and the status of implementation of legislation, compared to governmental entities.

RECOMMENDED RESEARCH TOOLS AND METHODOLOGIES:

Desk research: Researchers may want to consult the following recommended resources for country-specific data:

- » Official site of the UN CEDAW Committee: state reports, NGO shadow reports and the CEDAW Committee recommendations to governments (Concluding Observations), in English and Russian: <http://www2.ohchr.org/english/bodies/cedaw/sessions.htm>,
- » Official site of the UN Special Rapporteur on Violence against Women (in English and Russian): <http://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/SRWomenIndex.aspx>,
- » European Observatory on Health Systems and Policies, in particular country reports of the Health Systems in Transition series: <http://www.euro.who.int/en/about-us/partners/observatory>,
- » “Country Info” corner of the UNFPA-WAVE portal: www.health-genderviolence.org,
- » Most recent volume of WAVE's annual Country Report (in English): <http://www.wave-network.org/content/wave-publications>,
- » The Advocates for Human Rights, Stop Violence against Women, Country Pages (English): www.stopvaw.org.

Qualitative interviews and focus group discussions with service providers identified through desk research and service users. For specific guidance on planning and implementing these research methodologies on the context of health and GBV, refer to WHO/PATH 2005. When planning interviews or focus group discussions, it should be kept in mind that the process of identifying interview partners/participants can already provide useful insights. The searching for suitable governmental and non-governmental interview partners might show for instance, the extent to which responsibilities for GBV have been clearly assigned within government departments, the level of priority that is assigned to the role of the health sector in addressing GBV, or the level of technical and staff resources within NGOs working in the field of GBV and health. Furthermore, the process of asking questions in itself is an important part of awareness raising on the part of interview partners. When doing interviews through seeking written responses, it is recommended to call the persons in charge before sending a questionnaire, which increases the likelihood of receiving an answer.

Please refer to Annexes 4 and 5 for two questionnaires, which offer guidance for mapping and analyzing services for survivors of GBV through desk research and interviews aimed at developing a referral system. Users are encouraged to adapt and change the questionnaires to the local context, for example through selecting those parts that suit their needs or through combining or shortening certain elements.

4.3.2. SETTING UP A REFERRAL DIRECTORY

Following the mapping of GBV service providers in the relevant geographical area (chapter 4.3.1), the information collected should be organized in a referral directory. This should include in particular contact information, as well as information on types of services provided, the population served and any eligibility criteria. A referral directory tool can help to ensure that health care providers are familiar with existing options for referrals – be it as part of an existing formal referral mechanism or in the absence thereof. Please refer to Annexes 4 and 5 for two sample forms that can be used to compile a directory of referral organizations. Management should provide copies of this directory to all health care staff of their facility that interact with women patients, so that they can use it as basis for referrals. In case of resource constraints, the facility should have at least one copy in a convenient, accessible place (IPPF 2010).

Management should gather feedback from health care providers about how well the directory is working, to make sure that the format is workable and to find out whether providers faced any difficulties in making referrals. It is important to update the directory on a regular basis, to avoid giving women misinformation, which might put them at risk (IPPF 2010).

4.3.3. FORMALIZING THE PARTNERSHIP

Referral systems for survivors of GBV are likely to be most effective when they are based on a formal cooperation agreement among all agencies involved. Such an agreement can take the form of a Memorandum of Understanding or an inter-agency protocol. The main aim of such a document is to formalize the co-operation among agencies and to define respective roles and responsibilities, key principles of service provision as well as a referral pathway (e.g. to whom to refer the survivor, when, where and how). The agreement should be discussed by all participants of the referral system and signed by the authorized representative of the respective agency.

Before a Protocol is adopted, the partners of the referral system need to take time to develop a collaborative working relationship based on mutual trust. This requires, among others, that all members agree on a common understanding of GBV and a common vision on how to respond to it. For instance, it must be ensured that all referral agencies understand violence against women as gender-based, rather than reducing it to a matter of family protection or family reconciliation. All partners should be willing to share with their counterparts how their institution is handling cases of GBV and to accept feedback from other members on what might be changed to improve service provision and working together (adapted from Hagemester et al 2003).

COMPONENTS OF EFFECTIVE REFERRAL SYSTEMS

A joint understanding of the purpose of the partnership that all partners can subscribe to and are willing to commit resources to. The joint vision should describe in no more than one sentence what the partners want to achieve. The process of developing a vision is almost as important as the vision itself.

A workable structure that fits into more general local structures and consists of a strategic group that is mandated to define targets for and in consultation with partner agencies, **and an operational arm** that is supported by thematic sub-groups. Strategic direction and operational delivery need to be supported by effective resources and accountability mechanisms.

A joint strategy, describing strategic aims and indicators for their achievement, **accompanied by an operational action plan** that defines key outcomes and outputs planned, the persons responsible for producing the outputs, a timeline, budget, and a system of review and quality control.

The involvement of strategic leaders at the strategic direction level, **middle managers** with access to staff at the operational delivery level, **and front-line staff** at the level of sub-groups who implement plans and are consulted on possibilities for action. NGO representatives need to be part of this process.

The action plan must be matched by **adequate personal and financial resources**.

While the coordinator plays a facilitating role, is the participating agencies' activities that make the partnership work.

Training of all professionals involved that challenge existing myths and aim to develop skills and confidence in staff, reflecting the local context, procedures and services available. Partners should contribute to developing key messages for training and involve managers and supervisors in training, both as participants and co-trainers.

Developing a useful dataset to implement and monitor the partnership. This includes agreeing on a basic dataset to support the strategy, agreeing on aims and indicators and regularly reviewing data from the partner agencies during partnership meetings.

The existence of policies, protocols and standard operating procedures to support sustainability and accountability of the partnership (adapted from Standing Together Against Domestic Violence 2011).

For an example of how a formal local referral mechanism was developed in Kyrgyzstan, embedded in a national-level multi-sectoral framework, see box 26 (chapter 4.1).

4.3.4. PROVIDING STAFF WITH INFORMATION RESOURCES

Informing the patient of available services is a prerequisite to help her identify the most suitable options. Written information materials given to women need to be discreet to avoid perpetrators finding them.

Examples of information resources that health facilities can provide to staff include the following (see chapter 4.3.2 and Annex 7):

- » Posters with tear-off slips, pamphlets, or brochures in examination rooms and women’s toilets so that patients can take them away or read in private (WHO 2013);
- » Small pocket size lists of useful phone numbers (WHO 2013; see figure 7 for an example of palm size business card);
- » Phone numbers printed in the form of bar codes on stickers, lip balms or other small items that many women have in their handbag, giving info on support services in a low risk way (see figure 8); and
- » Key rings with information on support services hidden inside the key ring fob (see figure 9) or with personalized alarm and torch (see figure 10).

Figure 7: Palm size business card with useful phone numbers (Hammersmith and Fulham, London, UK)

London Wide Resources	Hammersmith and Fulham Local Resources
<ul style="list-style-type: none"> • 24-hour National Domestic Violence Helpline - Freephone..... 0808 2000 247 • SOLA (DV help line for lesbians)..... 020 7328 7389 • Broken Rainbow (LGBT DV support)0845 260 4460 • NHS Direct (24 hours).....0845 4647 • NSPCC helpline (24 hours).....0808 800 5000 • Childline (24 hours) 0800 1111 • Police (emergencies)..... 999 • Refugee Council..... 020 7346 6777 • Samaritans (24 hours).....08457 909090 • Shelter Advice Line (24 hours).....0808 800 4444 • Women’s Link (housing advice)..... 0800 652 3167 	<ul style="list-style-type: none"> • Council - Switchboard..... 020 8748 3020 • Social Services(Children & Families)Daytime..020 8753 5392 • Emergency Housing – Daytime..... 020 8753 4144 • Council - Emergency out of hours..... 020 8748 8588 • H&F Community Law Centre..... 020 8741 4021 • H&F Police..... 020 8563 1212 • Shepherds Bush Advice Service..... 020 8753 5913 • Citizens Advice Bureau Fulham..... 0845 458 2515 • DV Intervention Project Women’s Service .. 020 8748 6512 • Victim Support..... 020 7385 6868

Source: Standing Together Against Domestic Violence, UK

Figure 8: Phone number of women’s helpline in form of barcode



Source: Standing Together Against Domestic Violence, UK

Figure 9: Butterfly key ring with safe information inside



Source: Standing Together Against Domestic Violence, UK

Figure 10: Personal alarm key rings



Source: Standing Together Against Domestic Violence, UK

4.4. WHAT HEALTH PROFESSIONALS CAN DO IN THE ABSENCE OF A FORMAL REFERRAL MECHANISM

While the existence of a formal referral mechanism is an important prerequisite of effective referrals, it does not exist in all countries. In some countries, referral mechanisms might exist but the connected service providers might lack staff resources and/or infrastructure and therefore not be able to provide the full range or quality of services needed. This is what health professionals can do in the absence of a formal referral mechanism:

- » Use follow-up appointments to check the wellbeing of the patient discretely.
- » Consider establishing basic services in-house, for example, crisis intervention or support groups (IPPF 2010). When it is not safe for the woman go home and no shelter exists, hospitals might admit the patient for an overnight stay in cases when the woman discloses it is not safe to go home.
- » Refer the patient to known service providers, using a referral directory (see chapter 4.3.2 and Annex 7).

Box 26: Providing hospital-based accommodation for survivors of GBV in Tajikistan

In June 2012, the Ministry of Health of Tajikistan, in partnership with UNFPA established “victim-support rooms” to survive as temporary shelter for women survivors of GBV. To date, such rooms were established in eight hospitals and maternity houses in the cities of Dushanbe, Rasht, Vahdat Kurgan–Tube, Kulyab, Khujand and Kairakkum. This step was necessary, given the lack of a sufficient number of shelters in the country. While some NGO-run shelters exist, they lack funds to necessarily guarantee continuous provision of services.

In each health facility, one “victim support room” was established, providing women and girls survivors of GBV above the age of 14 and their children with temporary accommodation. Survivors are referred to the rooms by medical professionals, law enforcement or NGOs. Admission to the victim support room happens on a voluntary basis with their informed consent. Survivors may stay for a period of up to five days, while there is some flexibility in regards to the duration. The rooms are equipped with basic furniture including child beds, a cooking facility, tableware, bed sheets, towels, hygiene and sanitary items and diapers for babies. During their stay, they have access to basic medical and psychological care, counseling sessions that can be arranged in the evenings, as well as information on other services available in their city or district. The operation of the victim support rooms is guided by standardized policies, which foresee e.g. the provision of health services free of charge or at affordable prices, informing survivors of and referring them to other service providers, and the application of certain

protocols and guidelines, covering issues such as identification, emergency contraception and STI prevention/treatment. Security of the rooms is ensured through providing all doctors and nurses with mobile phones so that they can call the local police station in case of an emergency.

The added value of creating such a hospital-based service is that it takes into account the local cultural context: Women who do not spend the night at home (for example, in a shelter) might face rejection by their families or neighbours, whereas an overnight stay at a hospital will not raise any suspicious questions. Furthermore, doctors are well positioned to observe potential future problems faced by the survivor back home through follow-up appointments.

As of May 2014, about 50 women have received temporary accommodation in the victim support rooms. This type of service is innovative in Tajikistan and its awareness still needs to be raised among women and girls.

This effort is part of a broader initiative to strengthen the existing referral mechanism for survivors of GBV in Tajikistan. This includes joint training undertaken by UNFPA of health care staff working at the victim support rooms and police officers in the cities where the rooms are established. Following the trainings, participants became multipliers by in turn training their peer professionals. It is planned that the Ministry of Health will be rolling out the “victim support rooms” in other districts.

Source: Information provided by UNFPA country office in Tajikistan, May 2014

CHAPTER 5

Monitoring and evaluating health system interventions to gender-based violence

Monitoring and evaluation of interventions against GBV enable health care professional to maintain or improve the quality of their work. The information and data generated can help to identify lessons learned so that existing approaches can be adjusted and made more effective and efficient. Further, monitoring and evaluation systems that are based on a participatory approach also allow for greater transparency and accountability. Therefore, monitoring and evaluation can and should be integrated into the daily work of health professionals and other service providers.

This chapter provides a definition of the concepts of monitoring and evaluation (chapter 5.1) and explains their rationale and benefits (chapter 5.2). It addresses ethical considerations in evaluating interventions against GBV (chapter 5.3) and explains how monitoring and evaluation can be integrated in the different phases of an intervention (chapter 5.4). Further, it introduces different evaluation approaches (chapter 5.5) and provides practical tips for designing and implementing evaluations (chapter 5.6).

5.1. UNDERSTANDING MONITORING AND EVALUATION

5.1.1. WHAT DO WE UNDERSTAND BY MONITORING AND EVALUATION?

Monitoring is the continuous assessment of achievements during the implementation process. **Evaluation** is a periodic, comprehensive and systematic review of an intervention, its design, implementation and results.

Monitoring and evaluation have to be tailored for each intervention specifically. For example, monitoring and evaluation would look different for:

- » a school-based prevention programme,
- » a training program on the systematic use of screening protocols throughout the health sector,
- » the implementation of domestic violence legislation, or
- » a public awareness-raising campaign aimed at engaging men.

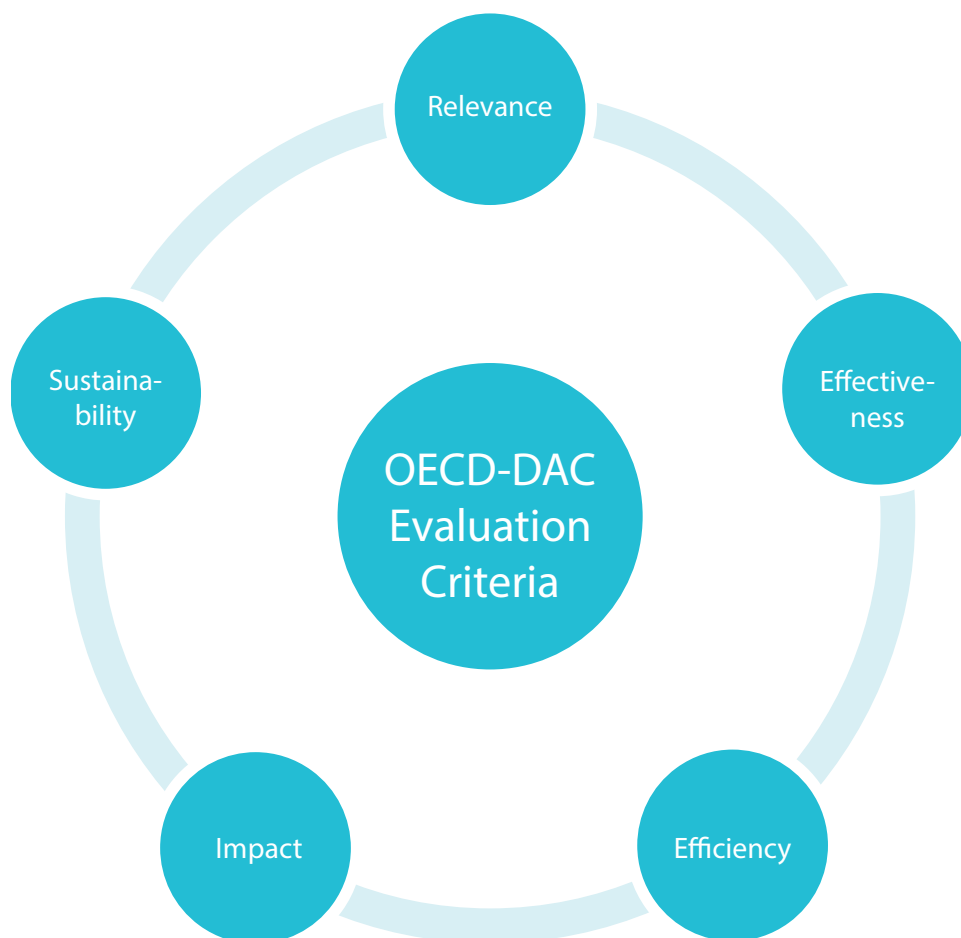
Table 12: Differences between monitoring and evaluation

	Monitoring	Evaluation
Time	Continuous process during the implementation of a project, programme, plan or strategy	Either done during the span of a project, program, plan or strategy (mid-term evaluation) or upon completion of projects, programmes, plans or strategies (ex-post evaluation)
Focus	Check how planned activities are progressing, identifying operational difficulties; recommend actions for improved implementation	Assess achievement of results, relevance, effectiveness, and impact of activities and their contribution to results
Aim	Improve efficiency and effectiveness; ensure the transformation of activities into results/outputs	Explore intended and unintended results; formulate recommendations for adjustments
Content	Progress attained measured against the set indicators	Fulfilment (degree of and quality) of success indicators
By whom	Often done internally by staff of the implementing organizations	Mostly done externally, sometimes by staff from the own organization, but external from the implementing stakeholders
For whom	Primarily for implementers	For implementers, but also for donors and beneficiaries, the wider interested public and research community, should the results be made public

Source: ICMPD 2010

Often the following five **criteria** are assessed during monitoring and evaluation: **relevance, effectiveness, efficiency, impact, and sustainability.**

Figure 11: Criteria for assessing interventions in monitoring and evaluation



Source: OECD-DAC 2009

These criteria, which have also been adopted by the Organization for Economic Cooperation and Development-Development Assistance Committee (OECD-DAC), summarize some of the key questions that monitoring and evaluation seek to answer. They constitute the general framework for monitoring and evaluation and can be concretized through the questions listed in chapter 5.1.3.

Relevance refers to the extent to which the intervention is suited to the priorities of the target group and implementing organizations such as health care facilities or the relevant policies and strategies against GBV.

Effectiveness measures the extent to which the intervention attains its objectives.

Efficiency relates inputs (time, money, resources) to outputs (qualitative and quantitative). It is an economic term which is used to assess the extent to which the least costly resources possible are used in order to achieve the desired results.

Impact implies analysing the positive and negative changes produced by the intervention, directly or indirectly, intended or unintended. Indirect results are results, which go beyond the narrow focus of the intervention. For example, the establishment of a counselling centre for battered women can also lead to increased awareness of the problem in the larger community.

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue, e.g. after funding has been withdrawn or after survivors of violence return to their home environment.

5.2. RATIONALE AND BENEFITS OF MONITORING AND EVALUATION

Monitoring and evaluation is essential to maintain or improve the **quality of health system interventions against GBV** and to understand whether these interventions have achieved the planned goals. Monitoring allows managers to track progress of projects, programmes or policies vis-a-vis the planned goals. Especially when new approaches are used, such as innovative early detection programmes, it is vital to closely monitor both intended and unintended results and to test and revise the assumptions on which the intervention is based. Evaluations involve an assessment of the strengths and weaknesses of projects, programmes or policy to improve their effectiveness. It is an important source of evidence of the performance of the project, programme or policy, of the persons and institutions in charge of implementation.

Monitoring and evaluation can and should be integrated into the daily work of health professionals and other relevant stakeholders. Once set up, these systems can generate data and information allowing for greater **transparency and accountability** and help identifying **lessons learned**. **These insights** can then be used in **adjusting the existing approach** in order to make it more effective and efficient. In some cases **external support by experienced evaluators** is required in order to establish a coherent system. Evaluations performed by external evaluators are also often perceived as being more objective than those done from within the organization.

The way planning, monitoring and evaluation are performed has considerably changed in the last decade. Many institutions and organizations **moved from activity planning** (what are we going to do?) **to planning for the overall results** (what do we want to achieve?). Therefore the focus is on the results and consequences of actions and implementation, rather than on the inputs (money, time, human resources) provided. This is called **results-based management** (RBM) and monitoring and evaluation play a vital role for results-based management. For more information on RBM in the context of management, monitoring, evaluation and donor reporting, see UNDG 2011.

Measuring the degree to which an intervention, strategy or policy (for example on combat violence against women) has achieved its planned results provides the basis for accurate reporting and the identification of lessons learned and obstacles faced. This can be used to plan new interventions as well as to adjust and tailor existing programs to combat violence. Monitoring and evaluation are also valuable planning and management tools. Building monitoring systems and envisaging evaluations at the outset of the intervention helps to design and review objectives and to forecast future resource needs. It allows organizations to identify where they might have failed to have the intended impact or even where they have had an unintended impact, which may be positive or negative.

Monitoring and evaluation are valuable tools to support the learning process within organizations and beyond as they help us to understand what works and why. Therefore, it is of vital importance that lessons learned derived from monitoring and evaluations are being shared both, within the organization and externally: with practitioners, policy and decision makers, and, if applicable, donors.

In order to implement a comprehensive monitoring and evaluation system on GBV, it is necessary to gather data, stemming from qualitative or multiple-choice questionnaires, surveys, focus group interviews with clients or staff, clinical observations, evaluation of the existing data (e.g. random record reviews), review of planning and strategic documents individual interviews with survivors. For an overview of quantitative and qualitative research strategies and methodologies in the context of GBV and health, see WHO/PATH (2005), *Researching Violence against Women, A Practical Guide for Researchers and Activists*. This manual seeks to provide researchers, activists, community workers, and service providers interested in applied research with background information and tools to apply public health research methods to the study of GBV, with a focus on developing countries and other resource-poor settings. After addressing ethical considerations for researching GBV, the manual provides guidance on the development of a research strategy. It further provides an overview of qualitative and quantitative approaches to research, shares tips for developing samples and introduces tools and tips for qualitative and quantitative data collection and analysis.

The following list provides examples of questions that can be answered by monitoring and evaluation (UN Women Virtual Knowledge Center).

Monitoring and evaluating initiatives addressing violence against women can provide us with answers to the following questions:

- » What interventions and strategies are effective in preventing and responding to violence against women and girls within health care systems?
- » What services are needed to help women and girls recover from violence?
- » What could be the role of different sectors and the health care sector in particular in addressing and preventing violence?
- » What factors (social, economic, political, cultural etc.) play a role in perpetuating vulnerability to violence or hindering access to services?
- » What kinds of investments produce more promising results than others and how much do they cost?

More specifically, the following lessons can be learned from monitoring:

- » Are the activities of the intervention being carried out as planned?
- » What services are provided, to whom, when, how often, for how long, in what context?
- » Is the quality of services adequate? Is the target population being reached?
- » Are women being further harmed or endangered because of the intervention?
- » Have there been any unforeseen consequences as a result of the activities?
- » Are activities leading to expected results?
- » Do the interventions or assumptions need to be amended in any way?
- » What results can be observed?

□ Other lessons can be learned from evaluations:

- » Why or why not have activities been implemented as planned or were adapted?
- » Did the intervention have an impact? Why or why not? How and for whom did it have an impact?
- » To what extent can the measured or observed changes be attributed to the intervention?
- » Did the intervention have any unintended consequences?
- » Is the intervention cost effective? Can the cost be compared with alternatives to investment, in other words, could the results have been reached with less input?

If the intervention was successful, can it be replicated to other settings and if so, in which settings? Can it be adapted, replicated or built on to increase its reach or scope (for a larger population or a different region)?

The following example showcases an evaluation of a domestic violence intervention in the maternity and sexual health services in a UK hospital (box 27).

Box 27: Evaluation of the MOZAIC Women's Wellbeing Project, UK

The MOZAIC project was implemented from 2004-2007 as a partnership between the maternity and sexual health services of Guy's and St. Thomas Foundation Trust and the 170 Community Project, a NGO providing specialized domestic violence support services on-site. As part of the intervention, clinical guidelines were introduced and a training programme was implemented to increase health professionals' knowledge on domestic violence and to enable them to identify and document violence and to refer survivors to MOZAIC Women's Wellbeing Service, who provided on-site support and counseling. Male patients who disclosed domestic violence were also provided with counselling. In this setting, routine enquiry was practiced for asking women about domestic violence¹³ (Bacchus et al 2010). In 2007, an evaluation was undertaken. The partnership did not stop at the end of the project: The partners built on the results of the evaluation to further improve the intervention.

The evaluation took into account the perspective of both, hospital staff and service users. It used the following methods:

- qualitative semi-structured interviews with service users and providers,
- focus-group discussion among service providers,
- review of patient records, and
- pre-post training questionnaires for health professionals, implemented before, immediately after and six months post-training.

The evaluation revealed, among others, the following findings:

- The vast majority of participants rated the increase in knowledge as result of the training as "very much" or "quite a lot". At the same time, findings from six months later revealed a number of challenges faced in day-to-day clinical practice

that prevented an effective response, such as the presence of partners or family members during consultations, language barriers, time constraints in busy clinics, or reluctance of some women to trust health professionals. Combined training of maternity staff and sexual health services staff was not found to be useful, mainly because sexual health professionals required specific skills that were not covered in the training, such as dealing with male patients experiencing domestic violence.

- Maternity and sexual health services were not found to be early points of intervention to prevent domestic violence from occurring. Rather, some women using maternity services revealed a long history of partner violence. Therefore, these services were found to provide "opportune" points of intervention for women survivors at different stages to seek and accept help.

○ Confidence and sensitivity on the part of health professionals was deemed helpful by patients in situations where they were reluctant to disclose abuse, as shown by the following quote from a 31 year old user of maternity services: "...I was in tears and she noticed the bruises on my arm... and she started questioning me and I said to her that I was fine and she said 'No, you can talk to me' and then she dug and dug and then I opened up to her."

- Survivors reported that the support provided by MOZAIC had initiated a process of re-assessing their personal situation and of gaining confidence in their ability to begin and sustain changes. They were able to tentatively explore options, such as temporarily leaving the abuser, contacting the police or seeking legal advice. At the same time, their ability to take decisions was impacted by the quality and availability of alternative options, such as housing or financial resources, also taking into account immigration status.

- The evaluation also identified potential sources of harm in clinical practice, such as negative labelling and stereotyping by health professionals, failure to document cases adequately or breaches of confidentiality.

Source: Bacchus et al 2010

5.3. ETHICAL CONSIDERATIONS IN EVALUATING INTERVENTIONS AGAINST GENDER-BASED VIOLENCE

Collecting data on sensitive topics such as GBV often raises a number of **ethical questions and safety concerns**. This is especially the case when the survivor of violence is interviewed. The following concerns should always be taken into account when interviewing survivors: ensuring safety of respondents since they often live with their abuser; protecting confidentiality since breaching it could provoke an attack; making sure the interview process is non-discriminatory and does not cause distress. The inherent risks entailed in collecting data for monitoring and evaluation can only be justified if the interview is used to provide information on available services and if findings are used to raise awareness of the issue and improve services for women who experience violence. **Having a comprehensive understanding of the risks, ethical concerns, and the practical realities can help minimize the dangers and potential for re-traumatization of the participants; it can also increase the likelihood of women disclosing relevant and accurate information and create an opportunity to receive feedback on services provided.**

The recommendations below are based on the *WHO Guidelines for interviewing trafficked women* and *Ethical and safety recommendations for research on domestic violence against women* and have been adapted for this context. They do not explicitly discuss the different risks and obligations of interviewing females who are minors, although many of the same principles will apply. The recommendations should be used in conjunction with existing professional standards applicable to the work being conducted.

Box 28: Ethical and safety principles

- 1 The **safety and well-being** of respondents and the personnel is paramount, and should guide all decisions.
- 2 Much of the information provided will be extremely personal. Protecting **confidentiality** is essential to ensure both women's safety and data quality. Interviews should be conducted in a private setting. Instead of names, unique codes should be used to distinguish questionnaires.
- 3 The setting and interview must include actions aimed at **reducing any possible distress** caused to the participants. The respondents should always have the opportunity to either stop the interview or not answer particular questions. All questions about violence and its consequences should be asked in a supportive and non-judgmental manner. In addition, care needs to be taken to ensure that the language of the questionnaire cannot be interpreted as being judgmental, blaming or stigmatizing.
- 4 It is essential to **listen carefully and to respect** each woman's assessment of her situation and risks to her safety. One should recognize that each woman will have different concerns, and that the way she views her concerns may be different from how others might assess them.
- 5 All **personnel** conducting interviews should be carefully selected and receive specialized training and on-going support. The training must provide a mechanism to confront and overcome own biases, fears and stereotypes regarding abused women.
- 6 Ideally, monitoring and evaluation is completely independent from management and implementation. However, in a setting of health-care providers, there might be a **dual role** of interviewing women in order to collect data - in this case focusing on monitoring and evaluation - and counselling. Whenever possible, it is therefore recommended to work in **teams of two**, so that one can take the role of asking questions whereas the other takes the role as counsellor, if necessary.
- 7 **Findings** should be properly interpreted and used to advance (institutional) policies and practical interventions. In the context of monitoring and evaluation efforts, the data gathered should be used to enhance the institutional response to violence against women.

Source: WHO 2003a

13 The WHO 2013 Clinical and Policy Guidelines do not recommend routine enquiry as such but state that this method could be considered in maternal health care settings (see chapter 3.1.1)

5.4. MONITORING AND EVALUATION DURING THE DIFFERENT PHASES OF AN INTERVENTION

5.4.1. THE CYCLE OF AN INTERVENTION

Monitoring and evaluation have to be integrated into all phases of an intervention, from the planning to the implementation phase and beyond. Figure 12 illustrates these different phases, using the concept of the project cycle. This concept can also be applied to interventions other than projects, such as larger-scale interventions in health facilities, communities and at the policy level.

Figure 12: The five stages of the project cycle



Phase 1 is the **assessment stage**. The situation needs to be analysed; health and human rights concerns need to be identified and addressed.

Phase 2 is the **strategic planning** stage. The stakeholders involved in the implementation process identify the objectives they plan to achieve through the suggested interventions. For this purpose, implementers need to make sure they have the necessary information available to them in order to be able to make decisions about how to allocate money and effort in order to meet the identified objectives. In this phase, the foundation for monitoring and evaluation is created, and both approaches need to be integrated into the intervention and planned for.

Phase 3 is the **design stage**. The intervention may be designed from scratch or be an already existing project, programme or policy that can be revised or adapted to meet the specified objectives. At this stage, the following questions need to be answered: What strategy or interventions should the intervention use to achieve these objectives? Monitoring and evaluation activities may include pilot testing and assessing the effectiveness and feasibility of alternative methods of service delivery, e.g. early detention methods or effective referral mechanisms.

Phase 4 is the **implementation and monitoring stage**. During this stage, the staff members begin the interventions. They adapt them as necessary to a particular setting, resolve problems that arise, and get the interventions to a point where it is running smoothly. Information describing how the intervention is operating and how it can be improved is needed: To what extent has the intervention been implemented as designed? How much does implementation vary from site to site? How can the intervention become more efficient or effective?

The final phase 5 is the **evaluation stage**. The intervention has been established and information is needed on the extent to which the highest priority goals of the intervention have been achieved. For monitoring and evaluation to be successful, strategic planning and the development of a monitoring and evaluation strategy should go hand in hand.

Even though the monitoring and evaluation system should be setup during the strategic planning and design phase, evaluations are - contrary to monitoring that is done continuously during the whole implementation period - done at certain times in the cycle of the intervention.

» **At the beginning of the planning stage** (also known as ex-ante evaluation): the focus here is on assessing the planned intervention in terms of relevance, feasibility, potential impact or expected benefits. The evaluation is like a second opinion on whether or not the intervention is viable. It includes checking to see if the needs of the stakeholders have been assessed properly and if the strategies and plans have been developed adequately. In the case of health sector initiatives to combat violence, an ex-ante evaluation could assess the incidence and patterns of violence, national policies and strategies, collaboration and referral mechanisms, as well as compare envisaged intervention strategies with international good practices.

» **At the mid-term (or other) point** during the intervention: the focus here is on looking at the progress and performance of the intervention and identifying changes in the environment that might affect its effectiveness. The evaluation involves collecting and analysing data for performance indicators, in order to find out to what extent the project is achieving the expected results. Sometimes a mid-term evaluation is conducted to explain an unusual event (e.g., the monitoring data might be showing a disturbing or remarkable trend). For example, a new health sector initiative against violence may lead to an increased number of reported cases. A mid-term evaluation can help health professionals to analyse whether this increase is due to increased awareness and counselling services or whether the violence rate has in fact increased. The latter would then most likely imply a change of strategy (e.g. stronger focus on prevention). The evaluation would also address the issue of what changes in the intervention are necessary to address the increased number of reported cases.

» **At the end of the intervention** (also known as ex-post evaluation): the focus here is on reviewing the whole cycle within the context of its background, objectives, results, activities and inputs. The evaluation looks at how well the intervention did in terms of the expected outcomes, how sustainable these outcomes appear to be and what factors led to the results. In this case, all of the internationally agreed criteria (see chapter 5.1.1, figure 11) should be assessed.

If possible, evaluation should also be a **learning event**. This can be achieved by, for example, organizing stakeholder workshops in order to generate information as well as to communicate and discuss key findings and lessons learned of the evaluation.

5.4.2. DEVELOPING AND IMPLEMENTING AN EVALUATION – STEPS AND PRINCIPLES

The following steps should be considered when planning an evaluation:

Preparing the terms of reference for the evaluation: This involves defining the scope and purpose of the evaluation, identifying data sources, deciding on methodology and communication tools, selecting the evaluation team and designing the work plan and budget.

Designing the evaluation: This involves reviewing the intervention and data needs, deciding on the focus of the evaluation and the key questions to address, selecting appropriate data collection and analysis methods, and communicating the results.

Implementing the evaluation: This involves collecting and analysing the data, and reviewing and reporting the findings.

Following up on the evaluation: This involves drafting a plan to act on the findings, monitoring its implementation and managing any follow-up activities or consequent changes.

There are several key principles, which should be applied to the design and implementation of evaluations.

- **Free and open evaluation process.** Evaluations should be independent from the management and implementation of interventions. All steps of an evaluation should be embedded in transparent processes. In order to enhance credibility and accountability, evaluations should integrate independent evaluators, which are recruited through a transparent process. Mixed teams of internal and external evaluators can increase acceptance internally and foster institutional learning as well as a positive institutional culture for monitoring and evaluation.
- **Evaluation ethics.** Evaluations must be undertaken with impartiality, integrity and honesty. All parties that oversee, manage and implement an evaluation must respect human rights and cultural diversity, customs, religious beliefs and practices.
- **Partnerships and mutual accountability.** It is likely that partners feel increased ownership and are willing to learn from an evaluation when they form an active part of it. Consequently, in order to increase ownership and credibility, enhance utilization, and build mutual accountability, a partnership approach should be applied early in the evaluation process. This implies, for example, that different institutions affected by or working on a problem, e.g. effectively identifying survivors of violence, should also be consulted before, during and after the evaluation. Evaluations conducted in partnership with other relevant stakeholders enhance shared understanding, learning and application of recommendations
- **Coordination and alignment.** Coordination of evaluations aim to reduce transaction costs, promote partnerships, and enhance mutual accountability and alignment. Therefore, wherever possible, evaluations should take into account national and local evaluation plans and corresponding activities and policies; where feasible, they should build on these and also regard them as capacity-building opportunities.

- **Capacity development.** If necessary, capacities within health institutions should be built in order to foster ownership and acceptance for the process and the results and to enhance institutional learning. It should be emphasized that evaluations serve for institutional learning and the generation of lessons learnt.
- **Ensuring quality.** Quality assurance is the responsibility of the evaluation team selected to conduct a particular evaluation and should be integrated in the contract with the selected evaluation team. This implies providing feedback on planned evaluation methods, cross-checking data and developing a coherent and readable evaluation report that provides lessons learned and relevant recommendations.

Source: OECD-DAC 2010

5.5. EVALUATION APPROACHES

Many approaches to monitoring and evaluation are based on linear **cause-effect models**. Such models aim to logically connect a flow of inputs and activities to outputs and outcomes and to **attribute change** to an intervention. One of the most prominent linear models is the logical framework approach (described below). The strength of the logical framework approach is in making the underlying assumptions of one's intervention transparent. It also helps to support a joint understanding among all involved actors of the logic underlying an intervention (meaning the relationship between inputs, activities and results). However, such linear models also have limitations, in particular when it comes to topics like violence against women. Sometimes a logical framework is limited in its ability to reflect the complexities of the real world and the different contributions made to the intended change by different stakeholders.

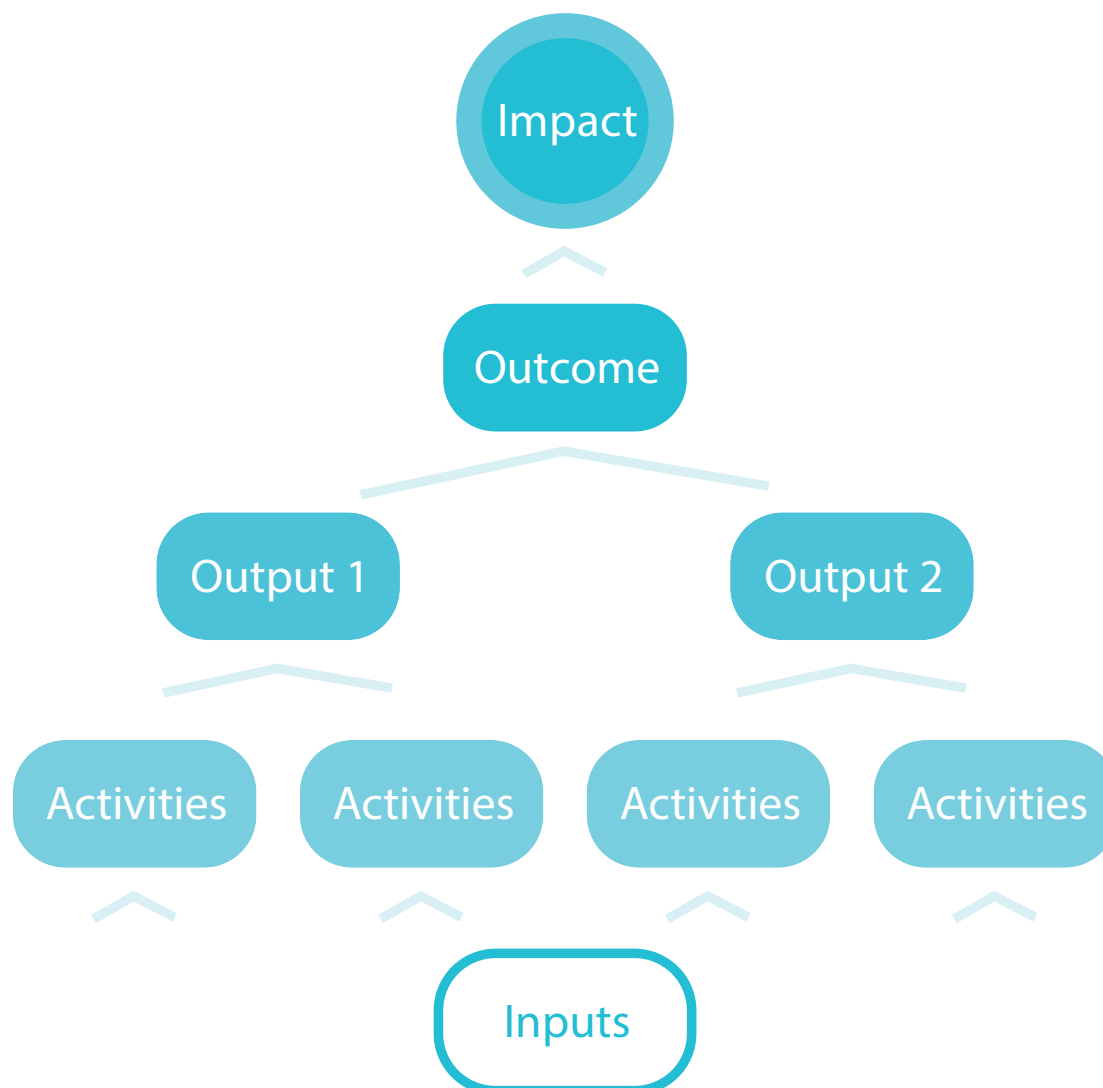
Therefore, health sector professionals might want to consider alternative approaches when developing a monitoring and evaluation framework. Three prominent alternative approaches are the **most significant change technique**, **outcome mapping**, and **the quality of life battery method**. They focus on the **contribution** one has made to a change, but do not intend to link the change to one's contribution only (attribution). Furthermore, they do not work with a pre-defined set of indicators, but tend to be more flexible in measuring the impacts achieved.

It is recommended to take into account the advantages and disadvantages of different approaches, and - where feasible - to **adapt and combine the approaches** to fit the context and suit the exact needs of the corresponding intervention and setting.

5.5.1. THE LOGICAL FRAMEWORK APPROACH

The **logical framework approach** (LFA) is a management tool mainly used in the design, monitoring and evaluation of international development interventions. **A logical framework brings together all key components of a project, programme, policy or other intervention.** Having all key components of an intervention in a systematic, concise and coherent way helps to clarify and demonstrate how interventions are expected to work. More specifically, it can help to link activities to different levels of results (objectives, outcomes, outputs). The LFA can also clarify and separate these various levels of results from each other in order to clearly distinguish between inputs, activities, outputs and objectives (see figure 13). In order to gain such clarity with all stakeholders involved, it is strongly recommended to develop the logical framework through a participatory approach and discuss all the assumptions and risks involved. The document will then serve as a reference for all stakeholders and staff involved during the implementation phase.

Figure 13: The logical model



Source: WAVE, based on OECD-DAC 2009

The logical framework takes the form of a four by four table. The four rows are used to describe four different types of results the intervention aims to achieve or to contribute to: the **objectives, outcomes, outputs** and activities (OECD-DAC 2009). **Objectives** are the overall results to which an intervention is expected to contribute, for example, enhanced services for battered women or lower re-victimization rates. **Outcomes** are the short-term and medium-term effects of an intervention's outputs, such as increased know-how among health personnel. **Outputs** are products and services which result from an intervention, for example training curriculum or health sector protocols. Outcomes and outputs need to be clear, simple and contain only one idea. For tips on formulating results statements, see UNFPA 2011b.

The four columns provide different types of information about the results in each row. The first column is used to provide a **description**. The second column lists one or more **objectively verifiable indicators** (OVIs) of these interventions. The third column describes the **means of verification** (MoV), i.e. the source of information on the OVIs, such as national statistics, training evaluations, interviews. The fourth column lists the **assumptions**. Assumptions are external factors that are believed to influence (positively or negatively) the events described in the narrative column. The list of assumptions should include those factors that potentially impact the success of the intervention but which cannot be directly controlled by the managers of the intervention. A good design of an intervention should be able to substantiate its assumptions, especially those with a high likelihood of having a negative impact.

A logical framework is usually developed from the top to the bottom (**direction of thinking**) and then during the monitoring process assessed from the bottom to the top (**direction of action**).

Table 13: Exemplary logical framework for a sexual and reproductive health intervention targeting GBV

Narrative	Indicators	Means of verification	Assumptions
Overall objective: Improve the situation of survivors of gender-based violence (GBV) in country X			
Outcome 1: Strengthen the institutional capacity of relevant stakeholders to offer services to survivors of GBV within existing sexual and reproductive health services	<ul style="list-style-type: none"> • Changes in knowledge, attitudes and practices of health care providers regarding GBV • Changes in the infrastructure, institutional policies and resources • Percent of providers with ability to identify survivors of GBV and make the appropriate referral (internal and external) by type of personnel • Number of women who receive services related to GBV by type of service • Client perceptions about the services provided by the organization 	<ul style="list-style-type: none"> • Survey among providers • Observation guide of clinics • Service statistics • Focus group discussions with staff • Client exit survey 	The institutions are interested in increasing their capacities and provide time and space for capacity building measures.
Outcome 2: Increase knowledge among reproductive health service providers about effective interventions that address the problem of GBV	<ul style="list-style-type: none"> • Changes in knowledge, beliefs and attitudes about GBV among health personnel • Guides, tools and protocols produced, field-tested and implemented • Lessons learned, documented and disseminated 	<ul style="list-style-type: none"> • In-depth interviews with health personnel • Organization records • Feedback on IEC materials 	Health service providers are willing to address GBV.
Outputs related to outcome 1: Strengthened institutional and individual capacities to address GBV	<ul style="list-style-type: none"> • Individual capacities increased • Institutional mechanisms and Code of Conduct established 	<ul style="list-style-type: none"> • Training evaluations • Documentation of institutional mechanisms 	Enhanced services are not hindered by financial means.
Outputs related to outcome 2: Specific information material available and tested for service-providers	<ul style="list-style-type: none"> • Guides, tools and protocols produced, field-tested and implemented • Lessons learned, documented and disseminated 	<ul style="list-style-type: none"> • Guides, tools and their testing evaluations • Publications with lessons learned and promising practices 	Better information leads to better services.
Activities for outcome 1: <ul style="list-style-type: none"> • Training needs assessment • Development of curricula • Implementation of trainings • Development of Code of Conduct • Establishment of collaboration mechanisms • Joint discussion events amongst leadership of relevant stakeholders on collaboration mechanisms 			
Activities for outcome 2: <ul style="list-style-type: none"> • Assessment of information gaps amongst service providers • Assessment of existing materials • Development of and provision of information materials • Development of institutional referral mechanisms • Generation of promising practices and lessons learned • Implementation of a inter-institutional conference on GBV 			

The following list provides **examples of results for interventions to end GBV**. While managers of interventions may wish to draw on these examples when formulating results, it should be kept in mind that planned results have to be formulated according to the identified needs.

□ **Supporting legal and institutional framework:**

- » Increased harmonization of the national legislation in the area of GBV with international human rights standards
- » Clarified procedures for national response mechanisms
- » National Referral Mechanisms for the treatment of survivors of violence in place
- » Improved structures for assistance and rehabilitation of survivors established
- » Budget for good quality health services for survivors of violence ensured

□ **Prevention:**

- » Increased awareness of violence against women among health workers, teachers and social workers
- » Proportion of people who have been exposed to preventive messages against violence against women
- » Increased knowledge about patterns of violence in the region among the general public
- » Hotline providing information on support services established
- » Proportion of girls who feel able to say no to sexual activity
- » Increase in early detentions of perpetrators

□ **Protection and support:**

- » Improved protection of survivors
- » Improved standards for identification of and dealing with survivors of violence
- » Legal framework for the protection of survivors strengthened
- » Proportion of health units with at least one service provider trained to care for and refer survivors of violence
- » Improved system for dealing with minors as survivors of violence
- » Increased number of support facilities for survivors
- » Enhanced and comprehensive services (medical, legal, social) for survivors of violence
- » Proportion of people who would assist a women being beaten by her partner
- » Proportion of rape survivors who received comprehensive care

□ **Prosecution:**

- » Legal system for the prosecution of perpetrators strengthened
- » Increased number of cases of domestic violence handled in courts
- » Increased number of cases of violence reported to the relevant authorities.

In order to implement a logical framework approach, **indicators** are vital to help to determine whether the planned results have been achieved. Indicators should follow the logic of the intervention (outcomes, outputs). Further, they provide a specific, observable, and measurable benchmark to show the changes or progress an intervention is making toward achieving a specific outcome, e.g. reduction of cases of domestic violence. The choice of indicators will determine how data is collected, interpreted and reported on. Indicators need to be **disaggregated** (male/female, age, rural/urban, ethnicity...) to the greatest extent possible and is necessary. Even if the indicator itself is not disaggregated, data collection should be disaggregated, so that the assessment can be specified according to different population groups.

Certain quality criteria should be applied to indicators. It should be checked that indicators are SMART and SPICED:

Box 29: SMART and SPICED indicators

SMART indicators

Specific and simple: Identify concrete events or actions that will take place

Measurable: Quantify the amount of resources, activity, or change to be expended and achieved

Appropriate and achievable: Logically relate to the overall problem statement and desired effects of the intervention

Realistic: Provide a realistic dimension that can be achieved with the available resources and plans for implementation

Time-bound: Specify a time within which the objective will be achieved

SPICED indicators

Subjective: Consider the special position or experience of the informants that gives them unique insights

Participatory: Develop indicators together with those best placed to assess them

Interpreted and communicable: Define the exact meaning of each indicator as it might differ from context to context

Cross-checked and compared: Assess the validity of assessment by cross-checking and by using different informants, methods, and researchers

Empowering: The process of setting and assessing indicators should be empowering in itself and allow groups and individuals to reflect critically on their changing situation

Diverse and disaggregated: There should be a deliberate effort to seek out different indicators from a range of groups, especially men and women. The information needs to be recorded in such a way that these differences can be assessed over time.

Source: MDF 2005

Generally, a mix of both qualitative and quantitative indicators help to reflect the intended changes most adequately and allow for a triangulation of data collected. The following indicators are examples, which could be used. However, the sources and baselines or percentages indicated are purely indicative and would need to be established and replaced with those valid for your context. Remember that indicators, no matter whether quantitative or qualitative, have to be related to the formulated outcomes.

□ **Quantitative indicators are statistical measures.** They help to measure results in terms of (ICMPD 2010):

» **Numbers...** e.g.: The number of survivors of violence assisted through specialized health institutions annually has risen from 78 (baseline 2012) to 100 (at the end of 2015) (Source: Statistics from NGOs).

» **Percentages...** e.g.: The number of calls received by the national hotline increased by 25% by the end of 2015 (Source: Statistics from hotline) Or: The number of cases of domestic violence brought to court increased by 20% in 2014 (Source: Statistics of the Ministry of Justice, established baseline in 2012) Or: Proportion of health units that have documented & adopted a protocol for the clinical management of VAW/G survivors (Source: Health Ministry Statistics)

» **Rates...** e.g.: The rate of re-affected survivors decreased by 25% between 2012 and 2015 (Source and baseline 2012: Health and police statistics) or: Rate of women who were asked about physical and sexual violence during a visit to a health unit.

□ **Qualitative indicators** reflect people's judgments, opinions, perceptions and attitudes towards a given situation or subject. They can measure changes in sensitivity, satisfaction, influence, awareness, understanding, attitudes, quality, perception, dialogue or sense of well-being. Qualitative indicators measure results in terms of (ICMPD 2010):

» **Compliance with...** e.g. **set international/national standards, legislation, procedures** e.g.: The national legal framework concerning GBV complies with the undersigned conventions and standards by 2015 (Source: Shadow reports.)

» **Quality of...** e.g.: 80 % of interviewed (potential) survivors assess the quality of health services provided as adequate and targeted to their gender and age specific needs (Source: Qualitative survey). Or: In 2017, 80 % of survivors were satisfied with the assistance rendered in the process by the different authorities involved (Source: Qualitative survey conducted). 80% of women in rehabilitation programs assessed the programs as targeted to their needs (Source: Questionnaire).

» **Level of...** e.g.: The level of knowledge on GBV among the participants of trainings has increased (Source: Questionnaire). Or: The level of coordination among the relevant stakeholders (government and non-governmental actors) for the fight against violence has increased (Source: Schedule of regular meetings and minutes, survey amongst stakeholders). Or: The (level of) awareness of the general population on governments action in the fight against violence has increased (Source: Survey and downloads of monitoring reports).

» **Extent of...** e.g.: The extent of regular joint analysis of monitoring results increased significantly by the end of 2011 (Source: Anonymous questionnaire to stakeholders). The extent to which standards for interviewing survivors are observed increased by the end of 2011 (Source: Police reports, Interview protocols, baseline 2010). The extent of NGO involvement in the national anti-trafficking response significantly increased by the end of 2011 (Source: survey amongst NGOs). For tips on formulating indicators, see UNFPA 2011b.

The following case study from Russia provides an example of using a combination of qualitative and quantitative indicators for evaluation purposes (box 30).

Box 30: A case study from "Vrachi Detyam" (Doctors for Children) in Russia

In St. Petersburg, different organizations used different qualitative and quantitative data for the evaluation of the effectiveness of their work. Consequently, a joint model of identifying survivors of domestic violence in health care settings was developed. Today, if a survivor of domestic violence is identified in the screening process, she will be referred to specialists and will then be provided with telephone numbers of local crisis centres and receive information on counselling services. In order to assess the effectiveness of the referral, both the numbers of identified survivors and the number of survivors who turned to a crisis centre after intervention of the appropriate information was provided, are collected.

The data is then analysed according to the following formula: $E = (B/A) \times 100\%$.

E stands for the effectiveness of identification and intervention;

B is the number of female survivors identified in the course of screening;

A is the number of women out of the number of identified survivors that turned to the crisis centre for further assistance.

In this particular context, 70 per cent was identified as target for the referral to be considered satisfactory.

For example, 70 survivors of domestic violence were identified by health care providers within one month. Interventions were conducted and contact information of crisis centres was provided. In the same month, 50 survivors turned to the crisis centre after the interventions were done in the health care setting. Based on the above-mentioned formula, the effectiveness of the referral was assessed as follows:

Indicator	Quantity
A. Number of survivors identified	70
B. Number of survivors who turned to crisis centre following referral	50
E. Effectiveness: $50/70 \times 100\% = 71\%$.	

As E exceeds 70%, the referral in this example would be considered effective.

Source: Information provided by ANNA – Center for the Prevention of Violence, Russia 2011

5.5.2. MOST SIGNIFICANT CHANGE TECHNIQUE

This sub-chapter provides an overview of the most significant change (MSC) technique. It would exceed the scope of the current publication to provide a comprehensive introduction to this approach. For further information, readers are encouraged to consult Davies/Dart 2005, which is also the main reference for this sub-chapter.

“The most significant change technique is a form of participatory monitoring and evaluation. It is participatory because many project stakeholders are involved both in deciding the sorts of change to be recorded and in analyzing the data. It is a form of monitoring because it occurs throughout the program cycle and provides information to help people manage the program. It contributes to evaluation because it provides data on impact and outcomes that can be used to help assess the performance of the program as a whole” (Davies/Dart 2005).

Essentially, the process involves the **collection of significant change (SC) stories** emanating from the field. At the outset, the designated staff and stakeholders are asked to ‘search’ for the impact of an intervention. Once the changes have been captured, the relevant stakeholders and staff sit down together, read the stories aloud and have regular and often in-depth discussions about the value of these reported changes. Then, panels of designated stakeholders engage in a **systematic selection of the most significant of these stories**. When the technique is implemented successfully, teams of health personnel or social workers are focusing on the impacts of the intervention rather than on the mere inputs provided.

Different from the logical framework approach, this technique does **not work with pre-defined indicators**, especially the ones that have to be counted or measured. The technique uses the following core question: **“When looking back over the past months, what do you think was the most significant change?”**

The technique usually incorporates **ten steps**; however, adaptations can be made to suit the specific context:

- 1 Start and raise interest amongst your key stakeholders
- 2 Define the domains of change
- 3 Define the reporting period
- 4 Collect SC stories
- 5 Select the most significant stories
- 6 Feedback the results of the selection process
- 7 Verify stories
- 8 Quantify stories
- 9 Secondary analysis and meta-monitoring
- 10 Revise the system

The first step in MSC generally involves **introducing MSC** to a range of stakeholders in order to generate interest and commitment to participate. The second step is **to identify the domains** of change to be monitored, in this case, changes resulting from interventions against violence against women. This involves selected stakeholders identifying broad domains (e.g. enhanced access to health services for survivors of violence or better referral mechanisms). The third step is to decide **how frequently to monitor** changes taking place in these domains.

SC stories are collected from those most directly involved, such as participants and field staff. The stories are collected by asking a simple question such as: *‘During the last month, in your opinion, what was the most significant change that took place for participants in the intervention?’* It is initially up to respondents to allocate their stories to a domain category (e.g. increased awareness, better referral, enhanced services). In addition to this, respondents are encouraged to report why they consider a particular change to be the most significant one.

Then, **stories are analyzed and filtered** at the different levels of authority typically found within a given organization or intervention. Each level of the hierarchy reviews a series of stories sent to them by the level below and selects the single most significant account of change within each of the domains. Each group then sends the selected stories up to the next level of the hierarchy of the intervention, so that the number of stories is reduced through a systematic and transparent process. Every time stories are selected, the criteria used to select them are recorded and fed back to all interested stakeholders, so that each subsequent round of story collection and selection is informed by feedback from previous rounds. The organization is effectively recording and adjusting the direction of discussion and, consequently, implementation.

After this process has been used for some time, for example one year, a collection of the selected stories is compiled at the uppermost organizational level in each domain of change. The reasons for selecting the stories are also mentioned. The funders of the intervention are asked to review the stories and to select those that best represent the sort of outcomes they wish to fund. They are also asked to document the reasons for their choice. This information is **fed back** to the managers.

The **selected stories can be verified** by visiting the sites where the described events took place. The purpose of this is two-fold: to check that stories have been reported accurately and honestly and to provide an opportunity to gather more detailed information about events seen as especially significant. If conducted sometime after the event, a visit also offers a chance to see what has happened since the event was first documented.

The next step is **quantification**, which can take place at two stages. When an account of change is first described, it is possible to include quantitative (e.g.: how many persons indicated that there is increased collaboration between different stakeholders working with survivors of domestic violence?) as well as qualitative information (e.g.: What kinds of characteristics were mentioned to indicate such a change?). It is also possible to compare such data between different locations and settings. The next step after quantification is **monitoring the monitoring system** itself, which can include looking at who participated and how they affected the contents, and analyzing how often different types of changes are reported. The final step is to **revise the design** of the MSC process to take into account what has been learned as a direct result of using it and from analyzing its use.

5.5.3. OUTCOME MAPPING

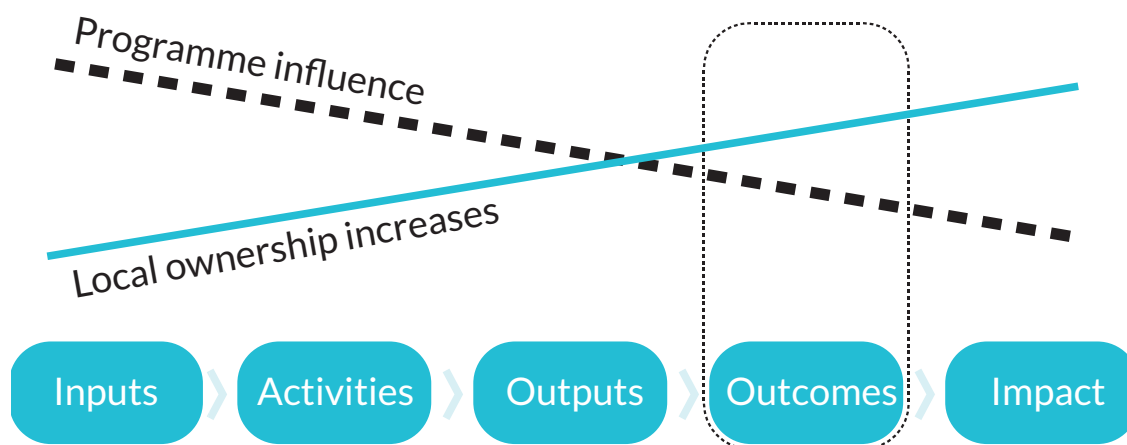
This sub-chapter provides an overview of outcome mapping. It would exceed the scope of the current publication to provide a comprehensive introduction to this approach. For further information, readers are encouraged to consult Patton 2010, which is the main reference for this sub-chapter, as well as the online platform of Outcome Mapping Learning Community (www.outcomemapping.ca).

The technique of outcome mapping focuses on **measuring changes in the behaviour of the people** with whom given intervention works most closely. Examples for such changed behaviours can be enhanced collaboration mechanisms between health centres and crisis intervention centres or increased awareness of the different forms of violence amongst health personnel. The main difference between the logical framework approach and outcome mapping is that the first also looks at overall objectives (e.g. eliminating violence against women), while the latter focuses **only on those outcomes that fall strictly within the sphere of influence** of a particular intervention (e.g. improved skills of health professionals trained). Thus, outcome mapping considers only those activities where the intervention can claim that it has had a direct impact on. This technique addresses only one type of results: behavioural change; it is oriented towards social and organizational learning.

Outcome mapping works with **boundary partners**, which are those individuals, groups and organizations with whom the intervention interacts directly and with whom the intervention anticipates opportunities for influence. For example, a health intervention might support a health facility in order to enhance its services for survivors of violence. In order to provide also social and legal services, the health facility collaborates with a non-governmental organization and government stakeholders (partners). Following the approach of outcome mapping, these partners should assess their own services instead of the intervention doing it for them.

The basic assumption of outcome mapping is that the **direct influence of an intervention decreases from each level of the intended change**, as the graph below demonstrates (figure 14). Instead, the ownership of the other stakeholders increases. This increased ownership of local stakeholders is also regarded as a prerequisite for sustainability. For example, an intervention is targeting enhanced referral mechanisms. A hospital can provide information on services and refer a survivor to a shelter. However, the hospital will not be able to guarantee that the woman is actually using the recommended services nor that these services are provided according to the standards of the hospital - the latter is the responsibility of the service providers and shelters. Consequently, the hospital would measure its referrals, whereas the service provider would evaluate its services. As the name indicates, the focus of outcome mapping as a monitoring and evaluation approach lays on the outcome level.

Figure 14: Changes in influence of an intervention and local ownership at the different levels of the results chain



There are three stages of outcome mapping, which involve a total of twelve steps:

The first stage, intentional design, helps to establish consensus among the relevant stakeholders on the intended macro level changes of the intervention, and to plan the strategies to be used. To this end the following four questions are being asked:

- » **Why?** What is the vision to which the intervention wants to contribute?
- » **Who?** Who are the intervention's boundary partners?
- » **What?** What are the changes that are being sought?
- » **How?** How will the programme contribute to the change process?

The intended changes are described as outcomes, which are defined in progress markers. Progress markers identify as a set of changed behaviour by the boundary partners. These changes are described and measured on three levels (behaviour change we plan to see, behaviour change we like to see and behaviour change we love to see).

The second stage, outcome and performance monitoring, provides a framework for the on-going monitoring of the intervention's actions and the boundary partners' progress toward the achievement of outcomes. It is based largely on systematized self-assessment. It provides the following data collection tools for the elements identified in the intentional design stage (vision, mission, boundary partners, progress markers): an "outcome journal"; a "strategy journal"; and a "performance journal." An outcome journal is used to monitor the intended outcomes and progress markers. A strategy journal documents changes in strategy and activities. The performance journal monitors organizational practices.

The third stage, evaluation planning, helps to identify evaluation priorities and develop an evaluation plan.

The following case study (box 31) illustrates the use of outcome mapping in an intervention to improve the health of women and girls in rural India.

Box 31: Improving the Health of Women and Girls in Rural India

Swayamsiddha is a 5-year project (2000-2005) to improve the health and empowerment of women and girls in rural India. The project involves nine partner organizations in six Indian states and is co-funded by the Canadian International Development Agency (CIDA) and the International Development Research Centre (IDRC). It is designed to reach about 75 villages and provide benefits to the female members of community-based organizations, as well as their families. The goal of Swayamsiddha is to bring about behavioural changes at different levels: within the community

at large; among the women with whom the project is working directly; through the establishment and strengthening of community-based organizations; and among the implementing teams and within their organizations. The Swayamsiddha project team has been using outcome mapping identification of boundary partners, outcome challenges, and progress markers. The staff reflects: "*Outcome mapping is a useful tool for seeing the process of change as a continuous chain of many smaller changes*" and states that "*outcome mapping can improve planning and monitoring.*"

Source: Earl undated

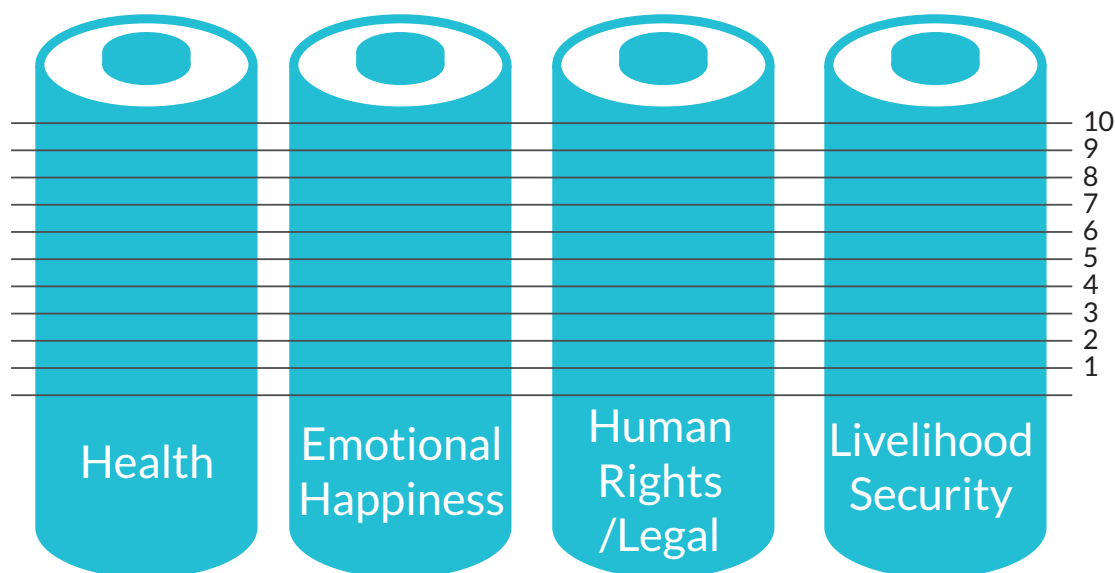
5.5.4. THE QUALITY OF LIFE BATTERY METHOD

This sub-chapter provides an overview of the Quality of Life Battery method. It would exceed the scope of the current publication to provide a comprehensive introduction to this approach. For further information, readers are encouraged to consult Jones 2010, which is also the main reference for this sub-chapter.

The Quality of Life Battery Method is a simple approach using the metaphor of a full or empty battery, which explores what quality of life means to beneficiaries and identifies changes which the intervention has had on different areas of their lives. The methodology was developed by Clodagh Byrne to support partners in assessing changes in the life of the beneficiaries of the intervention and to increase participation of clients in the planning and monitor-

ing of interventions. The method was originally piloted by Cambodia HIV/AIDS Education and Care (CHEC). It can be adapted when working with survivors of GBV. The information drawn from this evaluation methodology may be used by clients and program staff to review progress and identify future actions that can be taken by the client and within the program. Data analysis can also help to identify whether or not a holistic response is in place and if it is actually improving the quality of life of the beneficiaries.

Figure 15: Example of a Quality of Life Battery



This tool involves three main steps:

1 Participants identify key elements of a good quality of life and categorize them into domains (e.g. health, emotional happiness, human rights, livelihood security). Following the intervention, participants fill in two batteries: one to assess their quality of life at the end of the intervention and one to assess quality of life before the intervention.

2 Using the image of batteries, participants assess changes in different areas of their lives during the programme and examine the reasons for these changes.

3 The data is analyzed and recommendations on how the program can further improve the quality of life are collected.

Step 1: Identification of key elements

Quality of life means different things to different people and depends on personal views and the social environment in which people live. Factors that make one person happy and fulfilled may not have the same effect on other people. Common domains are health, psychosocial happiness, human rights and livelihood security. These categories should be adapted according to the context. The question is: “What elements do you need to have a full and happy life?”

Step 2: Definition of batteries fullness level and reflection of underlying reasons

To assess changes, this methodology requires participants to consider their quality of life at two or more points in time, using the image of full/empty batteries. This should ideally be done by carrying out the process at different stages of an intervention. Alternatively, it can be a retrospective process where the participant considers their quality of life at present and then thinks back to how it was at a previous point in time. Two or more sets of batteries are compared, one for each point in time. Each battery is divided into levels ranging from 1-10, representing low-high energy levels, to help measure and record their evaluation. It is important that participants consider their own sit-

uation and not that of their family members, partners or a person that they care for. Whilst assigning energy levels to their batteries, participants should reflect the reasons for the indicated energy level. An important part of the process lies in recording these reasons. This reflection not only helps individuals to think about actions they can take in their own lives to further improve their quality of life; the process can also be used to adapt future program practice.

The following case study illustrates how the Qualities of Life Batteries method has been used in the health context, albeit slightly adapted (box 32):

Box 32: Case study: Medical Missionaries of Mary, Addis Ababa, Ethiopia

Instead of using diagrams of the batteries, participants in Addis Ababa used drinking glasses to represent the batteries and coloured water to represent their energy levels. This was done in order to evaluate the impact of a health program on individual participants. The process was carried out looking back on how participants felt their quality of life had been before they joined the program. Participants filled their “now glass” and discussed the reasons for choosing

this level. They then filled their “before” glass and discussed the reasons for changes between the levels. The facilitators used cards marked with 10 levels to measure the level of the liquid and record this for each domain. The level changes were then transferred by facilitators to the batteries diagram and these, along with the reasons for the changes, made were recorded on a record sheet.

Source: Jones 2010

Step 3: Interpreting the data

An important next step is the accurate collation and analysis of data after the “batteries process” (step 2) has been carried out. While the process provides a useful individual review and planning tool, it also has wider relevance for evaluating interventions when the data from a range of program clients is collected and analyzed. During the process, both quantitative (the batteries energy level scores) and qualitative (the reasons for these scores) data is collected by staff or evaluators. Looking at a number of program clients over a specific period of time enables program managers to identify potential trends where a program has influenced the quality of their lives. If these are not the intended changes, the program can be adapted. It is recommended to cross-check the analysis with respondents and to collect their recommendations on how the program can be improved.

5.6. DESIGNING AND IMPLEMENTING A MONITORING AND EVALUATION SYSTEM

The **monitoring and evaluation system** – meaning the clarification of what should be monitored and evaluated, by whom, how and when – **should be set up during the planning phase** or at the latest in the beginning of implementation. A solid analysis of the problem and its context should be carried out as part of the strategy development and planning and can serve as a baseline for subsequent monitoring and evaluation. If such an analysis was not undertaken, it is essential to implement such an analysis at a later stage and make necessary adjustments in the planned intervention.

A monitoring system is a way of steering and organizing the monitoring work so that it is less time consuming and easy to implement. Monitoring systems vary in sophistication from a piece of paper and some notebooks or files, to electronic filing systems and databases. The most important thing is not how sophisticated the system is, but whether the information needed for decision-making is collected, reviewed systematically and used for necessary adaptations.

A well-designed and organized system will ensure that the **right data** are being collected at the **right time** during and after the implementation of the intervention and that this data will help guide implementation and strategic decision-making. It will also ensure that staff involved in the intervention and stakeholders will not be overwhelmed by the amount of data gathered and that a reasonable amount of time and money is being spent in collecting and analysing data, and collating and reporting the information.

5.6.1. STEPS IN SETTING UP A MONITORING AND EVALUATION SYSTEM

In order to set up a monitoring and evaluation system, health professionals should consider the **following steps and answer the following key questions:**

1. What do we need to assess?	Define the purpose and scope of the monitoring and evaluation system
<p>The purposes could include issues such as accountability to funding agencies, partners and beneficiaries; informing strategic directions, to make changes, if necessary; informing operational directions, to make changes, if necessary; and empowering key stakeholders. Each purpose has different consequences for the process (e.g. if the purpose is to empower the stakeholders, the process will be more participatory and learning-oriented). By 'scope' we mean the level of detail required, the level of stakeholder participation and the level of funding available (e.g. you might want to make the system highly participatory, but funding constraints limit the extent to which you can involve stakeholders).</p>	
2. What do we want to achieve?	Review the project concept and objectives
<p>This involves asking questions such as: What is the intervention about? What is the theory of action underlying it? What are the assumptions?</p>	
3. Who needs what kind of information?	Assess the stakeholders' key information needs
<p>The most important question here is: What do management, other staff, beneficiaries and other stakeholders need to know and when?</p>	
4. What are we specifically looking at to measure achievement? Where are we today relative to our goals? When do we want to achieve what?	Formulate indicators and other data requirements
<p>You need to formulate a list of criteria against which to measure effectiveness and efficiency, and determine the type of data (quantitative and qualitative) you will need to carry out this measurement (e.g. 'number of survivors applying for services' and 'reasons for not applying'). The quality of the indicators should then be assessed according to the SMART and SPICED rule (see chapter 5.5.1 on the logical framework approach, box 29 on indicators).</p>	
5. Who is responsible for data collection? In which sequence?	Organize the data collection and analysis
<p>What methods will you use to ensure the right data are being collected and analysed? And who will be responsible for this? Methods can be qualitative/quantitative, individual/group based, participatory/conventional. How will the various stakeholders be involved in these processes?</p>	
6. How are we doing relative to our targets? Why? What did we achieve and what needs to be done?	Organize critical reflection of events and processes
<p>Critical reflection means asking not only 'what happened' and 'why,' but also 'what does this mean' and 'what are we going to do about it?' This assists in learning and managing for impact.</p>	
7. How can we ensure the information is systematically being disseminated and used to generate lessons learned?	Develop the communication and reporting process
<p>You should decide whom you need to communicate with and report to during the monitoring and evaluation processes, and how to do this. Keep in mind that different stakeholders have different information needs and different reporting requirements. The evaluation results should be presented in an accessible format, so that they can be systematically distributed internally and externally for learning and follow-up actions and to ensure transparency. In light of lessons emerging from the evaluation, additional interested parties in the wider development community are identified and targeted to maximize the use of relevant findings.</p>	

5.6.2. ADDRESSING CHALLENGES IN MONITORING AND EVALUATION

Monitoring and evaluation of initiatives addressing violence against women can be hampered by several obstacles. This has to be taken into account when setting up a monitoring and evaluation system. This section on challenges summarizes some of the major obstacles and suggests ways to tackle them.

- There is a **lack of comparable definitions**, indicators and instruments, especially on the prevalence of forms of violence. Therefore, it is challenging to make comparisons across regions. Thus, when developing a monitoring and evaluation system, the concepts and terms have to be thoroughly defined, if appropriate, according to international or national standards.
- Many studies measure **processes and outcomes, but not impact**. For example, there could be data provided on a number of health professionals who have been trained, but no data on the impact the training had on their behaviour or certain institutional procedures. Often change is measured at the individual level rather than at the community level. For results-based management, it is vital to broaden the focus and measure the overall impact. For example, when training health personnel, the key is not to simply collect the evaluation forms but rather determine whether there was an improvement in the quality of services provided due to the higher knowledge level among the trained health care staff.
- Many indicators for **behaviour change rely on** self-reporting of either survivors or perpetrators. Due to the sensitivity of the topic of GBV, this information could be biased. Many participants might use the socially desirable answers rather than mentioning the violence episodes. Moreover, there is a ‘culture of silence’ surrounding GBV and in some settings violent behaviours are viewed as “normal” or “adequate.” Thus, there is considerable potential for under-reporting, especially in cases where violence is hidden, as it is in female homicide cases and trafficking in women. Furthermore, **rigorous statistical methods** are frequently not used since data collection and analysis is costly. This must be taken into account when analysing such data.
- Whenever possible, **triangulation of data** through other means of data collection should be the goal.
- **Different kinds of interventions** (policy and legal reforms; strengthening health, legal, security and support service; community mobilization; awareness raising campaigns) and different contexts require **different evaluation tools and methods**. If possible, consulting an experienced evaluator, in order to identify the most appropriate research methods, is recommended.
- It is often difficult to determine specific **contributions of individual institutions or strategies** to an observed outcome or impact, especially in the case of complex, multi-sectoral or integrated interventions. In this case, we should present arguments why we think that our intervention has caused a change.
- It is difficult to define **what success means or looks like**. This challenge has to be addressed already when establishing a monitoring and evaluation system, either through the definition of objectives and indicators (see logical framework) or by selecting alternative approaches, which allows for a flexible definition of objectives through the target group (see outcome mapping and most significant change). For more information on evaluation approaches, see chapter 5.4.
- Monitoring and evaluation plans often lack **clear, appropriate conceptual frameworks**. If possible, consulting a monitoring and evaluation specialist in order to establish such a system, which can then still be implemented by internal staff, is recommended.
- **Interpreting data** is often challenging and requires significant expertise and capacity that may not be available in-house.
- Budgets often fail to allocate **sufficient resources** towards monitoring and evaluation, which may cost as much as 10 to 40 per cent of the entire budget, depending on the goals and objectives of the program, scope and type of intervention and activities. Given the important role that sound monitoring and evaluation can play to improve the effectiveness of an intervention, factoring in adequate funds is a worthwhile investment.

□ Certain evaluation methods that are commonly used to assess the impact of interventions may be **unethical** in the context of violence against women. For example, survivors of violence might face discrimination or be re-traumatized during evaluation interviews if their specific conditions are not taken into consideration by the interviewer. The well-being of the persons interviewed should therefore always be on the forefront of any monitoring and evaluation efforts (see chapter 5.2 on ethical considerations).

□ Behaviour change is **long-term change**, which can often not be reached through short-term interventions. Monitoring and evaluations systems should therefore be targeted to measure both short-term and long-term impacts and therefore consequently need to be planned as continuous processes accompanying interventions against violence.

(Adapted and amended from UN Women Virtual Knowledge Center, citing Gage and Dunn 2009, Frankel and Gage 2007, Watts 2008, WHO 2005)

5.6.3. PRACTICAL TIPS FOR PLANNING AND IMPLEMENTING MONITORING AND EVALUATION

PRACTICAL TIPS – MONITORING

- » Ensure that the time and costs of the monitoring system are in balance with total time and costs of the intervention.
- » Link monitoring to the operational plan.
- » Involve stakeholders in the monitoring process. This will help to create understanding, ownership and commitment when making changes in the operational plan.
- » Decide on what is essential data to be collected, as well as how to go about collecting, processing and reflecting on it together with the stakeholders involved in the intervention.
- » Organize shared learning events with stakeholders during the monitoring process.
- » Use monitoring data as a management tool, particularly at the level of operations (inputs, activities, outputs/expected results), to inform management and stakeholders about possible action that needs to be taken.
- » Ensure adequate and timely reporting to management and stakeholders, addressing their specific information needs.

PRACTICAL TIPS – EVALUATION

- » Evaluations should be planned assessments that focus on the extent to which an intervention has realized its objectives.
- » Ensure that, as far as possible, evaluations are viewed by the implementers of the intervention and stakeholders as a learning mechanism to enhance strategic and operational management. If they are only perceived as external control, the openness to also reflect on critical issues might be limited and the evaluation becomes a pure academic exercise without further impact.
- » Plan evaluations carefully at the start of an intervention, preferably with stakeholders, ensuring that there are enough resources to conduct the evaluations properly, and also to create ownership and commitment.
- » Develop the evaluation process in collaboration with stakeholders, ensuring that their specific information needs are integrated and their views on data collection and analysis are considered; this will contribute positively to relevance, impact, usability, accessibility, sustainability, utility, effectiveness and efficiency.
- » Evaluation questions should be broad questions that help focus on what you need to know, both positive and negative.
- » Involve stakeholders in the implementing the evaluation process (e.g. by setting up a stakeholders' evaluation committee and organizing stakeholder workshops).
- » Consider an evaluation as an important opportunity to learn and interact with stakeholders.
- » Relate the recommendations generated through the evaluations back to the original evaluation questions.

PART II

Training package for health care professionals on strengthening health system responses to gender-based violence

1 About this training package



AIM OF THE TRAINING PACKAGE



The present training package aims to strengthen the knowledge and skills of health care professionals to understand GBV, to identify patients who have experienced GBV and to provide survivors with appropriate care, support and referrals. It seeks to provide trainers with a ready-made and user-friendly tool to deliver trainings to health care professionals in the EECA region, packaging the comprehensive background information included in part I into ten practical training modules.

Each module provides the trainer with:

- » An outline of the training session, including its objectives and key learning messages;
- » References to relevant chapters of Part I of the package that trainers may consult as background information, as well as other relevant documents, where applicable; and
- » A PowerPoint presentation, handouts and group exercises. For easy reference, each Power Point presentation makes references to handouts, using a star symbol with the letter H and the number of the respective handout.

Trainers are encouraged to adapt the curriculum in line with the time available and the learning needs of their specific target group.

TARGET GROUP



The training package aims to provide a comprehensive introduction to GBV and the health sector's response. Therefore, it targets training participants with little or basic training in this field.

The training package has been designed for health care professionals who are in direct contact with survivors of GBV. This includes doctors, but also nurses and midwives, who are of particular importance in remote rural regions. The package mainly addresses the level of non-specialized primary health care, which normally provides the first and most critical point of contact for women survivors of GBV seeking medical help. Additionally, the training package may also provide relevant guidance for secondary health care settings, where women survivors may be referred to by primary health care providers.

It is of relevance for health care professionals based in hospitals, clinics or health centres, as well as resident doctors and other health care providers working in non-hospital settings.

STRUCTURE OF THE TRAINING PACKAGE

After a number of practical tips and recommendations for preparing trainings (chapter 2), the training package proposes a training curriculum consisting of ten modules, for a two and a half-day training (chapter 3). Each day is calculated with 6-6,5 hours of training sessions. It is recommended to factor in a 1 hour lunch break and two coffee breaks of 15 minutes each (may be adapted by the trainer). This outline proposes a core structure for a training, which may be adapted by the trainer, for example by adding energizers or ice-breaker exercises.

Name of module	Proposed duration
Day 1	
1. Introduction and getting to know each other	45 minutes
2. Understanding gender-based violence	2,5 hours
3. The role of health systems in the response to gender-based violence	2 hours
4. Principles and standards for service provision	1 hour 15 minutes
Day 2	
Wrap up day 1 (summary, remaining questions)	15 minutes
5. Identifying gender-based violence	2 hours
6. Medical examination and care	1,5 hours
7. Documentation of gender-based violence	1 hour
8. Risk assessment and safety planning	1 hour
Day 3	
Wrap up day 2 (summary, remaining questions)	15 minutes
8. Risk assessment and safety planning (continuation: role play)	1 hour
9. Referrals to other service providers	1 hour 45 minutes
10. Evaluation and closing	45 minutes

2 Tips for preparing the training

BACKGROUND OF THE TRAINER(S)

Trainers should be knowledgeable about GBV and the health system's response. Having a team of two trainers with mixed backgrounds (one trainer specialized on GBV and/or women-specific services, one trainer with a medical background) will benefit effective delivery of the training curriculum in line with the needs of the target group.

When working with an international trainer, it is helpful to match her/him with a local trainer who is familiar with the specific country and/or regional context.

Ideally, the size of the group should not exceed 25 participants, to allow for an interactive exchange between the trainer and participants and among participants.

TAILORING THE TRAINING PACKAGE TO LOCAL CONTEXTS

The training package offers a framework for trainings in the EECA region, at regional and country levels. In preparing the training, trainers should further tailor the package to the specific local context in which the training held. Useful information to be collected includes:

- » The prevalence of GBV in the given country;
- » The overall organization of the country's health care system;
- » Any policies or protocols in place that apply to the health sector response to GBV;
- » Relevant national legislation, such as definitions of GBV under criminal law or separate statutes on GBV, or reporting obligations of health care professionals;
- » The existence of a referral system, in particular the existence of women specific services, such as shelters or telephone helplines; and
- » Any research studies analysing the health sector's response in the country.

In undertaking this background research, trainers may wish to consult the following sources:

- » Official site of the UN CEDAW Committee: state reports, NGO shadow reports and the CEDAW Committee recommendations to governments (Concluding Observations), in English and Russian: <http://www2.ohchr.org/english/bodies/cedaw/sessions.htm>;
- » Official site of the UN Special Rapporteur on Violence against Women (in English and Russian): <http://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/SRWomenIndex.aspx>;
- » European Observatory on Health Systems and Policies, in particular country reports of the Health Systems in Transition (HiT) series (available in English and Russian): <http://www.euro.who.int/en/about-us/partners/observatory>;
- » "Country Info" corner of the UNFPA-WAVE portal: www.health-genderviolence.org;
- » UNFPA Global and EECARO website, section on human rights and gender equality: <http://eeca.unfpa.org/topics/human-rights-and-gender-equality>
- » Most recent volume of WAVE's annual Country Report (in English): <http://www.wave-network.org/content/wave-publications>;
- » The Advocates for Human Rights, Stop Violence against Women, Country Pages (English): www.stopvaw.org.

LOGISTICS



When preparing for logistics, the trainer and/or the organization organizing the training will need to arrange for the following (adapted from Ganley 1998):

- » Securing a location;
- » Advertising and administering registration for the training;
- » Providing necessary equipment, such as microphones, or a computer, beamer and screen for PowerPoint presentations;
- » Organizing the setting-up of the room (organizing tables in a circle, U-shape or in small groups are preferable over class-room as they allow for more interaction among participants);
- » Organizing translation services, if needed: interpreters with necessary equipment (translation booths, microphones, headsets), translation of written materials;
- » Providing stationary, such as writing paper, pens and materials for exercises, as needed (e.g. flip charts, paper cards, color pens);
- » Preparing, photocopying and distributing the agenda and handouts;
- » Preparing, distributing and collecting evaluation forms for sessions (refer to training module 10 for a sample evaluation form); and
- » A certificate of attendance (optional).

TIME PLANNING



When planning the training, trainers should make sure there is enough time for discussions and interaction with the participants. This is important so as to enable the group to exchange experiences, get to know other participants, etc. Moreover, participants need time to process the material, ask for clarification, or state their misunderstandings so that the trainer or other participants can provide missing information (Ganley 1998).

When assigning time slots to the different modules, trainers are encouraged to take into account the needs and level of the participant group's knowledge. For example, for health professionals who have not undergone any previous GBV training, the trainer should make sure to devote sufficient time to module 2 on understanding GBV, so as to set a solid ground for the remainder of the training and to provide participants with the background knowledge needed to improve skills and clinical practice. For participants who have previously participated in GBV trainings, trainers could consider shortening module 2 and instead devote more time to other modules, such as identifying GBV (module 6) or risk assessment and safety planning (module 8).

It is also advisable to factor in a time slot of 30-60 minutes to enable participants to bring up any burning issues and ask remaining questions.

MIX OF METHODOLOGIES



Trainers should apply a mix of different methodologies and make sure to balance lectures with interactive exercises, to enable participants to contribute their views and experiences, to raise questions and to come up with their own ideas and solutions. Examples of interactive methodologies include group discussions in the plenary or small groups, brainstorming, case studies and role plays.

Trainers should keep in mind that some participants may have little to no experience in working with interactive methods. This may result in participants being too shy to respond to questions asked by the trainer to the group, to actively participate in plenary discussions or to engage in a role play. Trainers should therefore, at the outset of the training and throughout the training event, underline that all participants are here to learn from each other and that there is no such thing as a “wrong” answer. Trainers should be alert to such situations and be flexible in addressing them to make participants feel more comfortable. For instance, when doing a role play, trainers could split up participants in smaller groups and ask them to share their experiences with the bigger group.

When planning exercises in small groups, consider the size of the group and time available for deciding on the number of working groups. Keep in mind that having more, but smaller groups allows groups to have a more in-depth exchange, but takes more time for reporting back to the plenary.

It also a good practice for trainers to ask questions to the group when delivering presentations, to enable participants to ask questions and contribute from their experience. Questions trainers could ask include: “Have you made similar experiences in your organization/country?” “Do you agree to this statement?” or “Who of you has a suggestion on how this challenge could be addressed?”

POINTS TO BE CONSIDERED DURING THE TRAINING SESSION

- Listen for confusion among participants about the definition and root causes of GBV and for attitudes that express harmful myths and blaming of survivors. Address and clarify these issues in the discussion, referring to module 2.
- Encourage participants to try to improve their everyday work practice in responding to GBV. When confronting resistance, try to make a comparison between GBV and any other health issue that health care providers are used to diagnose, treat and refer to specialist treatment.
- Remind participants that change is a process that happens over time both for themselves and for their patients. Propose doable steps that practitioners can take this day, this week, this month.
- Point out successes that groups of individual practitioners have had in changing a system’s policy or procedure through development of protocols and underline that an improved response to survivors of GBV happens at both the individual and the systemic level.

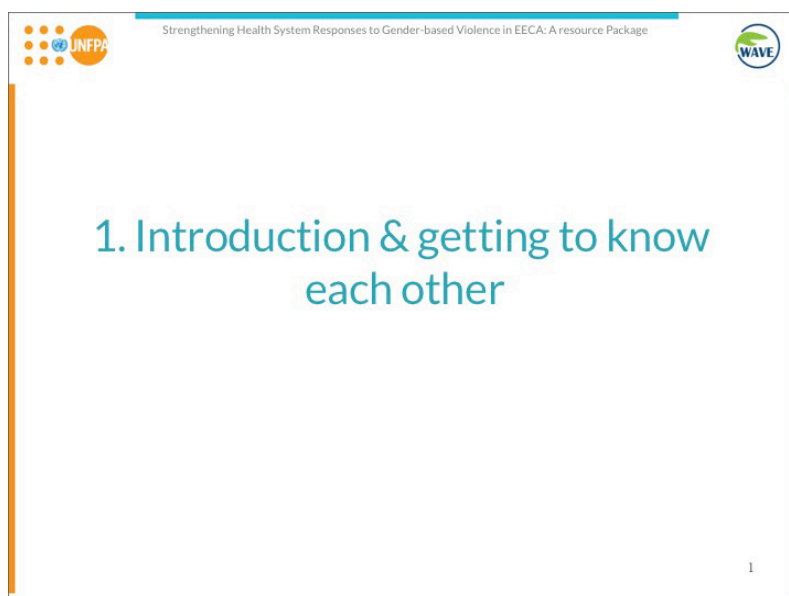
3 Training Modules

3.1. MODULE 1: INTRODUCTION AND GETTING TO KNOW EACH OTHER

3.1.1. OUTLINE OF THE MODULE

Duration of the module	45 minutes
Aim of the module	<ul style="list-style-type: none"> To provide participants with an outlook to the training (objectives, modules/themes covered) To enable the group to get to know each other and to build an atmosphere of trust To “break the ice” by giving each participant the opportunity to speak in front of the group in an informal setting
Main elements of the module and methods used	<ul style="list-style-type: none"> Introduction by the trainer Presentation by the trainer: outlook to the training session (objectives, schedule, breaks, modules/themes covered; PPT slides 1-6) Group exercise: Exercise 1: Introduce the partner
Notes for trainers	<p>Trainers should adapt the PPT for this module in line with the time available for the training and the modules covered.</p> <p>Exercise: Introduce the partner (30 minutes)</p> <p>Ask the group to get together in pairs of two and to ask the partner about his/her name, current profession and workplace, and professional experience. Depending on the setting you may want to add one question asking for slightly personal information, such as the person’s favourite dish, the last movie she/he has seen, or an adjective starting with first letter of the person’s first name that describes her/him best (such as “alert” for Anna or “energetic” for Eva). Write the questions on a flip chart or add them to the PPT. Allow 5 minutes for exchanging this information. Then, participants get together as a group and every participant introduces the partner.</p>
Materials for training session	Presentation: PowerPoint presentation Module 1

3.1.2. POWERPOINT PRESENTATION



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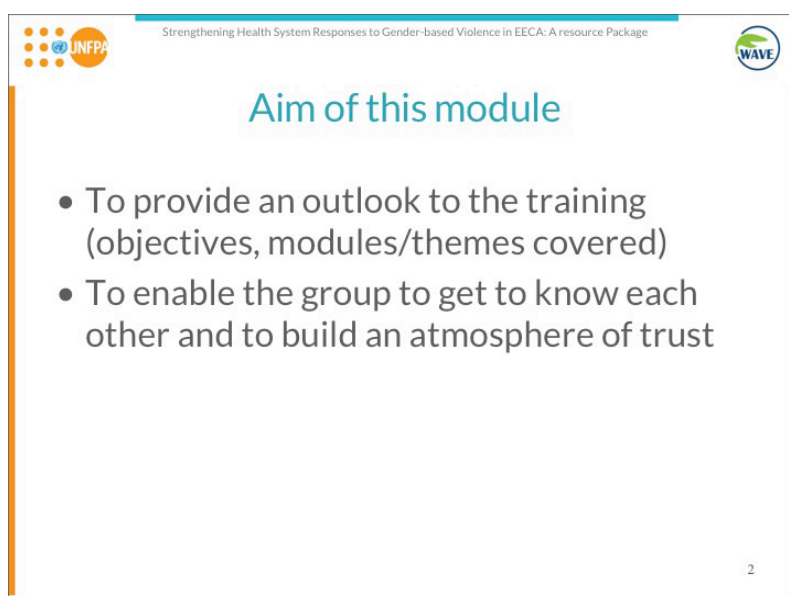
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WAVE

1. Introduction & getting to know each other

1

This slide is the first of two in a PowerPoint presentation. It features a white background with a blue header bar. The UNFPA logo is on the left and the WAVE logo is on the right. The title '1. Introduction & getting to know each other' is centered in a large, blue, sans-serif font. The number '1' is in the bottom right corner.



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WAVE

Aim of this module

- To provide an outlook to the training (objectives, modules/themes covered)
- To enable the group to get to know each other and to build an atmosphere of trust

2



This slide is the second of two in the presentation. It has the same header as slide 1. The title 'Aim of this module' is centered in a blue, sans-serif font. Below the title is a bulleted list with two items. The number '2' is in the bottom right corner.

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Outlook

- Objective of the training
- Background- training materials used
- Outlook to the training

3

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Objective of the training

- To strengthen the knowledge and skills of health care professionals to understand GBV
- To identify patients who have experienced GBV
- To provide survivors with appropriate care, support and referrals

4

Background – training materials used

- Training materials developed by Women Against Violence Europe (WAVE) in partnership with UNFPA, the United Nations Population Fund, Regional Office for Eastern Europe and Central Asia
- Available online at www.health-genderviolence.org

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Outlook to the training

1. Introduction and getting to know each other
2. Understanding GBV
3. The role of the health system in the response to GBV
4. Principles and standards for service provision
5. Identifying GBV
6. Medical examination and care
7. Documentation of GBV
8. Risk assessment and safety planning
9. Referrals
10. Evaluation and closing

6

3.2. MODULE 2: UNDERSTANDING GENDER-BASED VIOLENCE

3.2.1. OUTLINE OF THE MODULE

Duration of the module	2,5 hours
Aim of the module	To enable participants <ul style="list-style-type: none"> • to understand the concept of GBV, its causes and consequences on women's health, • to understand the dynamics of GBV in intimate partner relationships and the resulting behaviour of patients presenting with symptoms of GBV, and • to reflect on common myths surrounding GBV, corresponding facts and how such myths may influence the health care response to GBV.
Key learning messages	Violence against women <ul style="list-style-type: none"> • is gender-based, rooted in unequal power relationships between women and men and violates women's human rights, • affects women in public and private life and encompasses physical, sexual, psychological and economic violence, • affects women globally and in the EECA region, • has multiple root causes that require a comprehensive response, of which the health sector is an important part, • may affect women belonging to marginalized groups disproportionately in terms of either higher exposure to violence or specific obstacles in accessing services, • seriously impacts women and girls throughout the life cycle and has devastating impacts on their physical, sexual, psychological and behavioural health, and • in intimate partner relationships always affects children – as witnesses or direct targets of violence.
Background reading	UNFPA-WAVE Resource Package, Part I, chapter 1 Further readings: DEVAW, CEDAW GR 19, WHO et al 2013, WHO/LSHTM 2010, UN Secretary General 2006.
Main elements of the module and methods used	<ul style="list-style-type: none"> • Brainstorming: Defining GBV • Presentation by trainer (PPT slides 1-27, distribution of handouts 1-3) • Quiz and group discussion: Myths about GBV (handouts 6-6) • Presentation by trainer (PPT slides 28-42, distribution of handouts 7-8)
Notes for trainers	<p>Brainstorming: Defining GBV– duration - 20 minutes Ask participants to brainstorm on acts or patterns of behaviour they see as belonging to GBV. Write the answers on a flipchart. After the brainstorming, discuss the results before introducing the international definitions of GBV (PPT slides 4-7) Source: adapted from Roks/Myterna undated, cited in WAVE 2008</p> <p>Quiz and group discussion: Myths about GBV – 40 minutes Option 1: Distribute handout 5 and ask participants to complete it individually or in pairs (10 minutes). Then facilitate a group discussion in the big group along the questions for discussion listed on handout 5. Distribute handout 6 to present facts contrasting the myths (30 minutes). Option 2: Distribute handout 5 and split participants up in small groups. Assign 3-5 myths to each group and ask each group to discuss the questions for discussion listed on handout 5 (20 minutes). Then facilitate a group discussion in the big group. Distribute handout 6 to present facts contrasting the myths (see also PPT</p>

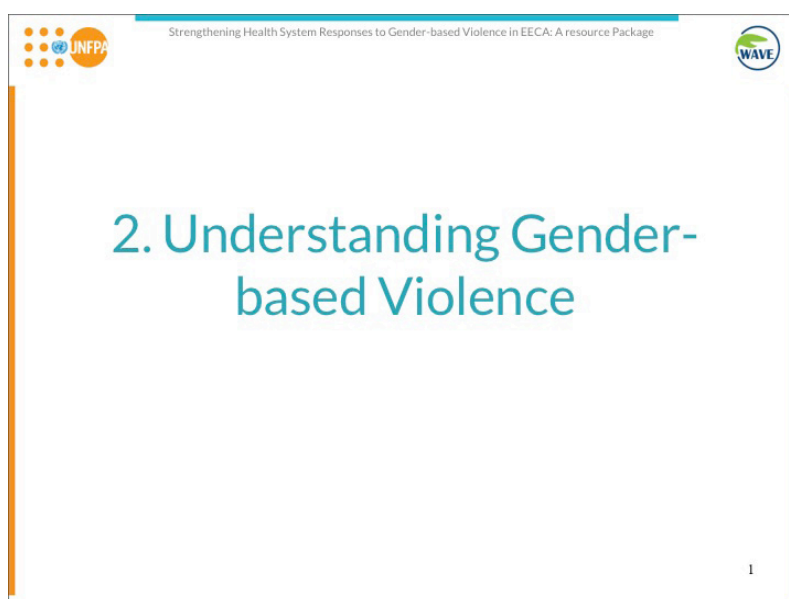
Materials for training session

Presentation: PowerPoint presentation Module 2

Handouts (in chronological sequence, following the structure of the PowerPoint presentation):

- Handout 1: Examples of acts of gender-based violence
- Handout 2: Examples of gender-based violence documented in Eastern Europe and Central Asia
- Handout 3: Prevalence studies on intimate partner violence and other forms of domestic violence in Eastern Europe and Central Asia
- Handout 4: Power and Control Wheel
- Handout 5: Quiz: Myths or facts about gender-based violence?
- Handout 6: Myths and facts about gender-based violence
- Handout 7: Health consequences of GBV
- Handout 8: Exposure to domestic violence: consequences on children

3.2.2. POWERPOINT PRESENTATION



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Aim of this module

- To understand the concept of GBV, its causes and consequences on women's health
- To understand the dynamics of GBV in intimate relationships and the resulting behaviour of patients showing symptoms of GBV
- To reflect on common myths surrounding GBV and on how they may influence the health care response to GBV

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Outlook

- Definitions and forms of GBV
- Scope of GBV (globally and in EECA)
- Causes of GBV
- Dynamics of violent relationships
- Myths and facts about GBV
- GBV and multiple discrimination
- Health consequences of GBV

3

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Definitions and Forms of GBV

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International definitions (1)

Violence against women: “Any act of **gender-based violence** that results in, or is likely to result in, **physical, sexual or psychological harm or suffering** to women, including threats of such acts, coercion or arbitrary deprivation of liberty, **whether occurring in public or in private life.**” *UN Declaration on the Elimination of Violence against Women (DEVAW, 1993)*

Gender-based violence: “Violence that is directed against a woman **because she is a woman** or that **affects women disproportionately.**” *CEDAW General Recommendation no. 19 (1992)*

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International definitions (2)

Violence against women is

- a **manifestation of the historically unequal power relations** between men and women, which have led to domination over and discrimination against women by men
- one of the crucial social mechanisms by which **women are forced into a subordinate position** compared with men
- constitutes a **violation of human rights** and a form of **discrimination** against women (*DEVAW*)

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International definitions (3)

Violence against women includes:

- Violence occurring in the **family**, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- Violence occurring within the **general community**, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- Violence perpetrated or condoned **by the State**, wherever it occurs. (*DEVAW*)

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Definition of GBV (1)

1. Violence against women is gender-based – it does not occur to women randomly.

- Structural problem embedded in unequal gender power relationships
- Gender dimensions of VAW:
 - GBV mainly affects women and girls
 - Women and men experience violence differently
 - Women are more likely to die at the hands of someone they know
 - Women survivors face specific barriers in accessing services
 - Fewer resources and options to access justice, care, and support
 - Laws and implementing authorities often fail to adequately respond to VAW

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Definition of GBV (2)

2. GBV is a violation of women’s human rights and a form of discrimination against women.

- Examples of violated rights:
 - Right to life
 - Right to be free from torture and inhuman or degrading treatment or punishment
 - Right to health
 - Right to equal protection by the law

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Definition of GBV (3)

3. Women experience GBV in all areas of life – the private and the public sphere.

- BUT most violence occurs in the family:
 - 30% of all women who ever lived in a partnership experienced physical or sexual violence by a partner (WHO 2013).
 - Women make up 2/3 of all persons killed by an intimate partner (but only 20% of homicide victims, UNODC 2014).

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Definition of GBV (4)

Domestic violence
Physical, sexual, psychological or economic violence,

- **within the family or domestic unit or between former or current spouses or partners,**
- whether or not the perpetrator shares or has shared the same residence with the victim (Art. 3 Istanbul Convention)

Intimate partner violence
Behaviour by an **intimate partner,**

- that causes physical, sexual or psychological harm,
- including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.
- It covers violence by both **current and former spouses and other intimate partners** (WHO et al 2013)

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Definition of GBV (5)

4. GBV encompasses a broad range of harmful acts:

- **Physical violence**, e.g.: slapping, hitting, pushing, choking, shaking, spitting, restraining, use of weapons. May or may not cause injuries
- **Sexual violence**, e.g. rape, other forms of sexual assault, forced marriage, forced abortion, forced sterilization, female genital mutilation (FGM)
- **Psychological violence**, e.g. threats, emotional violence, use of children
- **Economic violence**, e.g. withholding money, prohibiting the woman to work, excluding her from financial decisions

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Examples of GBV in EECA

Form of violence	Examples of countries
Bride kidnapping other forms of forced marriage	Kazakhstan, Kyrgyzstan, Turkey
Early/child marriage	Observed in most countries of the region
Gender-biased sex-selection in favour of boys	Albania, Armenia, Azerbaijan, Georgia
Ill—treatment and torture in detention	Observed in many countries of the region
Killings in the name of honour	Albania, Turkey
Bride kidnapping other forms of forced marriage	Kazakhstan, Kyrgyzstan, Turkey
Early/child marriage	Observed in most countries of the region

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Examples of GBV in EECA (2)

Form of violence	Examples of countries
Sexual harassment at the work place	Observed in many countries of the region
Sexual violence used as a weapon of war	Observed in many countries of the region
Suicides following experiences of domestic violence; suicide instigated by family members	Observed in many countries of the region
Trafficking in women	Observed in many countries of the region
Violence and harassment committed against sex workers	Observed in many countries of the region

H2

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Scope of GBV

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Global and regional prevalence estimates of GBV (WHO et al 2013)

Life-time prevalence rates	Global	Europe *
% women who have ever experienced IPV or sexual violence from a non-partner	35%	27,2%
% women who have been in a relationship and who have experienced IPV	30%	25,4%
% women who have experienced sexual violence from a non-partner	7,2%	5,2%

- For examples of country-specific prevalence data from Eastern Europe and Central Asia, see Handout 3.

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* Europe refers to low-and middle-income countries in Europe and Central Asia.

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Causes of GBV

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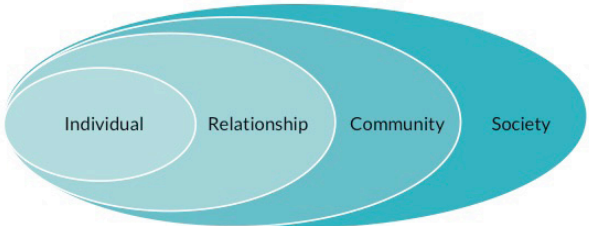
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The ecological framework for understanding GBV

- GBV is caused by a **combination of factors** that increase the risk of a man committing violence and the risk of a woman experiencing violence.



The diagram illustrates the ecological framework for understanding GBV. It consists of four nested, overlapping ovals representing different levels of influence: Individual (the innermost), Relationship, Community, and Society (the outermost). The ovals are shaded in a gradient from light blue to dark blue.

Source: Heise 1998

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The ecological framework

<p>Individual-level factors</p> <p>→ <i>Biological, personal history</i></p> <ul style="list-style-type: none"> • Low level of education • Young age (early marriage) • Past experiences of violence • Pregnancy • Use of alcohol (weak evidence for causal relationship) • Attitudes of violence as acceptable behavior 	<p>Relationship-level</p> <p>→ <i>Relationships with partners, family, peers</i></p> <ul style="list-style-type: none"> • Men with multiple partners • Partnerships with low marital satisfaction or continuous disagreements • Disparities in education status between partners • Family blaming the woman instead of the man for sexual violence
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Source: WHO/LSHTM 2010

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The ecological framework

Community-level

→ *Social relationships in school, workplace, and neighbourhood*

- Societies with community sanctions against violence have the lowest levels of IPV and SV
- Poverty – rather a “marker” than a factor increasing risk as such

Society-level factors

→ *Cultural and social norms that shape gender roles*

- Higher IPV when men have economic and decision-making powers in the household
- Ideologies of male sexual entitlement
- Social breakdown from conflicts or disasters

Source: WHO/LSHTM 2010

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Domestic Violence – Understanding the Dynamics of Violent Relationships

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Importance of understanding the dynamics

- Many health professionals share the norms, beliefs, and attitudes of broader society.
- Negative attitudes towards survivors can inflict additional harm on them.
- Not understanding the dynamics of violence may cause health professionals to wonder why she doesn't leave the abusive relationship and then think that she does not need or deserve help.

→ **Maintain a supportive, non-judgemental and validating attitude towards survivors.**

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Power & Control Wheel

Source: Domestic Abuse Intervention Project, Duluth.

USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt her. Threatening to leave her, to commit suicide, to report her to welfare. Making her drop charges. Making her do illegal things.

INTIMIDATION
Making her afraid by using looks, actions, and gestures. Sneaking things. Destroying her property. Abusing pets. Disabling weapons.

EMOTIONAL ABUSE
Putting her down. Making her feel bad about herself. Calling her names. Making her think she's crazy. Playing mind games. Humiliating her. Making her feel guilty.

ISOLATION
Controlling what she does, who she sees and talks to, what she reads, and where she goes. Limiting her outside involvement. Using jealousy to justify actions.

MINIMIZING, DENYING, AND BLAMING
Making light of the abuse and not taking her concerns about it seriously. Saying the abuse didn't happen. Shifting responsibility for abusive behavior. Saying she caused it.

USING CHILDREN
Making her feel guilty about the children. Using the children to relay messages. Using visitation to harass her. Threatening to take the children away.

ECONOMIC ABUSE
Preventing her from getting or keeping a job. Making her ask for money. Giving her an allowance. Taking her money. Not letting her know about or have access to family income.

MALE PRIVILEGE
Treating her like a servant: making all the big decisions, acting like the "master of the castle," being the one to define men's and women's roles.

physical **sexual**

physical **sexual**

POWER AND CONTROL

H4

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The cycle of violence (Walker 1978)

- Over time, phases of aggression increase in severity and duration; "honeymoon" phases become shorter.
- Women develop a strategy for survival (denying abuse, refusing help offered, defending the aggressor).

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Stockholm Syndrome (Grahams, Rawlings 1988)

- Explains why women in violent relationships develop close bonds and identify with the abuser
- For the first time observed: Stockholm, 1973 (hostage taking)
- 4 conditions:
 - The life of the victim is threatened.
 - The victim cannot escape or thinks that escape is impossible.
 - The victim is isolated from people outside.
 - The captor shows some degree of kindness to the victim.

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Concept of normalization of violence (Lundgren, 1993)

- Women may understand attacks as **manifestation of their own failure**.
- Many women feel strong **inner resistance to identify themselves as “battered women”** and their violent partners as “abusers.
- Making the violence experienced **look less serious** can be a **coping strategy** for women.
- It is only when the woman has left the violent relationship that she can describe her experiences as violent (“**renormalization process**”).

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Myths about GBV

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Why be aware of GBV myths?

Myths and stereotypical attitudes about GBV

- are harmful because they blame the survivor and not the perpetrator
- shape society and the health sector’s perceptions and responses
- may prevent health care providers from identifying GBV and providing care

H5

→ **Health care providers need to distinguish between myths and facts and maintain a professional and impartial attitude.**

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Examples of myths about GBV

- Battering is not a crime. Men have the right to control their wife's behaviour and to discipline them.
- Some women deserve the violence they experience.
- Battered women allow abuse to happen to them. They can leave if they really wanted to.
- Conflicts and losing control are a normal part of any relationship.
- Domestic violence is a private family matter and therefore the state or service providers have no right to intervene.

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GBV and multiple discrimination

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Women in conflict and post-conflict situations

Perpetrators	Consequences	Resources	Reporting
<ul style="list-style-type: none"> • Military personnel • Paramilitaries • Border guards • Resistance units • Male refugees • And more 	<ul style="list-style-type: none"> • Greater risk of unwanted pregnancies, STIs and HIV, and severe sexual and reproductive injuries 	<ul style="list-style-type: none"> • Inadequate infrastructure • Lack of professionals • Lack of basic medicines and health care supplies • Restriction on women's mobility and freedom of movement 	<ul style="list-style-type: none"> • Lower reporting due to: <ul style="list-style-type: none"> • Fear of reprisals • High level of stigma • Fear of exclusion from communities

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Women with disabilities

- Stereotypes contribute to sexual violence and lack of credibility when abuse is reported, e.g.
 - Regarding them as recipients of charity, objects of others' decisions
 - Portraying them as non-sexual beings, being compliant and timid
- Other forms of violence they experience:
 - Withholding of medication or communication aids
 - Refusal of caregivers to assist with bathing, dressing or eating
 - Restricting access to family, friends or phone calls
- Often denied control of sexual/ reproductive choices
 - Can lead to forced sterilization & forced termination of wanted pregnancies

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Migrant women

- Informal sector- domestic, agricultural, sex work
 - Lack of legal protection
- Limited access to justice and health care
 - Language barriers
 - Lack of information on rights & options
 - Exclusion from national health insurance coverage
- Fear of losing residency status
 - May prevent leaving an abusive partner or employer
- Undocumented migrant women: lack of access to protection because of fear of deportation

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Adolescent girls

At risk for	Consequences	Resources	Lower Reporting
<ul style="list-style-type: none"> • Child marriage • Incest • Sexual violence • Trafficking • IPV 	<ul style="list-style-type: none"> • Low birth-weight for newborns • Higher pre-natal, neonatal, and infant mortality • Morbidity • Pregnancy-related complications 	<ul style="list-style-type: none"> • Less awareness of services • Lack of financial resources to access services • Hesitant to seek services due to lack of confidentiality 	<ul style="list-style-type: none"> • They may not recognize the behaviour of perpetrators as violent • They are afraid of not being believed or taken seriously

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Older women

Consequences	Resources	Lower reporting
<ul style="list-style-type: none"> • Fear • Anger • Depression • Exacerbation of existing illness • Confusion and distress • Life-threatening injuries • Economic abuse 	<ul style="list-style-type: none"> • Knowing or depending on the perpetrator limits access to appropriate services • Lack of information about services • Lack of resources 	<ul style="list-style-type: none"> • Fear they will not be believed • Claims may be dismissed as illness or amnesia • They may be accustomed to abuse over time or not recognize abusive behaviour as domestic violence

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Rural women

At risk for	Causes	Resources	Lower reporting
<ul style="list-style-type: none"> • Violence • Sexual exploitation • Trafficking • Forced labour 	<ul style="list-style-type: none"> • Lower level of education and literacy • Traditional perceptions regarding the subordinate role of women (prevalent in rural areas) 	<ul style="list-style-type: none"> • Lack of services • Limited access due to long distance and lack of transportation 	<ul style="list-style-type: none"> • Due to lack of confidentiality in small villages

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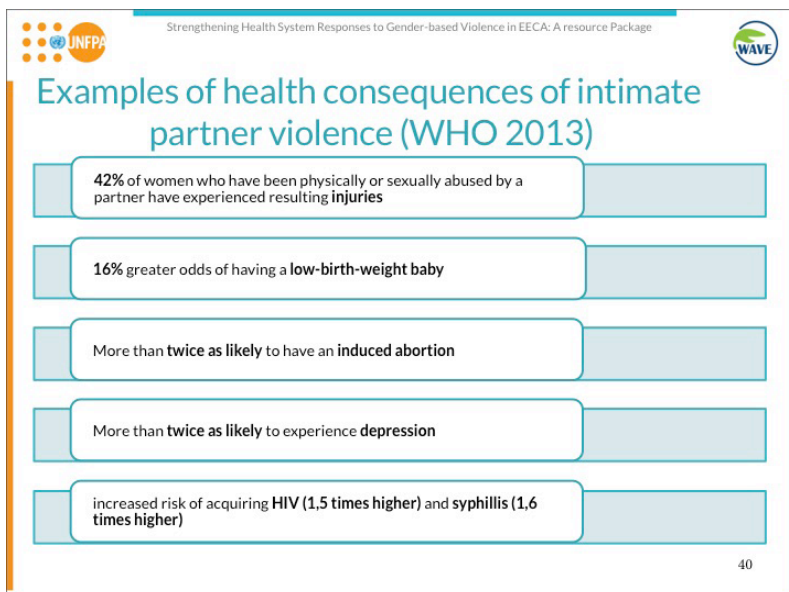
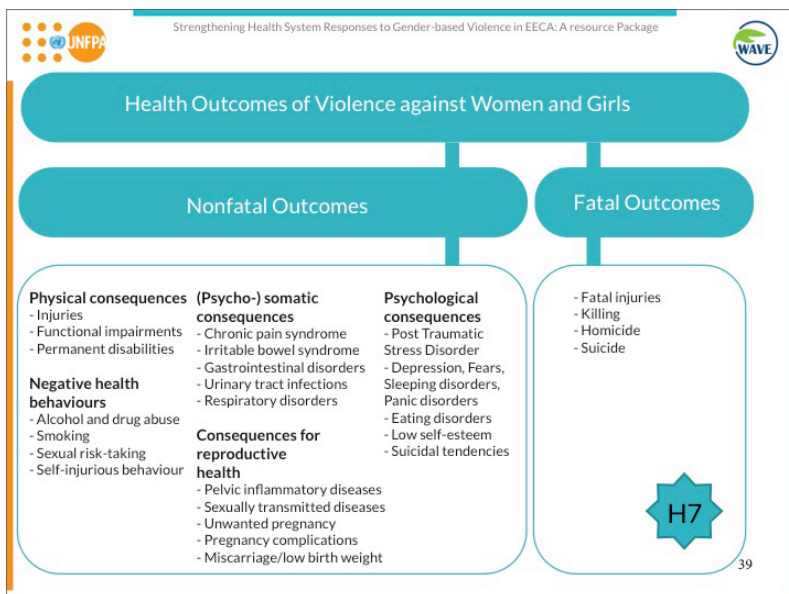
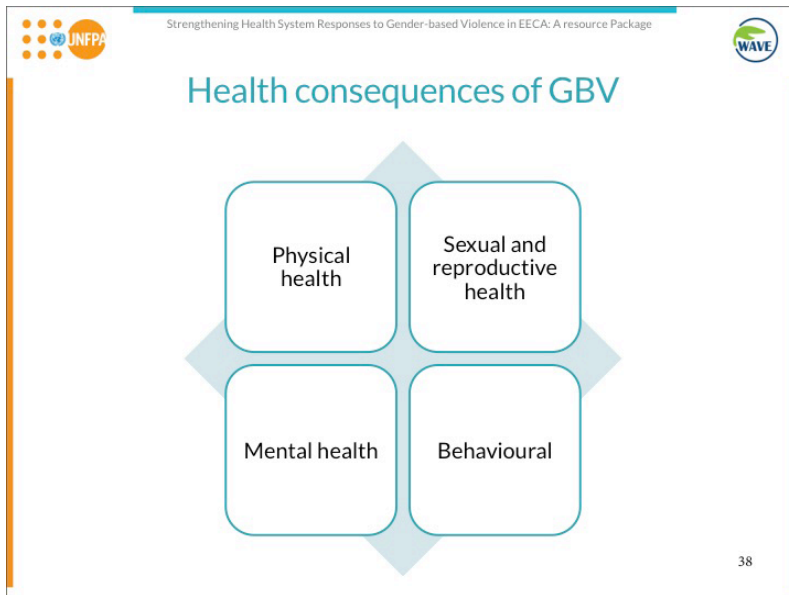
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Consequences of GBV

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Impact of violence on children (1)

- Directly or indirectly affected by domestic violence
 - Means of discipline: physical, cruel or humiliating punishment
 - Sexual abuse by family members
 - Injured (intentionally or unintentionally) during an attack against their mother
 - Witnessing violence against their mother
 - Used by the father/husband to coercively control their mother

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Impact of violence on children (2)

- Serious impact on their physical, psychological and sexual health and development
- Witnessing intimate partner violence against their mothers – even when the child is not physically targeted
 - Has negative social and health consequences for children, including anxiety, depression, poor school performance and negative health outcomes
 - Is a risk factor for experiencing (girls) or perpetrating (boys) intimate partner violence later in life



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3.2.3. HANDOUTS

HANDOUT 1: EXAMPLES OF ACTS OF GENDER-BASED VIOLENCE

Table 1: Examples of acts of gender-based violence against women

Physical violence	Physical force that results in bodily injury, pain, or impairment. The severity of injury ranges from minimal tissue damage, broken bones to permanent injury and death. Acts of physical violence include: <ul style="list-style-type: none"> • slapping, shoving, pushing, punching, beating, scratching, choking, biting, grabbing, shaking, spitting, burning, twisting of a body part, forcing the ingestion of an unwanted substance; • restraining a woman to prevent her from seeking medical treatment or other help; and • using household objects to hit or stab a woman, using weapons (knives, guns).
Sexual violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality, using coercion, by any person, regardless of their relationship to the victim, in any setting, including, but not limited to home and work (WHO 2002, cited in WHO 2013). Acts of sexual violence include: <ul style="list-style-type: none"> • rape, other forms of sexual assault; • unwanted sexual advances or sexual harassment (including demands for sex in exchange for job promotion or advancement or higher school marks or grades); • trafficking for the purpose of sexual exploitation; • forced exposure to pornography; • forced pregnancy, forced sterilization, forced abortion; • forced marriage, early/child marriage; • female genital mutilation; • virginity testing; and • incest.
Psychological violence (sometimes also referred to as emotional violence)	An action or set of actions that directly impair the woman's psychological integrity. Acts of psychological violence include: <ul style="list-style-type: none"> • threats of violence and harm against the woman or somebody close to her, through words or actions (e.g. through stalking or displaying weapons); • harassment and mobbing at the work place; • humiliating and insulting comments; and • isolation and restrictions on communication (e.g. through locking her up in the house, forcing her to quit her job or prohibiting her from seeing a doctor), • use of children by a violent intimate partner to control or hurt the woman (e.g. through attacking a child, forcing children to watch attacks against their mother, threatening to take children away, or kidnapping the child). These acts constitute both, violence against children as well as violence against women.
Economic violence	Used to deny and control a woman's access to resources, including time, money, transportation, food or clothing. Acts of economic violence include: <ul style="list-style-type: none"> • prohibiting a woman from working; • excluding her from financial decision making in the family; • withholding money or financial information; • refusing to pay bills or maintenance for her or the children; and • destroying jointly owned assets.

Sources: adapted from Warshaw/Ganley 1996, WHO 2003, WHO 2013

HANDOUT 2: EXAMPLES OF GENDER-BASED VIOLENCE DOCUMENTED IN EASTERN EUROPE AND CENTRAL ASIA

This table provides a snapshot of examples of GBV documented in the EECA region. It does not include domestic and intimate partner violence in their several forms, which are addressed by a range of national prevalence studies (see handout 3). This table is not exhaustive; nor does it imply that certain forms are common only in the EECA region and/or only in the countries listed as examples.

Form of violence	Definition	Examples of countries
Bride kidnapping and other forms of forced marriage	Bride kidnapping is the act of taking a woman or girl against her will through deception or force and using physical or psychological coercion to force her to marry one of her abductors (HRW 2006). Forced marriage is the union of two persons at least one of whom has not given their full and free consent to the marriage (CoE PA 2005).	Kazakhstan, Kyrgyzstan, Turkey ¹⁴
Early/child marriage	Child marriage is the union of two persons at least one of whom is under 18 years of age (CoE PA 2005).	Observed in most countries of the region ¹⁵
Gender-biased sex-selection in favour of boys	Sex selection can take place before a pregnancy is established, during pregnancy through prenatal sex detection and selective abortion, or following birth through infanticide or child neglect (OHCHR/UNFPA/UNICEF/UN Women/WHO 2011).	Albania, Armenia, Azerbaijan, Georgia
Ill-treatment and torture in detention	Violence committed against women in detention facilities (e.g. police cells, prisons, immigration detention centres). Forms of such violence against women in detention include: sexual violence, including rape; inappropriate surveillance during showers or undressing; strip searches conducted by or in the presence of men; and verbal sexual harassment, or demands for sexual acts in exchange for privileges, goods or basic necessities (UN Secretary-General 2006). Further, security forces may use ill-treatment, extrajudicial execution, torture, rape, or sexual abuse while in detention to make women reveal the whereabouts of male relatives or to “confess” to crimes (UN Special Rapporteur VAW 2006).	Observed in many countries of the region. ¹⁶
Killings in the name of honour	A practice in which women and girls suspected of defiling their family’s honour by their misconduct can be killed by their brother, father, uncle or another relative who thus restores the said honour. Honour killings are executed for instances of rape, infidelity, flirting or any other instance perceived as disgracing the family’s honour, and the woman is then killed by a male relative to restore the family’s name in the community. The allegation of misconduct alone is considered enough to defile a man’s or family’s honour, and is therefore enough to justify the killing of the woman. The men who commit the murder typically go unpunished or receive reduced sentences (UN Women Virtual Knowledge Centre).	Albania, Turkey ¹⁷
Sexual harassment at the work place	Harassment of a person because of her or his sex, as by making unwelcome sexual advances or otherwise engaging in sexist practices that cause the victim loss of income, mental anguish and the like (UN Women Virtual Knowledge Center).	Observed in many countries of the region
Sexual violence used as a weapon of war	Sexual violence used or commissioned as a tactic of war in order to deliberately target civilians or as a part of a widespread or systematic attack against civilian populations (Security Council 2008).	Observed in many countries of the region
Suicides following experiences of domestic violence; suicide instigated by family members	Suicides committed by women to escape violence and oppression, sometimes prompted by pressure from family members for in adherence to “proper” or “honourable” conduct. In some cases, recorded suicide cases may also be disguised murders (UN Special Rapporteur VAW 2007).	Observed in many countries of the region

14 Female and Feminist NGOs Initiatives on CEDAW - Kazakhstan 2014; HRW 2006; UN Country Team Kyrgyz Republic/UNFPA 2008, CEDAW 2010.

15 UNFPA 2014.

16 CoE PA 2011.

17 CEDAW 2010, CEDAW 2010a.

<p>Trafficking in women</p>	<p>The recruitment, transportation, transfer, harbouring or receipt of a woman, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over a woman, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs (UN 2000).</p>	<p>Observed in many countries of the region</p>
<p>Violence and harassment committed against sex workers</p>	<p>The use of harassment or violence, whether psychological, physical, sexual, or economical, against a sex worker. Sexual violence can also include forcing sexual intercourse without a condom (PROI 2011).</p>	<p>Observed in many countries of the region</p>

HANDOUT 3: PREVALENCE STUDIES ON INTIMATE PARTNER VIOLENCE AND OTHER FORMS OF DOMESTIC VIOLENCE IN EASTERN EUROPE AND CENTRAL ASIA

Table 4: Prevalence studies on intimate partner violence and domestic violence in the EECA region⁷

ALBANIA																
Albanian Institute of Statistics, UNDP (2013), Domestic Violence in Albania: National Population Based Survey																
Findings																
Intimate partner violence								Violence committed by other family members (non-partners)								
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence		
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	
14,70%	23,70%	5,00%	7,90%	52,80%	58,20%	4,30%	7,40%	-	-	-	-	-	-	-	-	
Background information																
Sample				Year(s) of the survey				Violence perpetrated by				Forms of violence				Data disaggregated by
Scope: national Size: 3.598 women between 15-55 years old				2013				Intimate partners				Physical Psychological Economic Sexual				Gender, age and relationship
Albanian Institute of Statistics, UNDP (2009), Domestic Violence in Albania: National Population Based Survey																
Findings																
Intimate partner violence								Violence committed by other family members (non-partners)								
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence		
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	
-	39,10%	-	12,70%	-	31,20%	-	-	-	0,2-13,8%	-	-	-	-	-	-	
Background information																
Sample				Year(s) of the survey				Violence perpetrated by				Forms of violence				Data disaggregated by
Scope: national Size: 2.590 households. 2.590 women between 15-49 years old				2007-2008				Intimate partners Other family members				Physical Psychological Sexual				Gender, age and relationship
ARMENIA																
UNFPA, National Statistical Service (2011), Nationwide Survey on Domestic Violence Against Women in Armenia 2008-2010																
Findings																
Intimate partner violence								Violence committed by other family members (non-partners)								
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence		
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	
-	8,90%	-	3,30%	-	25,00%	-	-	-	2,30%	-	0,10%	-	-	-	-	
Background information																
Sample				Year(s) of the survey				Violence perpetrated by				Forms of violence				Data disaggregated by
Scope: Urban areas Size: 2.763 women between 15-59 years old				2008-2010				Intimate partners Other / non partner				Physical Economic Psychological Sexual				Gender, age and relationship

AZERBAIJAN

UNFPA (2011), National Survey Report on Violence Against Women in Azerbaijan

Findings

Intimate partner violence								Violence committed by others							
Physical violence		Sexual violence		Emotional*		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
5,00%	15,00%	3,00%	7,00%	-	25,00%	-	-	11,00%	-	5,00%	-	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: 9 regions Size: 4.760 households. 3.000 women between 15-49 years old	2008	Intimate partners Others	Physical Emotional Sexual	Gender, age, region and relationship

*81% of all ever-partnered women covered in the survey reported being exposed to some form of controlling behaviour

BELARUS

UN Office in Belarus, Sociological and Political Research Center of the Belarusian State University (2008), Main Outcomes of the Survey on Domestic Violence Assessment in the Republic of Belarus in 2008

Findings*

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	24,20%	-	13,10%	-	83,20%	-	22,50%	-	-	-	-	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 512 women between 18-60 years old and 488 men	2008	Intimate partners Other family members	Physical Psychological Economic Sexual	Gender, age and relationship

*Information provided by UNFPA Country Office in Belarus, July 2014

BOSNIA AND HERZEGOVINA

Gender Equality Agency of Bosnia and Herzegovina (2013), Prevalence and Characteristic of Violence Against Women in BiH

Findings

Violence against women by their current partner*								Violence committed by other family members or relatives (non-partners)							
Physical violence		Sexual**		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
2,10%	7,70%	-	5,10%	10,20%	25,70%	-	-	13,90%	0,70%	-	-	2,80%	14,90%	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 3.300 women over 18 years old	2012	Intimate partners Other family members or relatives Others	Physical Psychological Economic Sexual	Gender, age and relationship

* Calculated for women who had partners at the time the survey was conducted

**For sexual violence, the figure is for current and former partners.

GEORGIA

UNFPA (2010), National Research on Domestic Violence Against Women in Georgia

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
3,90%	6,90%	1,95%	3,90%	-	14,30%	-	-	-	2,00%	-	0,20%	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 2.385 women between 15-49 years old	2009	Intimate partners Other domestic relationships	Physical Psychological Sexual	Gender, age and relationship

KAZAKHSTAN

The Agency of Statistics, RK, UNICEF, UNFPA (2012), Multiple Indicator Cluster Survey in the Republic of Kazakhstan, 2011-2012

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
7,10%	15,40%	1,30%	3,70%	8,50%	13,70%	-	7,00%	-	-	-	-	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national (urban and rural area) Size: 10.581 women between 15-49 years old	2010-2011	Intimate partners Other / non partner*	Physical Economic Psychological Sexual	Gender, age, relationship, place of residence (urban/rural), region, education, wellbeing

* From the report it is not possible to extract data on violence committed by other family members (non-partners).

KOSOVO (UNSCR 1244)

Agency for Gender Equality (2008), Security Begins at Home: Research to Inform the First National Strategy and Action Plan Against Domestic Violence in Kosovo

Findings

Intimate partner violence								Violence committed by family members (including partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	1,30%	18,00%	-	3,50%	10,30%	30,00%	-	15,00%

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 1.256 households. 636 women and 620 men over 18 years old	2008	Intimate partners Other family members	Physical Psychological Economic Sexual	Gender, age and relationship

KYRGYZSTAN

National Statistical Committee of the Kyrgyz Republic, Ministry of Health Kyrgyz Republic, ICF International (2012), Kyrgyz Republic Demographic and Health Survey

Findings

Violence against women								Spousal violence							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
13,00%	23,00%	-	3,00%	-	-	-	-	17,00%	25,00%	3,00%	4,00%	10,00%	14,00%	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 8.208 women and 2.413 men between 15-49 years old	2012	Intimate partners Other family members	Physical Psychological Sexual	Gender, age, region, education, marital status and relationship

FORMER YUGOSLAV REPUBLIC OF MACEDONIA

Government of the Republic of Macedonia (2012), Report on the National Survey of Domestic Violence

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological* violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	6,1%	-	1,5%	-	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 2.100 women and men over 15 years old	2012	Family members	Physical Sexual Psychological including economic	Gender, age, employment status and income levels, educational level, ethnicity, location, number of household members/children

* Prevalence rate for psychological violence: 36,86% (not disaggregated by gender).

** The study addresses economic violence as part of psychological violence.

MOLDOVA

National Bureau of Statistics of the Republic of Moldova, UNDP, UN Women, UNFPA (2011), Violence Against Women in the Family in the Republic of Moldova

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
9,00%	40,00%	4,00%	19,00%	26,00%	60,00%	4,20%	10,00%	1,00%	5,90%	-	-	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 1.575 women between 15-65 years old	2010	Intimate partners Other family members	Physical Psychological Sexual Economic	Gender, age and relationship

ROMANIA

Centrul de Sociologie Urbana si Regionala (2008), Violenta Domestica in Romania, Ancheta Sociologica la Nivel National

Findings

Intimate partner violence								Violence committed by family members (including partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	4,70%	13,50%	0,50%	2,50%	10,40%	18,50%	2,40%	5,30%

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 854 women and 450 men above 18 years old	2008	Intimate partners Other family members	Physical Economic Psychological Sexual	Gender, region and age

SERBIA

SeConS – Group (2010), The Mapping on Domestic Violence Against Women in Central Serbia

Findings

Intimate partner violence								Violence committed by family members (including partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	10,10%	21,60%	1,20%	3,80%	31,80%	48,70%	15,80%	11,40%

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national (except Vojvodina and Kosovo) Size: 2.500 women between 18-75 years old	2010	Intimate partners Other family members	Physical Psychological Sexual Economic	Gender, age, region, employment status, and urban/rural areas

TAJKISTAN

Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health Tajikistan, ICF International (2013), Tajikistan Demographic and Health Survey 2012

Findings

Violence against women								Spousal violence							
Physical violence*		Sexual violence**		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
13,00%	19,00%	-	4,00%	-	-	-	-	15,00%	20,00%	3,00%	4,00%	10,00%	11,00%	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 9.656 women between 15-49 year old	2012	Intimate partners Other family members	Physical Psychological Sexual	Gender, age, region, education, marital status and relationship

* In 69% of cases, physical violence was perpetrated by the current husband or partner and 13% by the former husband/partner.

**Concerning sexual violence, 90% of these cases were perpetrated by the current or former husband/partner.

TURKEY

Turkish Republic Prime Ministry Directorate General on the Status of Women (2009), National Research on Domestic Violence Against Women in Turkey

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
10,00%	39,00%	7,00%	15,00%	25,00%	44,00%	-	-	-	18,00%	4,00%	3,00%	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 12.795 women between 15-59 years old	2008	Intimate partners Other family members	Physical Psychological Sexual	Gender, age and relationship

UKRAINE

UNDP (2010), Prevalence of Violence in Ukrainian Families

Findings

Intimate partner violence								Violence committed by other family members (non-partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
-	-	-	-	-	-	-	-	-	21,00%	-	1,00%	-	35,00%		

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 1.800 men and women over 18 years old	2009-2010	Intimate partners Other family members	Physical Psychological Sexual	Gender, age and relationship

Ukrainian Center for Social Reforms, State Statistical Committee Ukraine, Ministry of Health Ukraine, Macro International Inc. (2008), Ukraine Demographic and Health Survey 2007

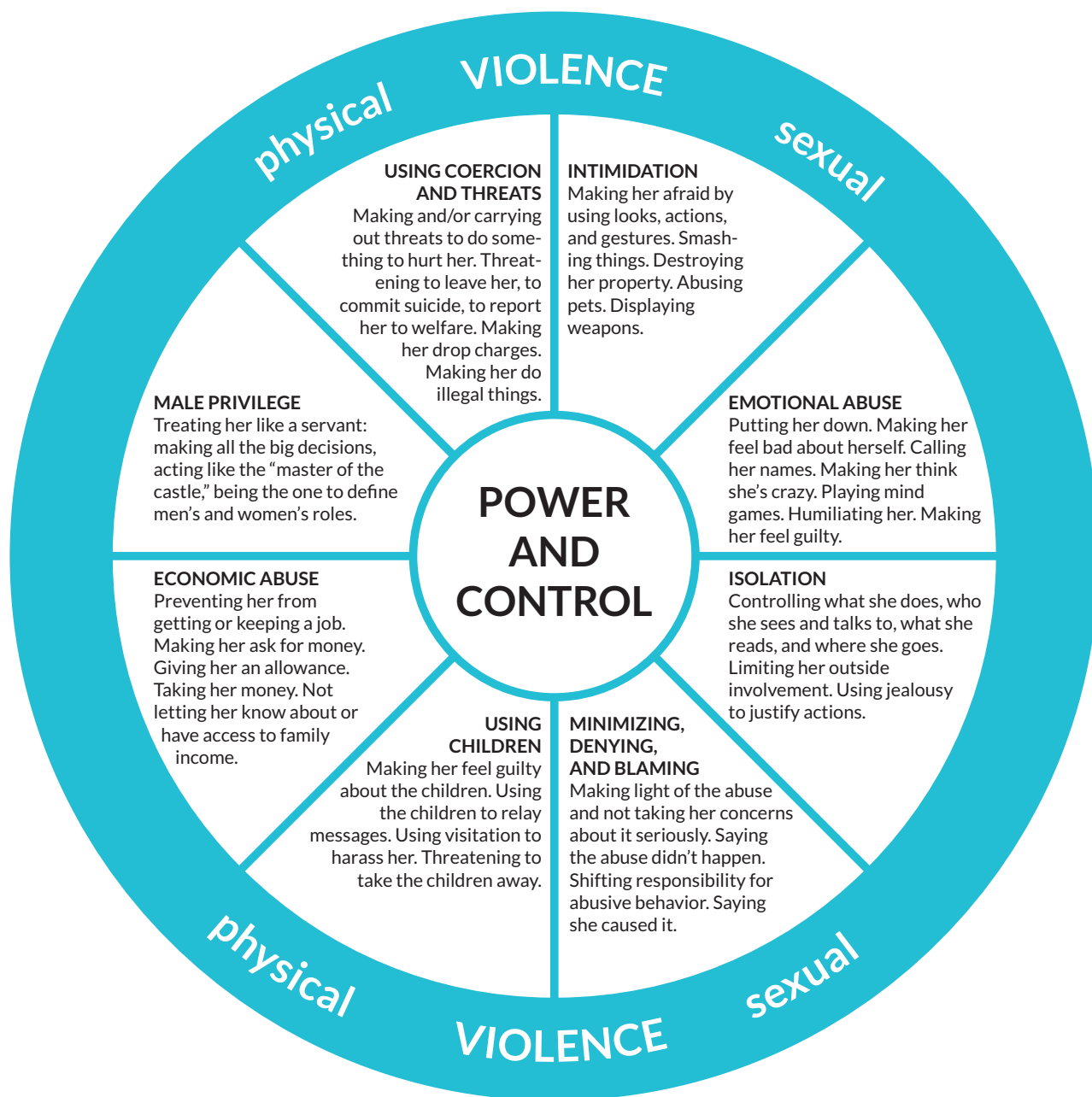
Findings

Intimate partner violence								Violence committed by others (including partners)							
Physical violence		Sexual violence		Psychological violence		Economic violence		Physical violence		Sexual violence		Psychological violence		Economic violence	
12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time	12 months	life-time
10,40%	12,70%	2,20%	3,30%	-	22,40%	-	-	8,80%	16,90%	-	5,40%	-	-	-	-

Background information

Sample	Year(s) of the survey	Violence perpetrated by	Forms of violence	Data disaggregated by
Scope: national Size: 6.842 women and 3.178 men between 15-59 years old	2007	Intimate partners Other family members	Physical Psychological Economic Sexual	Gender, age and relationship

HANDOUT 4: POWER AND CONTROL WHEEL



Source: Adapted from Domestic Abuse Intervention Center Duluth, MN 218/722-4134

HANDOUT 5: QUIZ: MYTHS OR FACTS ABOUT GENDER-BASED VIOLENCE?

INSTRUCTIONS FOR PARTICIPANTS:

Read the following statements and mark if you believe they are right or wrong.

1. Women allow intimate partner violence to happen to them and if they really want to, they can leave their abusive partners.
 true false
2. Conflicts and discord are a normal part of any relationship.
 true false
3. Men and women are equally violent to each other.
 true false
4. Domestic violence happens only to a certain type of person.
 true false
5. GBV only includes physical abuse (hitting, punching, biting, slapping, pushing, etc).
 true false
6. GBV is caused by substance abuse such as alcohol and/or drugs.
 true false
7. Women should tolerate violence to keep the family together.
 true false
8. Domestic violence is a private family matter, in which the state has no right to intervene. How a man treats his wife is a private matter.
 true false
9. Sex workers cannot experience rape.
 true false
10. A man cannot rape his wife.
 true false
11. Most GBV is perpetrated by strangers.
 true false

QUESTIONS FOR DISCUSSION:

Review these statements in light of the following questions:

- » Is the statement true or false?
- » Why is it true or not true?
- » Where does it come from?
- » How does it affect the way you work with patients in your daily work?

Source: adapted from Roks/Myterna undated cited in WAVE 2008

HANDOUT 6: MYTHS AND FACTS ABOUT GENDER-BASED VIOLENCE

MYTH 1: WOMEN ALLOW INTIMATE PARTNER INTIMATE VIOLENCE TO HAPPEN TO THEM AND IF THEY REALLY WANT TO, THEY CAN LEAVE THEIR ABUSIVE PARTNERS.

Facts: In no case does a woman deserve to be abused. The international community has recognized violence against women as a human rights violation that cannot be justified and requires a comprehensive state response. As explained in several theories on the dynamics of violent relationships, such as the Stockholm Syndrome or the Power and Control Wheel, perpetrators use a combination of tactics of control and abuse that make it very difficult for women to escape the violence. It is also important to understand that women who experienced violence from an intimate partner and seek to leave the relationship in order to ensure their own and their children's safety paradoxically face an increased risk of repeating and even escalating violence. Women are also prevented from leaving violent relationships due to feelings of shame and guilt, lack of safe housing, or the belief that divorce is wrong for children (adapted from Hagemester et al 2003).

MYTH 2: CONFLICTS AND DISCORD ARE A NORMAL PART OF ANY RELATIONSHIP

Facts: “Everybody can lose control,” is a commonly used excuse to justify intimate partner violence. However, violence is not about “losing” control – rather, it is about “gaining” control through the use of threats, intimidation, and violence, as demonstrated by the Power and Control Wheel. Violence in a relationship is not normal - it is a manifestation of historically unequal power relations between men and women (DEVAW).

MYTH 3: MEN AND WOMEN ARE EQUALLY VIOLENT TO EACH OTHER.

Facts: The majority of those affected by GBV, in particular intimate partner violence, are women and girls. World-wide, almost half (47%) of all female victims of homicide in 2012 were killed by their intimate partners or family members, compared to less than 6% of male homicide victims (UNODC 2013). According to EU-wide data, 67% of physical violence and 97% of sexual violence perpetrated against women is committed by men (FRA 2014). This fact is also confirmed by research from the region. For example, a study from Moldova shows that the perpetrators of violence against women are often family members, the overwhelming majority being husbands or former husbands (73.4%), followed by fathers or stepfathers (13.7%) (UN Special Rapporteur VAW 2009a).

MYTH 4: DOMESTIC VIOLENCE HAPPENS ONLY TO A CERTAIN TYPE OF PERSON.

Facts: GBV is a global problem of pandemic proportions. 35% of all women worldwide have experienced either physical and/or sexual violence from an intimate partner or sexual violence from a non-partner (WHO et al 2013). While a number of factors may increase the risk of women experiencing GBV, domestic violence affects all women, irrespective of socio-economic status, educational achievements, ethnic origin, religion or sexual orientation (IGWG undated). While some studies have found that women living in poverty are disproportionately affected by intimate partner violence and sexual violence, it has not been clearly established whether it is poverty as such that increases the risk of violence or rather other factors accompanying poverty.

MYTH 5: GENDER-BASED VIOLENCE ONLY INCLUDES PHYSICAL ABUSE (HITTING, PUNCHING, BITING, SLAPPING, PUSHING, ETC.).

Facts: Physical abuse is just one form of violence. International law defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women” (DEVAW, Art. 1). For example, prevalence research from Romania shows that 18,5% of women experienced psychological violence from family members including intimate partners; the percentage for economic violence was 5,3% (Centrul de Sociologie Urbana si Regionala 2008). Some studies show that women often consider psychological abuse and humiliation more devastating than physical assault (Casey 1988, cited in Heise et al 1994).

MYTH 6: GENDER-BASED VIOLENCE IS CAUSED BY SUBSTANCE ABUSE SUCH AS ALCOHOL AND/OR DRUGS.

Facts: While substance abuse is present in many domestic violence cases and may lower inhibitions, it is a contributing factor, not the cause of violence (see also chapter 1.3). Neither should alcohol or drug abuse be used to justify violence (IGWG undated). Not all perpetrators of violence use drugs or alcohol, and not all those who use drugs or alcohol are violent (Roberts 1984, cited in Hagemester et al 2003).

MYTH 7: WOMEN SHOULD TOLERATE VIOLENCE TO KEEP THE FAMILY TOGETHER.

Facts: Every woman has the right to safety, dignity and a life free of violence. Every woman survivor of GBV has the right of self-determination- she can decide to stay with her abusive partner or to leave him and either way she is entitled to support and protection from the state. The argument that women should stay in an abusive relationship is often justified for the well-being of the children. However, it is well established that the safety and health of children are negatively affected when children experience or witness domestic violence. State support for perpetrator programmes teaching violent men to adopt non-violent behaviour in interpersonal relationships is key for preventing further violence and changing violent behavioural patterns (Art. 16 Istanbul Convention). This is of particular importance in situations where women are not willing or able to leave a violent relationship, for instance, due to economic dependence and risk of stigmatization by the community, particularly in rural areas. At the same time, perpetrator interventions should supplement, but not replace, or withdraw resources from, the work of women-specific support services.

MYTH 8: DOMESTIC VIOLENCE IS A PRIVATE FAMILY MATTER, IN WHICH THE STATE HAS NO RIGHT TO INTERVENE. HOW A MAN TREATS HIS WIFE IS A PRIVATE MATTER.

Facts: Violence against women is a human rights violation, no matter whether it occurs in the family or in the public sphere. Under international human rights law such as CEDAW or the Istanbul Convention, states are not only entitled to eliminate all forms of violence against women, they are obligated to do so.

MYTH 9: SEX WORKERS CANNOT EXPERIENCE RAPE.

Facts: International definitions of rape and other forms of sexual assault (WHO 2013) focus on the type of violent acts committed, without consideration of who is the perpetrator or the victim. Accordingly, any man who forces a woman into a sexual act against her is committing rape, whatever her profession. A survey from Bosnia-Herzegovina demonstrates the high amount of violence experienced by sex workers- three out of five sex workers surveyed reported experiences of sexual violence (PROI 2011).

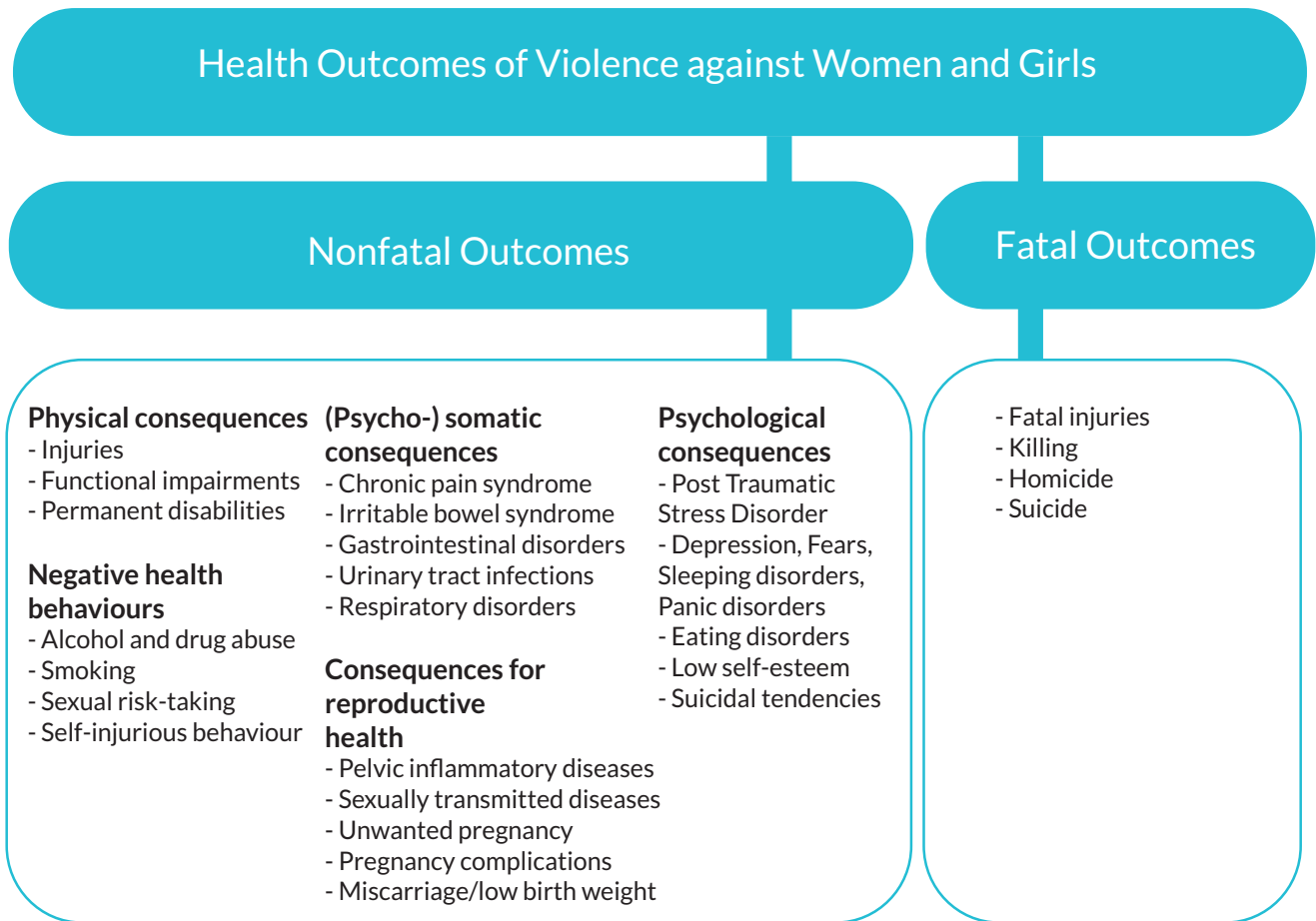
MYTH 10: A MAN CANNOT RAPE HIS WIFE.

Facts: As mentioned earlier, rape is defined by an action and not by the identity of the perpetrator or the victim. Accordingly, any forced sexual intercourse is rape, irrespective of whether the woman survivor is married to the perpetrator or not. This statement is also grounded in international human rights law definitions, which encompasses all forms of physical, sexual, psychological or economic violence against women, no matter if they are committed in the family or in public. Even though international human rights law obliges states to criminalize and prosecute rape, not all jurisdictions recognize marital rape as a criminal offence, resulting in impunity of rape committed by intimate partners.

MYTH 11: MOST GBV IS PERPETRATED BY STRANGERS.

Facts: The majority of women experience GBV at the hands of a person close to them, as confirmed by the 2013 Global Study on Homicide. It is estimated that women make up 79% of all persons killed by their intimate partners. Additionally, 47% of all women killed in 2012 were killed by their family members or intimate partners; for men, the respective percentage totals 6% (UNODC 2014). This statement is confirmed for instance by a study from Kyrgyzstan, of which 3% of the women interviewed have been victims of sexual violence, with 98% of the perpetrators being current or former partners or husbands (National Statistical Committee 2012).

HANDOUT 7: HEALTH CONSEQUENCES OF GENDER-BASED VIOLENCE ON WOMEN



Source: Hellbernd et al 2004, CHANGE 1999, all cited in PRO TRAIN 2009

HANDOUT 8: EXPOSURE TO DOMESTIC VIOLENCE: CONSEQUENCES ON CHILDREN AND ADOLESCENTS

Exposure to Domestic Violence and Child Development	
Developmental expectations	Potential consequences of exposure to domestic violence
Infancy (Birth-12 months) Trust versus mistrust (E. Erikson) Attachment; survival (Bowlby), Nonverbal; sensorimotor stage (Piaget) Essential brain development	Poor health Disrupted sleeping patterns Excessive fussing, crying, screaming Unpredictable or disrupted care resulting inability to get basic needs met Exposure possibly impairs or alters brain development Developmental delays in motor skills such as sitting, crawling, walking
Toddler (12 months-3 years) Beginning to have initiative Essential brain development Pre-operational/symbolic stage (Piaget)	Impaired/altered brain development Delays in speech and communication skills Emotional and physical disregulation Difficulties with sleep regulation and potty training
Preschool (3-6 years) Magical thinking Pre-operational/symbolic stage (Piaget) Autonomy versus shame and doubt (E. Erikson) Cause-effect still undeveloped	Signs of fear/terror; yelling/hollering Irritable behaviour/mood Hiding Shaking, stuttering Emotional distress Somatic complaints Regression to behaviours of previous stage of development Attribution to self of problems going on in household, family
Middle childhood (6-12 years) Cognitive development changes markedly Concrete operational stage (Piaget) Industry versus inferiority (E. Erikson) Orientation to learning and peer relationships	Poor peer relationships and difficulties making friends; poor social skills Poor academic performance "School phobia" Somatic complaints Regression to previous stage of development Guarded, secretive; denial Anxiety and agitation Displays of strong anger and hostility Irritability often associated with depression
Adolescents (12-17 years) Identity versus identity confusion (E. Erikson) Relationships and identification with peers over identification with family Formal operational stage (Piaget)	Poor peer relationships Use of aggression for solving problems Project blame on others Anxiety and lack of ease with self and relationships Manipulation of mothers Aggression toward mother Dating violence – perpetrator or victim Running away Delinquent behavior Truancy Not finishing school Substance abuse
Early adulthood (18-20 years) Pairing/coupling Development of intimate relationships Intimacy versus isolation (E. Erikson) Formal operational stage (Piaget) Differentiation of self from family of origin Development of family of choice Parenting decisions	Courtship/dating violence Violent or abusive relationships Relationship or marital conflict Difficulties in separating from family of origin Parenting difficulties Maltreatment of children/others' children Employment problems Substance abuse Housing problems

Source: adapted from Hagemester et al 2003

3.3. MODULE 3: THE ROLE OF HEALTH SYSTEMS IN THE RESPONSE TO GENDER-BASED VIOLENCE

3.3.1. OUTLINE OF THE MODULE

Duration of the module	2 hours
Aim of the module	<p>To enable participants</p> <ul style="list-style-type: none"> • to understand why the health sector plays a crucial role in responding to GBV, • to understand what this role entails, at the levels of both front line staff and management of health facilities, and • to reflect on the barriers to effective health system responses to GBV that exist at the levels of both the patient and the health care professional and on ways to address these barriers.
Key learning messages	<ul style="list-style-type: none"> • States are under an obligation under international human rights law to improve health system responses to GBV. • Health care professionals are the first and sometimes only point of contact for women survivors of GBV seeking help. • Health care professionals who are knowledgeable and skilled in the response to GBV can make an important contribution to improving the health, wellbeing and safety of the patient. At the same time, lack in knowledge and skills on the part of health care professionals can put women at further risk and harm. • Health facilities need to provide an institutional framework to guide the day-to-day interventions of health care staff, to address any barriers to an effective response, and to ensure sustainability of efforts.
Background readings for trainer	<p>UNFPA-WAVE Resource Package, Part I, chapters 2.1-2.4</p> <p>Further readings: CEDAW, Istanbul Convention, IFFP 2010, UNFPA 2001, WHO 2013</p>
Methods	<ul style="list-style-type: none"> • Presentation by trainer (PPT slides 1-15, handout 8) • Group exercise: The role of health care professionals (handout 9) • Presentation by trainer (PPT slides 16-23, handout 10) • Group exercise: Barriers to an effective health care response (handout 11) • Presentation by trainer (PPT slides 24-25, handout 12)

Notes for trainers

When preparing the presentation, check the website of the Council of Europe Istanbul Convention for any updates on signatures and ratifications by the country/countries covered in your group of participants.

Group exercise: The role of health care professionals (handout 10) – duration: 45 minutes

Distribute handout 10. Divide participants in small groups and ask them to read the case study and answer the questions listed on the handout in the small group (20 minutes for group work). Ask each group to nominate a rapporteur, to write the answers on flip chart paper and to present them to the group (max. 5 minutes for presentation) to the group. Wrap up the summaries presented, using PPT slide 20.

Group exercise: Barriers to an effective health care response to GBV (handout 12) – duration: 45 minutes

Distribute handout 12. Divide participants in small groups and ask them to read and answer the questions listed on the handout. Each group should identify

- barriers that prevent women survivors of GBV from accessing and receiving health services (survivor barriers), as well as
- barriers that prevent health professionals from providing effective care and treatment to patients who have experienced GBV (provider barriers).

It is suggested to divide survivor barriers and provider barriers among the groups (e.g. in case of four groups, ask groups 1 and 2 to work on survivor barriers and groups 3 and 4 to work on provider barriers).

Each group should also try to come up with 2-3 suggestions on what health care professionals can do in their daily work to address these barriers.

Ask the group to summarize their results on a piece of flipchart paper. Allow 20 minutes for the group work. Each group should assign one rapporteur who will present the points collected on the flip chart to the group (5 minutes max. per group).

For wrapping up the summaries presented by the groups, use PPT slides 24-25 and handout 13.

Materials for training session

Presentation: PowerPoint presentation Module 3

Handouts

Handout 9: State obligations under international human rights law to improve the health system's response to gender-based violence

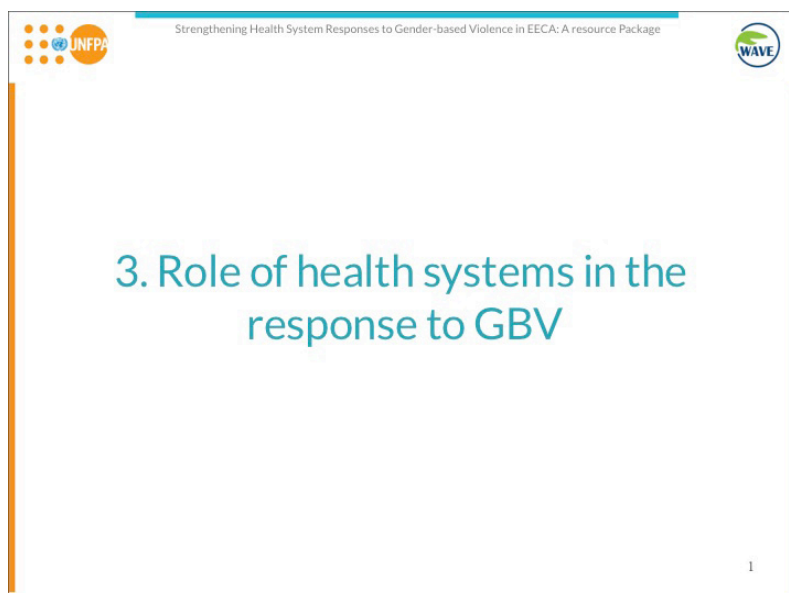
Handout 10: Group exercise: The role of health care professionals in responding to gender-based violence

Handout 11: Types of clinical policies and protocols recommended for health facilities

Handout 12: Group exercise: Barriers to an effective health care response to end gender-based violence

Handout 13: Barriers to an effective health care response to gender-based violence

3.3.2. POWERPOINT PRESENTATION



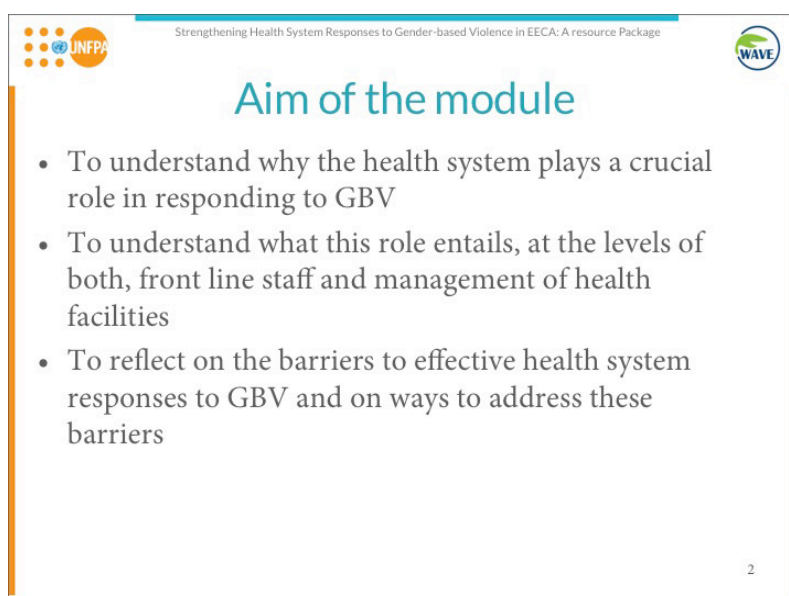
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3. Role of health systems in the response to GBV

1



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Aim of the module

- To understand why the health system plays a crucial role in responding to GBV
- To understand what this role entails, at the levels of both, front line staff and management of health facilities
- To reflect on the barriers to effective health system responses to GBV and on ways to address these barriers

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Outlook

- International obligations of States under human rights law
- Why do health care professionals play an important role in addressing GBV?
- Three levels to address:
 - Role of the health care staff
 - Role of the health care facilities - management
 - Role of policy makers and public administration
- Barriers to effective health care response to GBV and ways to address them

3

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International obligations of States to eliminate GBV

4

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States' international obligations to eliminate GBV – the “3 p’s”

Also involves a duty to improve the health sector's response to GBV.

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States international Obligations to eliminate GBV (2)

Key international human rights conventions and declarations:

- United Nations Convention on the Elimination of all Forms of Discrimination against Women (CEDAW, 1979)
- Programme of Action of the International Conference on Population and Development, Cairo (1994)
- Ministerial Council Decision No. 15/05 "Preventing and Combating Violence against Women" (2005)
- Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention, 2011)
- Agreed Conclusions of the 57th session of the Commission on the Status of Women (2013)

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United Nations Convention on the Elimination of all Forms of Discrimination against Women (CEDAW, 1979)

- **Legally binding**
- Ratified by all states in the EECA region
- Obliges states parties to end discrimination against women in the political, economic, social, cultural, civil or any other field
- **VAW/GBV is not explicitly mentioned, but:**
- CEDAW Committee General Recommendation No. 19 on VAW (1992): **GBV is a form of discrimination against women and therefore covered by CEDAW**

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CEDAW General Recommendation 19 on VAW (1992)

Specifies the obligations of CEDAW states parties to respond to GBV, such as:

- Ensure that **laws** against GBV give adequate protection to all women (penal sanctions, civil remedies, compensation)
- Establish or support appropriate **protective and support services** (shelters, counselling, specially trained health workers, etc)
- Implement gender-sensitive **training** of public officials and health care professionals
- Undertake **preventive** measures to overcome harmful attitudes, customs and practices
- **Compile statistics and research** (extent, causes and effects of GBV, effectiveness of interventions)

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CEDAW General Recommendation 24 on women and health (1992)

Specifies the obligations of CEDAW states parties to address GBV in the context of health care, such as:

- Enact and implement **laws, policies, protocols and procedures** to address GBV and to provide appropriate health services to survivors
- **Remove all barriers** to women's access to health services
- **Ensure women's access to health services**, in line with their right to dignity, autonomy, privacy, confidentiality, informed consent and choice
- Implement **gender-sensitive trainings** for health professionals on identifying and response to GBV

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OSCE Ministerial Council Decision No. 15/05

“Preventing and combating VAW”

All countries in EECA are politically bound

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Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention, 2011)

- **Legally binding**, in force since 2014
- EECA region (as of June 2014)
 - Ratified by Albania, Bosnia-Herzegovina, Montenegro, Serbia and Turkey
 - Signed by Georgia, The Former Yugoslav Republic of Macedonia, Ukraine

H8

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Istanbul Convention – examples of obligations (1)

Integrated policies and data collection:

- Adopt and implement comprehensive and coordinated policies to prevent and combat all forms of GBV that
 - place the rights of the survivor at the centre
 - effective cooperation among all relevant organizations
- Collect disaggregated relevant statistical data and support research on GBV

Prevention:

- Train professionals dealing with survivors of GBV on: gender equality, prevention and detection of violence, needs and rights of survivors, prevention of secondary victimization

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Istanbul Convention – examples of obligations (2)

Protection and support

- Ensure access of survivors to adequate support services, health care, social services (with trained professionals)
- Establish enough appropriate and easily accessible shelters and services for survivors of sexual violence
- Establish state-wide 24/7 telephone helplines (free of charge and anonymous)
- Ensure access of survivors to adequate and timely information on available support services and legal measures in a language they understand
- Basic principles for service provision

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Agreed conclusions, 57th session of CSW (2013) on Eliminating and Preventing Violence against Women and Girls

- Better implementation of laws and policies:
 - Develop effective multi-sectoral policies
 - Allocate sufficient resources
- Tackle root causes and risk factors for GBV: discrimination, structural violence
- Provide accessible, comprehensive and multi-sectoral services
 - Police, judiciary, legal aid, health care, counseling services – important role of women’s organizations
 - Training of medical professionals on GBV
- Research and comprehensive data collection

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Select international guidelines on the health care response to GBV

- WHO, Guidelines for medico-legal care for victims of sexual violence (2003)
- UNFPA, A Practical Approach to Gender-based Violence: A Programme Guide for Health Care Providers & Managers (2010)
- WHO, mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings (2010)
- IPPF, Improving the health sector response to GBV: A resource manual for health care professionals in developing countries (2010)
- WHO, Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (2013)

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Why do health care professionals play an important role in addressing GBV?

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Why do health care professionals play an important role in addressing GBV?

- GBV as a public health issue
- Health care professionals are often the first point of contact for survivors of GBV
- Forensic medicine plays an important role in collecting evidence to support the prosecution
- Knowing about women's situation helps in diagnosing and treating health conditions
- Responding to GBV helps to improve the overall quality of health care
- **Health care professionals are in a strategic position to identify women who have experienced and/or are at risk of experiencing violence**

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Levels to address the health care response to GBV

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Levels to address the health care response to GBV

Health administration and policy makers

Health facilities/management

Health care staff

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Role of health care staff

- **Understand GBV and provide information** to patients on GBV and consequences to women's health
- **Ask about GBV** in case of clinical symptoms
- Create a **friendly and confidential environment**
- Collect patient's **medical history**
- Undertake a **medical examination**
- Provide **medical and psychological care**
- **Document** the health consequences
- **Refer** to other service providers as needed
- Assist patients to **safety planning**
- Ensure **follow-up care**

H10

20

Role of health facilities (1)

Provide the institutional framework to enable health care professionals to perform their role. This includes:

- Putting in place **guidelines and protocols**
- Ensuring **top-down** support
- Providing **adequate infrastructure**
- Providing **informative materials** to patients and staff
- Providing **support** to health care professionals
- Networking with **other organizations** working on GBV
- Implementing a system for **monitoring & evaluation**

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Role of health facilities (2)

Examples of recommended clinical policies and protocols for health facilities:

- Sexual harassment policy
- Policies and protocols about client privacy and confidentiality
- Protocols for treating cases of VAW, including sexual abuse and rape
- Protocols for handling situations of risk and crisis



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Role of policy makers and public administration

- To provide a **policy framework** to guide the response of health facilities and health care professionals to GBV
 - Integration into wider GBV policies or action plans, e.g. *2011-2015 Strategic Action Plan to Combat Gender Based Violence, Armenia*
 - Adoption of special protocols or policies by Ministries of Health, e.g. *Special Protocol for the Protection and Treatment of Women Victims of Violence, Republic of Serbia*
- **Effective implementation** of policies requires:
 - Wide dissemination
 - Training of health care facilities and staff

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Barriers to medical care

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Barriers to medical care - examples

Female patients	Health care providers
<ul style="list-style-type: none">• Shame, guilt• Fear of negative response, being blamed• Fear of an escalation of violence• Social isolation• Lack of safe options for themselves and their children• Lack of physical access, especially in remote areas• Language and cultural barriers	<ul style="list-style-type: none">• Insufficient knowledge about domestic violence and competent handling of cases• Lack of time• Lack of institutional support, such as standardized protocols and institutionalized training• Own attitudes and misconceptions about GBV

H12
H13

25

3.3.3. HANDOUTS

HANDOUT 9: STATE OBLIGATIONS UNDER INTERNATIONAL HUMAN RIGHTS LAW TO IMPROVE THE HEALTH SYSTEM'S RESPONSE TO GENDER-BASED VIOLENCE

UNITED NATIONS CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted by the United Nations (UN) General Assembly in 1979. It provides a legally binding framework for state measures to end discrimination against women in all spheres of life: the political, economic, social, cultural, civil or any other field. All states in Eastern Europe and Central Asia have ratified CEDAW and are therefore obliged to implement its provisions in their countries.

Interestingly, the Convention does not explicitly mention violence against women. The reason for this omission is that in the 1970s, when the text of CEDAW was drafted, GBV, in particular violence committed in the home, was not yet regarded as a human rights issue. The CEDAW Committee closed this gap in 1992, when it adopted General Recommendation No. 19 on violence against women. This document clarifies that GBV against women constitutes a form of “discrimination,” and is therefore covered by the Convention (for the Committee’s definition on GBV, see chapter 1.1). In 1994, the CEDAW Committee adopted another important document, General Recommendation No. 24 on women and health, which specifies the obligations of states to end discrimination against women in the field of health care and to ensure women’s equal access to health care services. Importantly, General Recommendation No. 24 also addresses the health sector’s role in responding to GBV. Both General Recommendations specify the obligations of state parties to CEDAW to eliminate GBV, including through strengthening the response of the health care system:

CEDAW standards for an effective state response to GBV (General Recommendation No. 19):

- » Ensure that **laws** against GBV give **adequate protection** to all women. Effective legal measures include penal sanctions, civil remedies and compensatory provisions.
- » Implementing gender-sensitive **training** of public officials including judges and police.
- » Provide women survivors with **effective complaint procedures and remedies**, including compensation.
- » Establish or supporting appropriate **protective and support services** for women who have experienced or are at risk of violence, rape, sexual assault and other forms of GBV. This includes an obligation to provide shelters, specially trained health workers, rehabilitation and counselling services, and to ensure that such services are accessible to rural women.
- » Undertak **preventive** measures, including public information and education programmes to **overcome attitudes, customs and practices that perpetuate GBV**.
- » **Compile statistics and research** on the extent, causes and effects of GBV, and on the effectiveness of measures to prevent and respond to violence.

CEDAW standards for strengthening the health system’s response to GBV (General Recommendation No. 24):

- » Enact and implementing **laws, policies, protocols and procedures** to address violence against women and girls and to provide appropriate health services.
- » Implement a **comprehensive national strategy to promote women’s health throughout their lifespan, including interventions responding to GBV** and ensuring access to high quality and affordable health care, including sexual and reproductive health services.
- » **Remove all barriers to women’s access** to health services, education and information.

- » Ensure women's **access to health services** in line with women's human rights, including their right to **autonomy, privacy, confidentiality, informed consent and choice**. Further, services should be delivered in a way that they respect women's **dignity** and are sensitive to **women's needs and perspectives**. This implies, among others, prohibiting coercive practices such as non-consensual sterilization or mandatory testing for sexually transmitted diseases.
- » Gender-sensitive **training** to enable health-care workers to detect and manage the health consequences of GBV. Training curricula should include comprehensive, mandatory, gender-sensitive courses on health and women's human rights, in particular GBV.
- » Ensure **adequate protection and health services**, including trauma treatment and counselling, for women in **especially difficult circumstances**, such as women trapped in armed conflict and refugee women.
- » Ensure **complaint procedures and sanctions** against health care professionals guilty of sexual abuse of women patients.

COUNCIL OF EUROPE CONVENTION ON PREVENTING AND COMBATING VIOLENCE AGAINST WOMEN AND DOMESTIC VIOLENCE (ISTANBUL CONVENTION)

On 7 April 2011, the Committee of Ministers of the Council of Europe adopted the Convention on preventing and combating violence against women and domestic violence. As it was adopted in Istanbul, this document is often referred to as the "Istanbul Convention". The Convention will enter into force on 1 August 2014. As of 30 June 2014, eleven countries have ratified it, including the following EECA countries: Albania, Bosnia and Herzegovina, Montenegro, Serbia and Turkey. The Former Yugoslav Republic of Macedonia and Ukraine have signed, but not yet ratified. The Istanbul Convention is also open for accession by non-member states of the Council of Europe. Therefore, countries such as Belarus or the Central Asian states could also accede to the Convention.

The Istanbul Convention provides a detailed, comprehensive and legally binding framework for state measures to eliminate GBV, covering, among others, the following areas:

- **Integrated policies and data collection:** This includes an obligation to adopt and implement comprehensive and coordinated policies to prevent and combat all forms of violence that place the rights of the victim at the centre and are implemented through effective cooperation among all relevant organizations (Article 7); an obligation to support and effectively cooperate with relevant non-governmental organizations (Article 9); and an obligation to collect disaggregated relevant statistical data and support research on violence against women (Article 11).
- **Prevention:** Among others, the Convention establishes a duty to ensure training of relevant professionals dealing with victims of violence on gender equality, the prevention and detection of such violence, the needs and rights of survivors, as well as how to prevent secondary victimization. Such training should also address coordinated multi-agency co-operation to ensure comprehensive and appropriate referrals to services (Article 15).
- **Protection and support:** States shall ensure access of victims to adequate support services to facilitate their recovery from violence. This includes health care and social services that are adequately resourced and staffed with professionals who are trained to assist survivors and refer them to appropriate services (Article 20). Further, the Convention foresees appropriate and easily accessible shelters and rape crisis or sexual violence referral centres that should exist in sufficient numbers (Article 23, 25) and state-wide 24/7 telephone helplines that operate free of charge and provide confidential advice (Article 24). States shall ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand (Article 19). The Convention also specifies a set of basic principles for service provision (Article 18, see chapter 2.5, box 8).

The Convention further establishes state obligations in the areas of legislation; investigation, prosecution and protection measures; migration and asylum; and international cooperation.

HANDOUT 10: GROUP EXERCISE: THE ROLE OF HEALTH CARE PROFESSIONALS IN RESPONDING TO GENDER-BASED VIOLENCE

INSTRUCTIONS FOR PARTICIPANTS:

Read the case study below and discuss the following questions in your working group:

- 1 What, in your opinion, is the role of a doctor/nurse when being confronted with a patient like Anna?
/// List some examples of steps that the doctor should undertake.
- 2 What, in your opinion, is not the role of the doctor/nurse?

Each group should write the answers on flip chart paper and nominate a rapporteur to present the results to the bigger group (max. 5 minutes for presentation).

CASE STUDY – THE STORY OF ANNA:

Anna, 45 years, lives in a small village in country X. She is married and has three children; together with her family, she lives with her parents in-law. One day, Anna comes to the accident and emergency department of the hospital in the nearest city to seek medical help. She bleeds from her ear and has several bruises on her stomach and legs; when asked by the doctor/nurse about the cause of the injuries she states that she fell down the stairs. Anna's medical file shows that she visited the hospital several times in the past, with unexplained symptoms of chronic stomach pain and bladder infections; she also sought emergency contraception twice because of unwanted pregnancies. The doctor is concerned about the health of his patient, and believes that her symptoms could be caused by intimate partner violence. He is unsure what to do, as he realizes that Anna is unwilling to talk about the nature of her health problems.

HANDOUT 11: TYPES OF CLINICAL POLICIES AND PROTOCOLS RECOMMENDED FOR HEALTH FACILITIES

Type of policy or protocol	Why this type of policy or protocol is important and what it needs to contain
Sexual harassment policy	<p>Every health care organization should have a written policy that prohibits sexual harassment by staff members against other staff members and against clients. The policy should:</p> <ul style="list-style-type: none"> • state the types of actions that are prohibited, • provide a clear definition of sexual harassment, • specify the procedures for reporting a case of sexual harassment, and • specify consequences of violating the policy. <p>Health care organizations cannot adequately address the issue of GBV if they cannot ensure respect for the rights of their own staff members and clients. A sexual harassment policy that has a clear procedure for handling violations is therefore an essential part of this effort.</p>
Policies and protocols about client privacy and confidentiality	<p>Every health care organization should have written policies that explain how staff should protect client privacy and confidentiality. These policies should address issues such as:</p> <ul style="list-style-type: none"> • where in the clinic and under what circumstances staff members are allowed to discuss information about clients with other staff or with clients themselves, • the circumstances under which providers are allowed to share information about clients with other people, including family members, • confidentiality of medical records, • whether or not providers are required to get parental consent for certain services, and • whether or not adolescents can keep their personal and medical information confidential from their parents.
Protocols for treating cases of violence against women, including sexual abuse and rape	<p>Ideally, health care organizations should develop protocols for caring for women who experience GBV, including rape. These protocols can help providers know how to respond to a woman's disclosure of violence in a caring and supportive way, that preserves her legal rights. In cases of sexual violence, for example, the protocol should include guidelines about the provision of emergency contraception and testing for STIs. Such protocols may increase the chances that women will receive adequate treatment, especially when health care professionals have misconceptions about issues such as sexual abuse, emergency contraception and STIs/HIV.</p>
Protocols for handling situations of risk and crisis	<p>Health care organizations that want to strengthen their response to the issue of violence against women should develop protocols for caring for women who are in situations of crisis or high risk. This includes clients who appear to be at high risk of suicide, homicide, injury or extreme emotional distress. A protocol for situations of risk and crisis should include a discussion of:</p> <ul style="list-style-type: none"> • how to identify risk factors, • how to ensure that women get at least the basic assistance that they need, and • among who the staff can provide emotional counseling and safety planning.

Source: IPPF 2010

HANDOUT 12: GROUP EXERCISE: BARRIERS TO EFFECTIVE HEALTH SERVICES – THE PERSPECTIVE OF SURVIVORS AND HEALTH CARE PROFESSIONALS

In your working group, please identify barriers to an effective health care response to GBV.

Group(s) working on survivor barriers:

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

Group(s) working on provider barriers:

- Which barriers prevent health professionals from providing effective care and treatment to patients who have experienced GBV (provider barriers)?
- What can you as a health professional do in your daily work to address these barriers? (2-3 suggestions)
- What support do you need from the management at your health facility in order to address these barriers?

Please write your barriers and suggestions 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 flip chart to the group (5 minutes max. per group).

HANDOUT 13: BARRIERS TO EFFECTIVE HEALTH SERVICES – THE PERSPECTIVE OF SURVIVORS AND HEALTH CARE PROFESSIONALS

BARRIERS FACED BY WOMEN SURVIVORS IN ACCESSING HEALTH SERVICES AND DISCLOSING VIOLENCE

1 The following reasons may prevent women who experienced GBV from accessing health care and disclosing violence to health professionals:

- » Shame, guilt, and the feeling to be solely or partly responsible for the violence suffered: A woman who experienced violence from an intimate partner may be convinced that she can stop the violence if she obeys the perpetrator's wishes and "betters" herself.
- » Fear of reprisals from the perpetrator: Women who live in violent relationships may fear an escalation of violence and further threats, as violent partners usually forbid women to talk about the violence with any other person and threaten with further violence.
- » Fear of stigma and social exclusion by their families and communities.
- » Social isolation and the feeling of having to deal with the experienced violence all by themselves.
- » Long-term experiences of mistreatment that can damage women'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 to irregular immigration status or of losing status following separation from a violent spouse.
- » Lack of realistic options, e.g. for financial resources, housing, employment or safety.

Even though these barriers operate at the levels of partner relationships, families and the wider community and therefore require interventions beyond the health care system, health professionals nevertheless need to be aware of them, in order to be able to provide effective care and referrals to relevant service providers, such as shelters, crisis centres or counselling centres. These organizations may assist women in addressing some of these barriers, for instance through providing accommodation, legal counselling or other support.

2 Other barriers faced by women can and should be addressed by health care systems, including the following:

- » Lack of physical access to health care services for women living in remote areas;
- » Fear of negative responses from service providers and of being blamed for not separating from the abusive partner, in particular when the woman has received inappropriate and victim-blaming responses from other service providers in the past;
- » Not knowing which steps health care professionals will take, for instance whether police will be informed or whether the perpetrator will be approached;
- » Language and cultural barriers faced by migrant women and women belonging to ethnic minorities; and
- » Situational aspects of the counselling and treatment situation, such as inappropriate physical conditions of the facility or insensitive behaviour of doctors and nursing staff.

BARRIERS FACED BY HEALTH CARE PROFESSIONALS IN PROVIDING EFFECTIVE SERVICES PROVIDER BARRIERS TO AN EFFECTIVE HEALTH CARE RESPONSE TO SURVIVORS OF GBV

The following barriers prevent health care professionals from identifying GBV as a cause of medical symptoms, from asking patients about violence and/or from providing effective care and support

- » Insufficient knowledge about causes, consequences and dynamics of GBV: If health professionals do not ask about or do not recognize symptoms of GBV, they may misdiagnose survivors or offer inappropriate care.
- » Own attitudes and misconceptions about GBV that may result in perceiving intimate partner violence as a private matter or blaming the survivor for the violence.
- » Own experiences of GBV in the past.
- » Lack of clinical skills in responding to GBV. As a consequence, health care professionals may be reluctant to ask about GBV, so as to avoid “opening Pandora’s box” (McCauley et al 1998, cited in PRO TRAIN 2009). Lack of knowledge and skills may also put the patient’s safety, life and wellbeing at risk, for instance when health professionals express negative attitudes to a patient who has been raped or by discussing a woman’s injuries in a way that can be overheard by a potentially violent spouse waiting outside.
- » Lack of information about existing support services and appropriate professional contacts, which could serve as basis for referral.
- » Lack of time for medical care, as well as inadequate funding of counselling. It may be difficult to estimate how time-consuming a conversation would be and health care professionals are worried about having to cut back on the time needed for other patients.
- » Missing intra-institutional support such as standardized protocols, documentation forms or staff training on dealing with survivors of GBV.
- » 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 GBV follow standards of good clinical care.

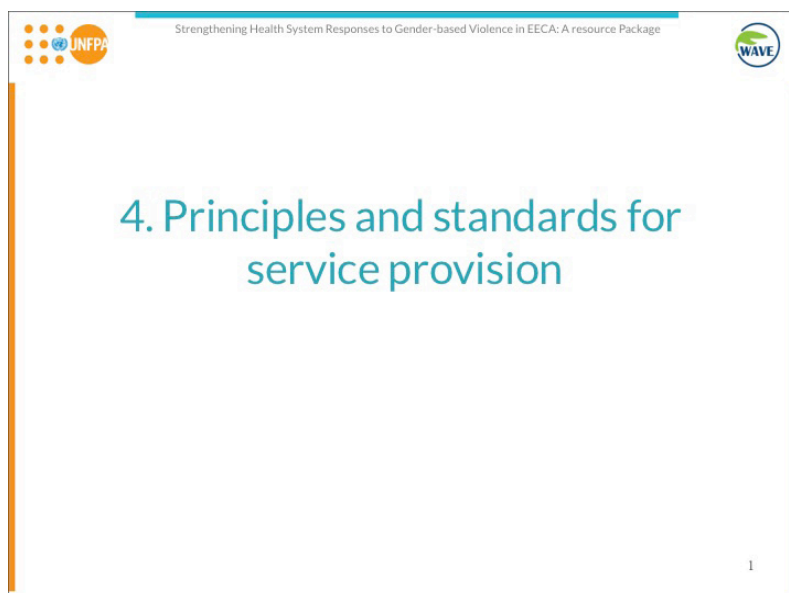
Sources: adapted from Ganley 1998 and Hellbernd 2006, cited in PRO TRAIN 2009, IPPF 2010, Warshaw/Ganley 1996

3.4. MODULE 4: PRINCIPLES AND STANDARDS FOR SERVICE PROVISION

3.4.1. OUTLINE OF THE MODULE

Duration of the module	1 hour 15 minutes
Aim of the module	To provide participants with an overview of basic principles and standards for health care services to survivors of GBV, based on: <ul style="list-style-type: none"> • a gender-sensitive approach, • a survivor-/women-centred approach, • a human rights-based approach, • integrating the health system's response to GBV into existing services.
Key learning messages	<ul style="list-style-type: none"> • A gender-sensitive approach requires that health care professionals have a sound understanding of GBV, its causes and consequences and how it affects women belonging to marginalized groups. • A survivor-/women-centred approach prioritizes the rights, needs and wishes of the GBV survivor. This requires in particular, efforts to ensure the patient's safety, dignity, privacy and confidentiality, as well as empowerment, autonomy and participation. • A human-rights based approach addresses the human rights violations that are the causes and consequences of GBV. It is based on universal human rights principles and holds states and service providers ("duty bearers") accountable to fulfil their obligations vis-à-vis individuals ("right holders"). • Integrating the health care response to GBV into existing services, rather than offering them stand-alone services, helps to facilitate women's easy access to comprehensive services and to ensure sustainability, especially in low-resource settings.
Background readings for trainer	UNFPA-WAVE Resource Package, Part I, chapters 1.6 and 2.5 Further readings: Istanbul Convention and Explanatory Report, WHO 2013, IPPF 2010, UNFPA 2010b
Methods	Presentation by trainer (PPT slides 1-9, handouts 14-18)
Notes for trainers	When disseminating the case studies (handouts 16-18), briefly highlight key points from each example documented. Then you may want to facilitate a discussion, asking the group if they know other examples on integrating GBV responses into health care – from their own country or other countries.
Materials for training session	Presentation: PowerPoint presentation Module 4 Handouts Handout 14: Quality standards for providing health services to women survivors of GBV Handout 15: A comparison of different models of delivering care for survivors of gender-based violence Handout 16: Setting up victim support groups in hospitals – an example from Austria Handout 17: Providing hospital-based accommodation for survivors of GBV - an example from Tajikistan Handout 18: Integrating the response to domestic violence services in maternity and sexual health services - an example from the UK

3.4.2. POWERPOINT PRESENTATION



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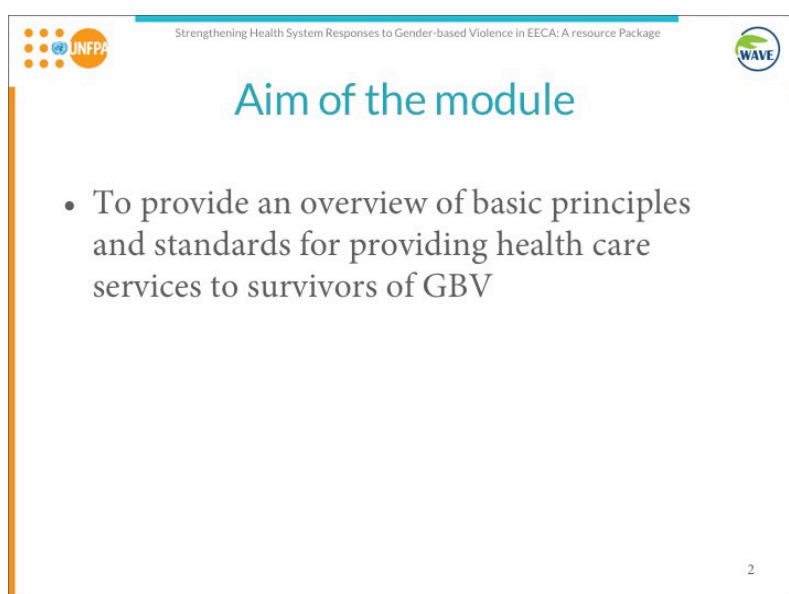
Strengthening Health System Responses to Gender-based Violence in EECA: A resource Package

WAVE

4. Principles and standards for service provision

1

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Aim of the module

- To provide an overview of basic principles and standards for providing health care services to survivors of GBV

2

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Outlook

- Gender-sensitive approach
- Survivor-/women-centered approach
- Human rights-based approach
- Integration of the health care response to GBV into existing services

3

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Gender-sensitive approach – implications for health care providers

- Understand the gender-based nature of VAW
- Take into account the needs of specific groups of survivors (women with disabilities, pregnant women, adolescent girls, older women, sex workers, migrant women)
- Respect the diversity of services users and apply a non-discriminatory approach
- Provide services that are appropriate and tailored to the particular needs of service users
- Understand the impact of intimate partner violence on children

4

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Survivor-/women-centered approach - implications for health care providers

- Prioritize the survivor’s rights, needs and wishes by:
 - Creating a supportive and validating environment
 - Promoting the survivors’ recovery
 - Promoting the survivors’ ability to identify and express her needs and wishes
 - Reinforcing her capacity to make decisions about possible interventions
- Prioritize the right to safety survivors and their children
- Prioritize the survivor’s right to privacy and confidentiality
- Ensure the survivor’s right to dignity and avoid secondary victimization
- Provide services that support the survivor’s empowerment, autonomy and participation

5

H14

Human rights-based approach (HRBA)

- A HRBA seeks to redress the human rights violations that are both the root causes and the consequences of GBV
- Added value of the HRBA:
 - Adds **legitimacy** since it is based on **universal human rights principles and standards**
 - Establishes rights of individuals (“**rights holders**”) and corresponding duties of the State and non-state service providers (“**duty bearers**”) → shift from “welfare paradigm”
 - Supports the creation of **accountability** mechanisms
 - Grounded in the **full spectrum of civil, political, economic, social and cultural rights**

6

HRBA – Implications for health services and providers

- Policies, protocols or programmes are in line with human rights standards
- Health services aim at empowering survivors
- Health services are based on an assessment of the capacities of
 - women survivors to access health care services
 - health providers to fulfil their obligations vis-à-vis survivors
- Processes and outcomes of health system interventions to GBV are monitored and evaluated, based on human rights standards
- National accountability of duty bearers for non-compliance with international and national standards

7

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Integration of the response to GBV into existing health services

- Medical care for survivors of GBV should be integrated into existing services, rather than having stand-alone services
- A stand-alone services may be difficult to sustain and may have a potential harmful effect
- Integrated services may facilitate women's easy access to a range of care and support services
- There is no "one size fits all" model → take into account specific context when considering a particular model of service provision

H15

8

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Examples of integration

- Setting up **victim support groups** in hospitals (Austria) **H16**
- Providing **hospital-based accommodation for survivors** of GBV (Tajikistan) **H17**
- Integrating the response to domestic violence in **maternity and sexual health services** – MOZAIC project (UK) **H18**

9

3.4.3. HANDOUTS

HANDOUT 14: QUALITY STANDARDS FOR PROVIDING HEALTH SERVICES TO WOMEN SURVIVORS OF GENDER-BASED VIOLENCE

STANDARDS FOR SUPPORT SERVICES (COUNCIL OF EUROPE ISTANBUL CONVENTION, ARTICLE 18)

- » Services are based on a **gendered understanding** of violence against women and focus on the human rights and safety of the victims.
- » Services are based on an **integrated approach**, which takes into account the relationship between victims, perpetrators, children and their wider social environment.
- » Services aim at **avoiding secondary victimization**.
- » Services aim at the **empowerment and economic independence** of women victims of violence.
- » Services allow, where appropriate, for a **range of protection and support services** to be located on the **same premises**.
- » Services address the **specific needs of vulnerable persons**, including child victims, and are made available to them.

ELEMENTS OF WOMEN-/SURVIVOR-CENTRED CARE (WHO CLINICAL AND POLICY GUIDELINES 2013)

- Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered **immediate support**.
- Health-care providers should, as a minimum, offer **first-line support** when women disclose violence.
- First-line support includes:
 - » being **non-judgmental and supportive and validating** what the woman is saying;
 - » providing **practical care and support** that responds to her concerns, but **does not intrude**;
 - » **asking about her history of violence**, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved);
 - » **helping her access information about resources**, including legal and other services that she might think helpful;
 - » **assisting her to increase safety** for herself and her children, where needed; and
 - » **providing or mobilizing social support**.
- Providers should ensure:
 - » that the consultation is conducted **in private** and
 - » **confidentiality**, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting).
- If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.

HANDOUT 15: A COMPARISON OF DIFFERENT MODELS OF DELIVERING CARE FOR SURVIVORS OF GENDER-BASED VIOLENCE

Site	Advantages	Disadvantages
Health centres and clinics	<ul style="list-style-type: none"> • Located close to the community • Can provide some core services • Improves access for follow-up services • If a good network is established, it can improve access to an inter-sectoral network of services, including legal, social, other 	<ul style="list-style-type: none"> • May not be able to treat serious injuries or complications • May not have laboratory or specialized services • In services in small communities, where providers are members of the community, confidentiality and providers' fear of retaliation may be a challenge
District and regional hospitals	<ul style="list-style-type: none"> • Equipped to provide 24-hour services • Have specialized services • Can be centralized in one department (emergency department, gynecology, reproductive health, HIV/STI) or distributed throughout the hospital 	<ul style="list-style-type: none"> • Can reduce accessibility • If services are split across departments, can hamper services, especially if some services are only available during working hours
One-stop centres	<ul style="list-style-type: none"> • More efficient and coordinated services • Provide a full range of services (sometimes including police, prosecutors, social worker, counsellors, psychological support, etc.) 	<ul style="list-style-type: none"> • More space and resources required • Client load may be small (e.g. in rural areas), raising concerns on cost effectiveness • May draw staff and resources out of other services • May not be fully integrated into general health services • If administered by the judicial system, may focus too much on prosecution and not on women's health • Costly to sustain

Source: WHO 2013

HANDOUT 16: SETTING UP VICTIM SUPPORT GROUPS IN HOSPITALS – AN EXAMPLE FROM AUSTRIA

In 2011, a new provision was introduced into the Austrian Health Facilities Act, establishing so-called “victim protection groups” in hospitals.¹⁸ The law specifies that separate groups are to be set up for children victims of violence and adult victims of domestic violence, respectively. In exceptional situations, hospitals may also establish one group providing support to both adult and minor victims, or establish joint groups with other hospitals. The law defines two main purposes of the victim protection groups (early identification of violence and sensitization of health care providers on domestic violence) and specifies the composition of the groups (at least two doctors specialized in accident surgery and gynaecology/obstetrics, as well as nurses and health care professionals specialized in psychological and psychotherapeutic care). This law built on practice that already existed earlier in some hospitals in the country and transformed it into a legal obligation.

To date several hospitals have set up victim support groups, including for example the General Hospital of the City of Vienna (AKH), Austria’s largest hospital. AKH set up a victim protection group in 2011 and adopted rules of procedure to further specify the group’s aims and tasks, as follows: providing advice to health care professionals in contact with survivors of domestic violence, sensitization of health care professionals, development of standardized procedures and guidelines for interventions, organization of trainings, and coordination of the different departments and case conferences.

While the creation of victim protection groups has been widely welcomed, practice shows that a number of challenges still exist. Practitioners involved have identified the following prerequisites for the effective operation of the victim support groups: the creation of specific country-wide standards to guide the operation of the groups, the provision of adequate human and financial resources, making trainings on GBV mandatory for all health care professionals, ensuring stronger institutional support to avoid that an improved response rests on the responsibility of committed individuals, as well as effective cooperation both internally and with external stakeholders, such as shelters, police or general practice doctors.

Sources: Austrian Health Facilities Act; Rules of Procedure of the Victim Protection Group at the General Hospital of the City of Vienna; information provided by Anneliese Erdemgil-Brandstätter, Training project “Domestic violence – the role of the health sector”, 2014

¹⁸ More specifically, the law establishes an obligation of parliaments of Austria’s nine provinces to adopt laws for their province in order to set up such groups. This is because Austria is a federal state, with health care being part of the competency of the provinces (Länder).

HANDOUT 17: PROVIDING HOSPITAL-BASED ACCOMMODATION FOR SURVIVORS OF GBV- AN EXAMPLE FROM TAJIKISTAN

In June 2012, the Ministry of Health of Tajikistan, in partnership with UNFPA established “victim-support rooms” to survive as temporary shelter for women survivors of GBV. To date, such rooms were established in eight hospitals and maternity houses in the cities of Dushanbe, Rasht, Vahdat Kurgan–Tube, Kulyab, Khujand and Kairakum. This step was necessary, given the lack of a sufficient number of shelters in the country. While some NGO-run shelters exist, they lack funds to necessarily guarantee continuous provision of services.

In each health facility, one “victim support room” was established, providing women and girls survivors of GBV above the age of 14 and their children with temporary accommodation. Survivors are referred to the rooms by medical professionals, law enforcement or NGOs. Admission to the victim support room happens on a voluntary basis with their informed consent. Survivors may stay for a period of up to five days, while there is some flexibility in regards to the duration. The rooms are equipped with basic furniture including child beds, a cooking facility, tableware, bed sheets, towels, hygiene and sanitary items and diapers for babies. During their stay, they have access to basic medical and psychological care, counseling sessions that can be arranged in the evenings, as well as information on other services available in their city or district. The operation of the victim support rooms is guided by standardized policies, which foresee e.g. the provision of health services free of charge or at affordable prices, informing survivors of and referring them to other service providers, and the application of certain protocols and guidelines, covering issues such as identification, emergency contraception and STI prevention/treatment. Security of the rooms is ensured through providing all doctors and nurses with mobile phones so that they can call the local police station in case of an emergency.

The added value of creating such a hospital-based service is that it takes into account the local cultural context: women who do not spend the night at home (for example, in a shelter) might face rejection by their families or neighbours, whereas an overnight stay at a hospital will not raise any suspicious questions. Furthermore, doctors are well positioned to observe potential future problems faced by the survivor back home through follow-up appointments.

As of May 2014, about 50 women have received temporary accommodation in the victim support rooms. This type of service is innovative in Tajikistan and its awareness still needs to be raised among women and girls.

This effort is part of a broader initiative to strengthen the existing referral mechanism for survivors of GBV in Tajikistan. This includes joint training undertaken by UNFPA of health care staff working at the victim support rooms and police officers in the cities where the rooms are established. Following the trainings, participants became multipliers by in turn training their peer professionals. It is planned that the Ministry of Health will be rolling out the “victim support rooms” in other districts.

Source: Information provided by UNFPA country office in Tajikistan, May 2014

HANDOUT 18: INTEGRATING THE RESPONSE TO DOMESTIC VIOLENCE SERVICES IN MATERNITY AND SEXUAL HEALTH SERVICES - AN EXAMPLE FROM THE UK

The MOZAIC project was implemented from 2004-2007 as a partnership between the maternity and sexual health services of Guy's and St. Thomas Foundation Trust and the 170 Community Project, a NGO providing specialized domestic violence support services on-site. As part of the intervention, clinical guidelines were introduced and a training programme was implemented to increase health professionals' knowledge on domestic violence and to enable them to identify and document violence and to refer survivors to MOZAIC Women's Wellbeing Service, who provided on-site support and counseling. Male patients who disclosed domestic violence were also provided with counselling. In this setting, routine enquiry was practiced for asking women about domestic violence¹⁹ (Bacchus et al 2010). In 2007, an evaluation was undertaken. It took into account the perspective of both, hospital staff and service users. The partnership did not stop at the end of the project: The partners built on the results of the evaluation to further improve the intervention.

The evaluation revealed, among others, the following findings:

- » Training resulted in increased knowledge rated as “very much” or “quite a lot” by the vast majority of health professionals. At the same time, findings from six months later revealed a number of challenges faced in day-to-day clinical practice that prevented an effective response, such as the presence of partners or family members during consultations, language barriers, time constraints in busy clinics, or reluctance of some women to trust health professionals.
- » Combined training of maternity staff and sexual health services staff was not found to be useful, mainly because sexual health professionals required specific skills that were not covered in the training, such as dealing with male patients experiencing domestic violence.
- » Maternity and sexual health services were not found to be early points of intervention to prevent domestic violence from occurring. Rather, some women using maternity services revealed a long history of partner violence. Therefore, these services were found to provide “opportune” points of intervention for women survivors at different stages to seek and accept help.
- » Confidence and sensitivity on the part of health professionals was deemed helpful by patients in situations where they were reluctant to disclose abuse, as shown by the following quote from a 31 year old user of maternity services: “...I was in tears and she noticed the bruises on my arm... and she started questioning me and I said to her that I was fine and she said ‘No, you can talk to me’ and then she dug and dug and then I opened up to her.”
- » Survivors reported that the support provided by MOZAIC had initiated a process of re-assessing their personal situation and of gaining confidence in their ability to begin and sustain changes. They were able to tentatively explore options, such as temporarily leaving the abuser, contacting the police or seeking legal advice. At the same time, their ability to take decisions was impacted by the quality and availability of alternative options, such as housing or financial resources, also taking into account immigration status.
- » The evaluation also identified potential sources of harm in clinical practice, such as negative labelling and stereotyping by health professionals, failure to document cases adequately or breaches of confidentiality.

Source: Bacchus et al 2010

¹⁹ The WHO does not recommend routine enquiry as such but state that this method could be considered in maternal health care settings (WHO 2013)

3.5. MODULE 5: IDENTIFYING GENDER-BASED VIOLENCE

3.5.1. OUTLINE OF THE MODULE

Duration of the module	2 hours
Aim of the module	To provide participants with knowledge and skills to <ul style="list-style-type: none"> • recognize clinical conditions and behaviours that may indicate a patient's exposure to GBV, • understand the minimum requirements for enquiring about GBV, in particular whether it is safe to ask, • communicate with survivors in a non-judgemental and supportive manner, and • formulate questions about GBV.
Key learning messages	<ul style="list-style-type: none"> • When health care professionals sensitively enquire about GBV, this can increase the chances of disclosure to them . • Clinical enquiry (i.e. asking about GBV based on clinical conditions) is preferred over routine enquiry (i.e. routinely asking all women presenting in a health care setting about GBV). • Certain clinical conditions and behaviours should raise suspicion and prompt health care professionals to ask about GBV. • Before asking about GBV, health care professionals need to establish that it is safe to ask. • Health care professionals should observe the following recommendations for communicating with survivors: <ul style="list-style-type: none"> » show a non-judgemental and supportive attitude, » be patient, listen carefully and validate what the patient is saying, » when asking about GBV, start with a more general introductory question, before continuing with more specific, direct questions, » do not pressure the patient to disclose and, if she does not disclose, offer her to come back for further support, and » emphasize that there is help available.
Background readings for trainer	UNFPA-WAVE Resource Package, Part I, chapter 3.1 Further readings: WHO 2013
Methods	<ul style="list-style-type: none"> • Presentation by trainer (PPT slides 1-6) • Group discussion: How to recognize gender-based violence • Presentation by trainer (PPT slides 7-16, distribution of handouts 19-22) • Role play: Asking about gender-based violence – the case of Natasa (handout 23) • Presentation by trainer (PPT slides 17-19)

Notes for trainers

Group discussion: How to recognize gender-based violence (duration: 15 minutes)

Before the presentation on clinical indicators of GBV, ask participants to think about situations from their professional experience when they suspected a case of GBV. What were the signs that made them think of GBV? Facilitate a group discussion and wrap up the results, using PPT slide 8 and handout 19.

Role play – Asking about gender-based violence (handout 23; duration: 30-45 minutes):

Disseminate handout 23 with the instructions. Ask for volunteers for the following four roles: patient, her little son, doctor/nurse, observer. A bigger training group can be divided into small groups (factor in more time for the discussion). Allow 10-15 minutes for the role play. Parties can change roles, if there is enough time. After the role play, facilitate a discussion (15-20 minutes):

- Questions to the person playing the survivor: How did you feel in your role? Which questions were helpful and encouraged me to talk more? Which questions were not that helpful? What could the doctor have done differently?
- Questions to the person playing the doctor/nurse: How did you feel in your role? What did I handle well? What was the most difficult for me? How could I have done it differently?
- Ask the observer to share her/his observations and feedback.
- Open the discussion to the group.

Materials for training session

Presentation: PowerPoint presentation Module 5

Handouts:

Handout 19: Understanding the signs of gender-based violence

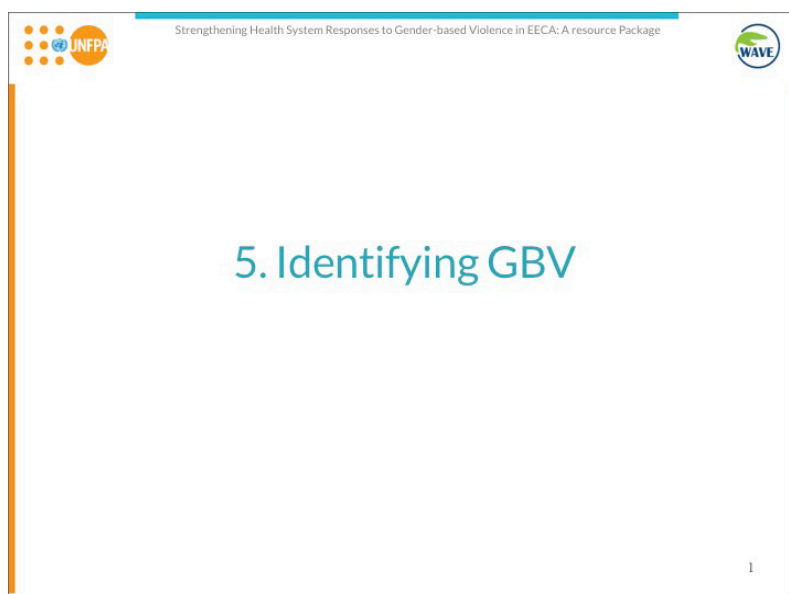
Handout 20: Is it safe to ask about gender-based violence?

Handout 21: Asking about gender-based violence - examples of questions

Handout 22: Tips for communicating with survivors – do's and don'ts

Handout 23: Role play – Asking about gender-based violence – the case of Natasa

3.5.2. POWERPOINT PRESENTATION



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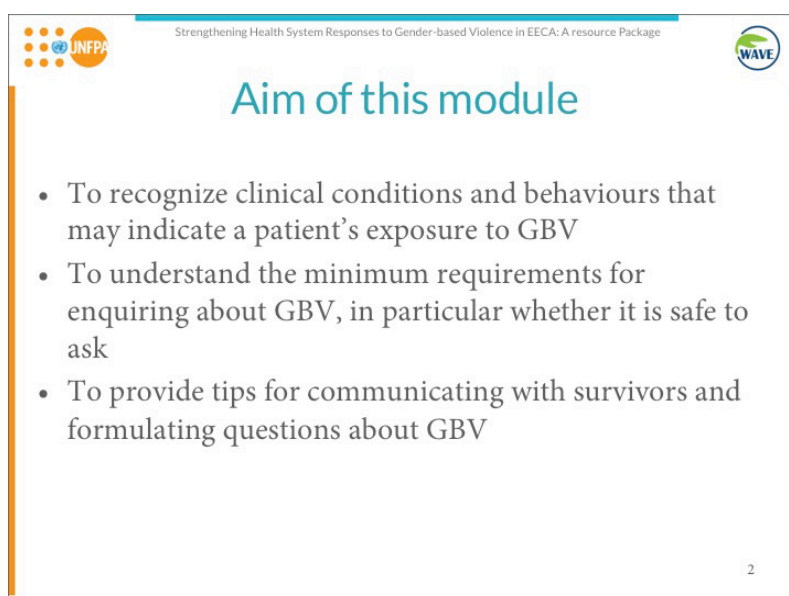
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5. Identifying GBV

1

This slide is the title slide for the module. It features the UNFPA logo in the top left and the WAVE logo in the top right. The title '5. Identifying GBV' is centered in a large, teal font. The slide number '1' is in the bottom right corner.



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Aim of this module

- To recognize clinical conditions and behaviours that may indicate a patient's exposure to GBV
- To understand the minimum requirements for enquiring about GBV, in particular whether it is safe to ask
- To provide tips for communicating with survivors and formulating questions about GBV

2

This slide outlines the aims of the module. It features the UNFPA logo in the top left and the WAVE logo in the top right. The title 'Aim of this module' is centered in a large, teal font. Below the title is a bulleted list of three aims. The slide number '2' is in the bottom right corner.

Outlook

- Routine vs. clinical enquiry
- Signs of GBV
- Minimum requirements to ask about GBV
- How to ask about GBV
- Resources to facilitate disclosure of GBV

3

Key Messages

- Enquiring sensitively about GBV can increase the chances of disclosure, help break the cycle of isolation, guilt and shame experienced by many survivors of GBV, and convey that help is available.
- Not enquiring or asking questions in an inappropriate way can create more harm.
- Before asking about GBV, health professionals need to ensure that it is safe to ask.

4

Routine vs. clinical enquiry

5

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Ask all or some?

Routine Enquiry

- Or: Universal Screening
- Routinely asking **ALL** women presenting in health care settings about exposure to intimate partner violence
- WHO does **not** recommend except in certain situations

Clinical Enquiry

- Or: Case-finding
- Based on their **presenting conditions**, asking women about exposure to intimate partner violence

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Signs of GBV

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About signs of GBV

- Health professionals should consider asking about GBV when certain **symptoms** and certain **types of behaviour** are present.
- These signs
 - should raise suspicion
 - prompt the provider to ask patient in private about violence
 - are not automatic indications of GBV
- If patient does not disclose, do not pressure her because she may come back for further help

H19

8

Minimum requirements to ask about GBV

9

Minimum requirements to ask

- A protocol or standard operating procedure is in place
- Health care providers ensure that it is safe to ask
- Health care providers are trained
 - How to ask and respond to women who disclose violence
- A referral system is in place
- Health care providers are able to refer women to available resources and services

10

Is it safe to ask about GBV?

- Are you in quiet and confidential space?
- Is the woman with a partner, family member of a child over 2 years of age?
- If the woman does not speak the local language
 - Is there a professional interpreter present?
 - Does the woman feel comfortable to use this interpreter?



→ IF YOU HAVE ANSWERED ANY OF THESE QUESTIONS WITH „NO“, IT IS NOT SAFE TO ASK.

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Requirements of working with interpreters

- Avoid using family members as interpreters
- Ensure that patient is comfortable with using the interpreter
- Ensure that interpreter is trained to interpret around issues of GBV

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How to ask about GBV

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Guide to ask about GBV

- Research shows: women don't start talking about violence, but most women react positively to being asked.
- Raise questions appropriate to the patient's age, education, culture and level of tranquillity at the time.
- Avoid technical terms like "domestic violence" – women may not know the meaning and therefore not identify with it.

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Steps to ask about GBV

1. Start with a more general introductory question
 - Explain that GBV affects many women and its impact on women's health
 - E.g. *"We know that many women experience abuse and violence at home and that it impairs their health. I wonder if you've ever experienced violence at home?"*
2. Then continue with more direct specific questions
 - *"Has your partner or ex-partner ever hit you or physically hurt you or someone close to you?"*

H21

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Key Do's & Don'ts to ask about GBV

Do's

- Show a non-judgemental and supportive attitude
- Be patient, listen carefully and validate what the patient is saying
- Emphasize that there is help available

Don'ts

- Don't ask in the presence of a partner, family member, or friend
- Don't blame the woman
- Do not pressure her to disclose

H22
H23

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Resources to facilitate disclosure of GBV

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Resources to facilitate disclosure of GBV

- Resources to encourage women to speak about violence
- E.g. stationery, posters, pamphlets/leaflets in waiting rooms or women's washrooms



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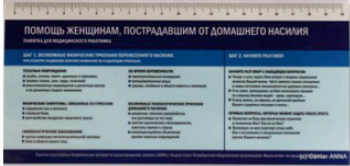
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Resources to facilitate disclosure of GBV (2)

- Resources to help staff memorize clinical indicators of GBV, tips for asking questions...
- E.g. laminated handouts/cards or stationery



Center ANNA (Russia) designed an office desk organizer that says, “There is NO Excuse for Domestic Violence! You can talk to me about violence.”

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3.5.3. HANDOUTS

HANDOUT 19: UNDERSTANDING THE SIGNS OF GENDER-BASED VIOLENCE

The following list presents symptoms that should make health professionals consider asking about GBV, in particular intimate partner violence.

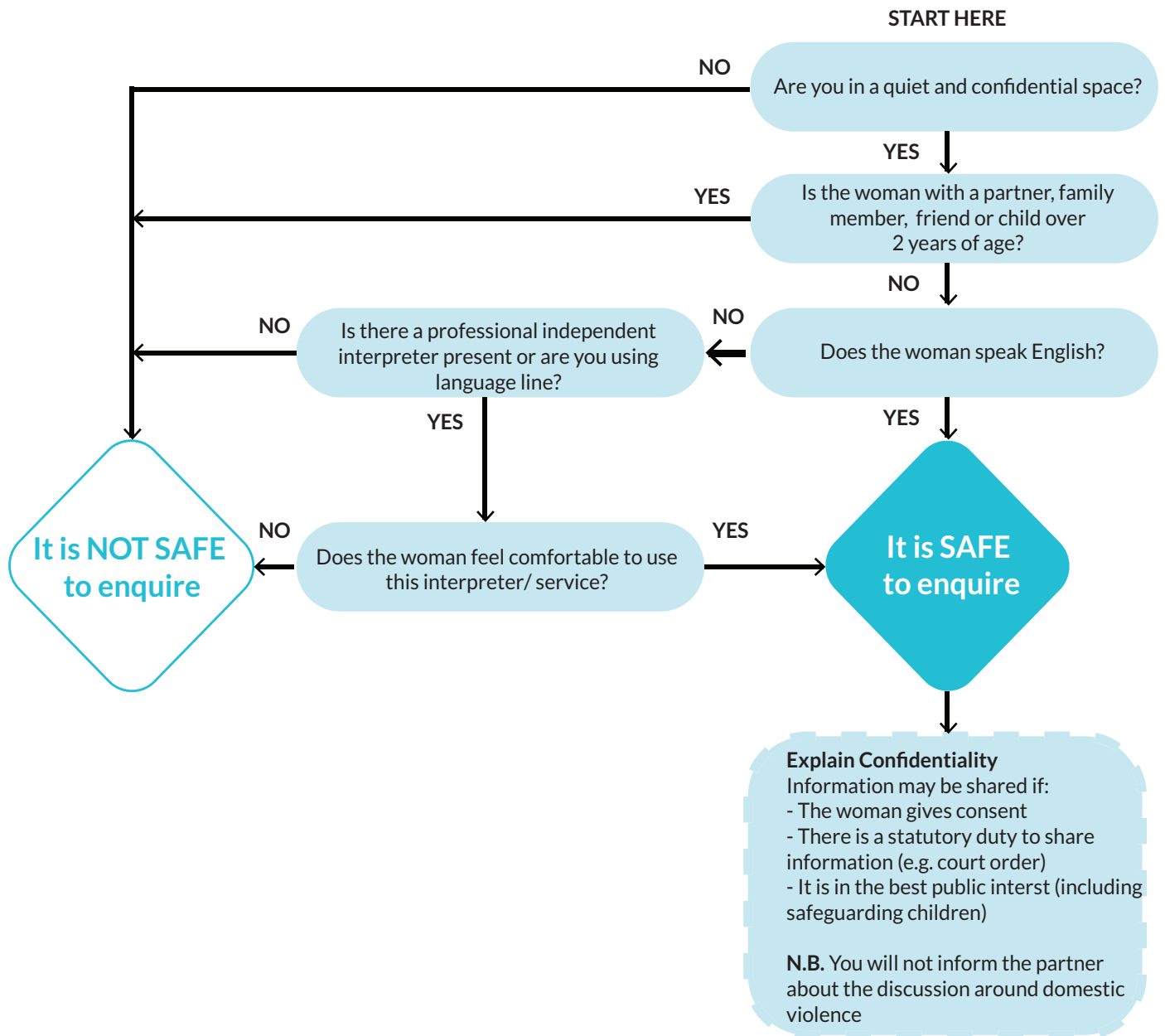
- **Examples of clinical conditions associated with intimate partner violence**
 - » Symptoms of depression, anxiety, PTSD, sleep disorders
 - » Suicidality or self-harm
 - » Alcohol and other substance use
 - » Unexplained chronic gastrointestinal symptoms
 - » Unexplained reproductive symptoms, including 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)
 - » 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

Source: adapted from Black 2011, cited in WHO 2013

- **Examples of behaviours that may indicate intimate partner violence**
 - » Frequent appointments for vague symptoms
 - » Injuries inconsistent with explanation of cause
 - » Woman tries to hide injuries or minimize their extent
 - » Partner always attends unnecessarily
 - » Woman is reluctant to speak in front of partner
 - » Non-compliance with treatment
 - » Frequently missed appointments
 - » Multiple injuries at different stages of healing
 - » Patient appears frightened, overly anxious or depressed
 - » Woman is submissive or afraid to speak in front of her partner
 - » Partner is aggressive or dominant, talks for the woman or refuses to leave the room
 - » Poor or non-attendance at antenatal clinics
 - » Early self-discharge from hospital

Source: Department of Health 2005

HANDOUT 20: IS IT SAFE TO ASK ABOUT GENDER-BASED VIOLENCE?



Source: Standing Together Against Domestic Violence, UK

HANDOUT 21: ASKING ABOUT GENDER-BASED VIOLENCE – EXAMPLES OF QUESTIONS

When asking about GBV, it is advisable to begin the enquiry with an introductory question, explaining the patient that GBV affects many women and underlining the impact of violence on women's health, before continuing with direct and more specific questions.

□ **Examples of introductory questions:**

- » “From my experience, I know that abuse and violence at home is a problem for many women. Is it a problem for you in any way?”
- » “We know that many women experience abuse and violence at home and that it impairs their health. I wonder if you have ever experienced violence at home?”
- » “We know that violence against women is a very common problem. About 30% of women in this country are abused by their partners. Has that ever happened to you?”
- » “Some women think they deserve abuse because they have not lived up to their partners' expectations, but no matter what someone has or hasn't done, no one deserves to be beaten. Have you ever been hit or threatened because of something you did or didn't do?”
- » “Many of the women I see as patients are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves. Have you ever experienced violence from your partner?”

□ **Examples of direct questions:**

- » “I am concerned that your symptoms may have been caused by someone hitting you. Has someone been hurting you?”
- » “According to our experience, women get these kinds of injuries when assaulted. Has someone assaulted you?”
- » “Did someone hit you? Who was it? Was it your partner/husband?”
- » “Has your partner or ex-partner ever hit you or physically hurt you or someone close to you?”
- » “Has your partner ever forced you to have sex when you did not want to? Has he ever refused to practice safer sex?”
- » “Does your partner frequently belittle you, insult you and blame you?”
- » “Has your partner ever tried to restrict your freedom or keep you from doing things that were important to you (like going to school, working, seeing your friends or family)?”

Source: adapted from Perttu/Kaselitz 2006, Warshaw/Ganley 1996).

HANDOUT 22: TIPS FOR COMMUNICATING WITH SURVIVORS – DO'S AND DON'T'S

Do's	Don'ts
<ul style="list-style-type: none"> ○ Take the initiative to ask about violence – do not wait for the woman to bring it up. This shows that you take a professional responsibility for her situation, and it helps to build trust. ○ Explain that the information will remain confidential and inform her about any limitations to confidentiality. ○ Use eye contact and focus all her attention on her. Avoid doing paper work at the same time. ○ Be aware of your body language. How you stand and hold your arms and head, the nature of your expression and tone of voice all convey a clear message to the woman about how you perceive the situation. ○ Show a non-judgemental and supportive attitude and validate what she is saying. ○ Use a sympathetic voice to reassure the survivor. ○ Carefully listen to her experience and assure her that her feelings are justified. ○ Show her that you believe her story. ○ Be patient with women and girls survivors of GBV, keeping in mind that they are in a state of crisis and may have contradictory feelings. ○ Emphasize that violence is not her fault and that the perpetrator is responsible for his behaviour. ○ Use supportive statements, such as “I am sorry that this happened to you” or “You really have been through a lot,” which may encourage the woman to disclose more information. ○ Underline that there are options and resources available. Try to find adequate services together with her. Leave “the door” open for her to come back to you. 	<ul style="list-style-type: none"> ○ Don't ask about violence in the presence of a partner, family member or friend. Remember that the patient's safety is paramount. ○ Avoid passive listening and non-commenting. This may make her think that you do not believe her and that she is wrong, and the perpetrator is right. ○ Don't blame the woman. Avoid questions such as “Why do you stay with him?”, “Did you have an argument before violence happened?”, “What were you doing out alone?”, “What were you wearing?” Instead, reinforce that GBV cannot be tolerated. ○ Avoid body language conveying the message of irritation, disbelief, dislike or anger toward the survivor. ○ Do not judge a survivor's behaviour based on culture or religion. ○ Don't pressure her to disclose. If she does not disclose, tell her what made you think about violence. Document your doubts and the evidence they are based on. Explain her that she can come back for further assistance. Bring up the issue at the next appointment.

Sources: Adapted from Perttu/Kaselitz et al 2006, Warshaw/Ganley 1996, WHO 2003, WHO 2013

HANDOUT 23: ROLE PLAY – ASKING ABOUT GENDER-BASED VIOLENCE – THE CASE OF NATASA

Please read the instructions and the case scenario below. Then engage in a role play, according to the roles assigned.

Instructions for the role play:

- » The aim of the role play to practice the identification of and enquiry about GBV, according to the principles discussed in training.
- » The role play has four parties: Natasa, a survivor of GBV, Ivan, her two-year old son, a doctor/nurse, and an observer.
- » Situation: Natasa has arrived at the health centre to ask for advice, together with her little son, Ivan. The doctor/nurse suspects that she might have experienced GBV and tries to bring up the issue.
- » Maximum duration of the conversation between the doctor/nurse and the survivor: 15 minutes.
- » After the role play, please come back to the bigger group for a feedback round (patient, doctor/nurse, observer), followed by comments from the larger group.

Case scenario:

Natasa, 35 years, comes to the health centre with her two-year old son, Ivan. The boy has been restless and crying a lot at night. When discussing this with Natasa, the doctor/nurse notices the black marks on her wrists. The doctor/nurse hesitates a while but then asks about them. First Natasa says that she got them when carrying her son around the house at night. Natasa seems to be very uncomfortable about the issue and doesn't want to discuss it further. The doctor/nurse says that according to her experience this kind of marks can be caused by physical violence as well. Natasa says nothing and the doctor is afraid that she will rush from the room.

Source: adapted from Ganley 1998

3.6. MODULE 6: MEDICAL EXAMINATION AND CARE

3.6.1. OUTLINE OF THE MODULE

Duration of the module	1,5 hours
Aim of the module	To provide participants with an overview of the different steps involved in <ul style="list-style-type: none"> • providing first-line support to patients disclosing GBV, • taking a medical history and undertake a physical examination, • providing treatment and follow-up care, with a focus on patients who experienced sexual violence and/or suffer from pre-existing and GBV-related mental disorders
Key learning messages	Following disclosure of GBV by a patient, health care providers should <ul style="list-style-type: none"> • provide first-line support, • obtain informed consent from the patient on all aspects of the consultation, • take a complete medical history, • undertake a complete physical examination, • treat injuries, • for survivors of sexual violence: offer emergency contraception and post exposure prophylaxis for HIV and STI, • for survivors with pre-existing diagnosed or GBV-related mental disorders: provide mental health care in line with WHO mhGAP guidelines or refer survivors to specialist mental health care providers.
Background readings for trainer	UNFPA-WAVE Resource Package, Part I, chapter 3.2 Further reading: WHO 2003, WHO 2010a, WHO 2013
Methods	<ul style="list-style-type: none"> • Presentation by trainer (PPT slides 1-10, distribution of handout 24) • Presentation by trainer (PPT slides 11-13, distribution of handout 25) • Presentation by trainer (PPT slides 14-17)
Notes for trainers	When distributing the checklist for the examination on handout 24, you may want to facilitate an exchange in the group to discuss participants' work practice. Possible questions for discussions include: Do you find this checklist useful for your work? Are there any challenges in the examination of survivors of GBV that you have experienced? How could they be overcome?
Materials for training session	Presentation: PowerPoint presentation Module 6 Handouts: Handout 24: Checklist for physical examination of survivors of gender-based violence Handout 25: WHO guidelines for prevention of unwanted pregnancies, HIV and STIs

3.6.2. POWERPOINT PRESENTATION

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6. Medical examination and care

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Aim of this module

- To provide an overview of the different steps involved in
 - providing first-line support to patients disclosing GBV
 - taking a medical history and undertake a physical examination
 - providing treatment and follow-up care, with a focus on patients who experienced sexual violence and/or suffer from pre-existing and GBV-related mental disorders

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Outlook

- First-line support
- Medical history
- Physical examination
- Treatment and follow up care
 - Injuries
 - Unwanted pregnancies, STIs & HIV
 - Psychological/mental health interventions

3

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First-line support

4

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Elements of first-line support (WHO 2013)

- Be non-judgemental and supportive, validate what the woman is saying
- Provide practical care and support that responds to her concerns, but does not intrude
- Ask about her history of violence, listen carefully, but do not pressure her to talk
- Help her access information about resources
- Assist her to increase safety for herself and her children
- Provide or mobilize social support
- Ensure the consultation is conducted in private and inform women of the limits of confidentiality

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Medical history

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Steps for medical history

1. Obtain informed consent
 - Explain all aspects of consultation
 - Explain limits of confidentiality
 - Ask patient to sign or mark consent form, if required by law
2. Take complete medical history
 - the time since assault and type of assault
 - the risk of pregnancy
 - the risk of HIV and other STIs
 - the woman's mental health status

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Tips for interviewing

- Ask her to tell in her own words what happened
- Avoid unnecessary interruptions
- Be thorough, some patients may purposely avoid embarrassing details (e.g. oral sexual contact, anal penetration)
- Use open-ended questions and avoid questions starting with “why”, which tends to imply blame
- Address questions and concerns non-judgementally (using a calm tone of voice, maintaining eye contact, and avoiding expressing shock or disbelief)

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Physical examination

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Checklist: general principles

- ✓ Explain the medical examination
- ✓ Ask her to disrobe completely and to put on a hospital gown, so that hidden injuries can be seen
- ✓ Examine both serious and minor injuries
- ✓ Throughout the physical examination inform the patient what you plan do next and ask permission, always let her know when and where touching will occur, show and explain instruments and collection materials
- ✓ Patients may refuse all or part of the examination
- ✓ Provide medical and legal (forensic) services at the same time, in the same place, by the same person, if possible

H24

10

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Treatment and follow-up care

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Treatment of injuries

- Refer patients with severe, life-threatening conditions for emergency treatment right away
- Try to treat patients with less severe injuries (cuts, bruises, superficial wounds) in situ.
- The following medications may be indicated:
 - antibiotics to prevent wounds from becoming infected
 - a tetanus booster or vaccination (according to local protocols)
 - medications for the relief of pain, anxiety or insomnia

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Prevention of unwanted pregnancies, STIs & HIV

- Emergency contraception
- HIV post-exposure prophylaxis
- Post-exposure prophylaxis for STIs



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Treatment of psychological/mental health outcomes (1)

- Where referral possibilities are available: **refer** survivors with pre-existing diagnosed or IPV-related mental disorders **to specialist health care providers** for psychological/mental healthcare interventions
- Some interventions may be performed by **primary health care providers**, in line with WHO mhGAP guidelines that apply to non-specialized health care settings
- In settings with limited or no referral possibilities, provide **psychological first aid** support

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Treatment of psychological/mental health interventions (2)

For survivors of IPV (or mental health outcomes of non-partner violence)

- For survivors with *pre-existing diagnosed or IPV-related mental disorders*: provide mental health care in line with WHO mhGAP Intervention Guide
- For women who are either *breastfeeding or pregnant*: consult with a specialist for use of psychotropic medicine
- For women who *no longer experience IPV but are suffering from PTSD*: arrange for psychotherapy (cognitive behavioural therapy [CBT] or eye movement desensitization reprocessing [EMDR])
- *Mother-child* intervention (though not always feasible): offer children who are exposed to IPV a psychotherapeutic intervention, including sessions with and without their mother.

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Treatment of psychological/mental health interventions (3)

For survivors of sexual violence

1. During the first days of the assault
 - continue providing first-line support, but not psychological debriefing
 - provide written info on coping strategies for dealing with severe stress
2. Up to three months post-trauma
 - continue first-line support
 - apply “watchful waiting” for 1-3 months after the event
 - arrange CBT or EMDR interventions (only if necessary)
 - provide care in line with the WHO mhGAP Intervention Guide if the person has any other mental health problems
3. After three months post-trauma
 - assess for mental health problems
 - if suffering from PTSD, arrange for PTSD treatment with CBT or EMDR

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Treatment of psychological/mental health interventions (4) General Principles

- Ensure patients’ informed consent and safety
- Therapies should be implemented by a trained health care provider with a good understanding of sexual violence
- Consider pre-existing mental health conditions
 - Higher likelihood in rape survivors
- Consider pre-existing traumatic events (sexual abuse in childhood, IPV, war-related trauma)

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3.6.3. HANDOUTS

HANDOUT 24: CHECKLIST FOR PHYSICAL EXAMINATION OF SURVIVORS OF GENDER-BASED VIOLENCE

- » Explain the medical examination, what it includes, why it is done and how, to avoid the exam itself becoming another traumatic experience. Also, give the patient a chance to ask questions.
- » Ask the patient if she wishes a female doctor (especially in cases of sexual violence).
- » Do not leave the patient alone (e.g. when she is waiting for the examination).
- » Ask her to disrobe completely and to put on a hospital gown, so that hidden injuries can be seen.
- » Examine especially areas covered by clothes and hair.
- » If she has experienced sexual violence, examine her whole body – not just the genitals or the abdominal area.
- » Examine both serious and minor injuries.
- » Note emotional and psychological symptoms as well.
- » Throughout the physical examination inform the patient what you plan do next and ask permission. Always let her know when and where touching will occur. Show and explain instruments and collection materials.
- » Patients may refuse all or part of the physical examination. Allowing her a degree of control over the examination is important to her recovery.
- » Both medical and forensic specimens should be collected during the course of the examination. This should be done by a health care professional trained in forensic medicine. Providing medical and legal (forensic) services at the same time, in the same place and by the same person reduces the number of examinations that the patient has to undergo and can ensure the needs of the patient are addressed more comprehensively.

Source: Perttu/Kaselitz 2006, Warshaw/Ganley 1996, WHO 2003

HANDOUT 25: WHO GUIDELINES FOR PREVENTION OF UNWANTED PREGNANCIES, HIV AND SEXUALLY TRANSMITTED INFECTIONS IN CASE OF SEXUAL VIOLENCE

EMERGENCY CONTRACEPTION

Health care professionals should offer emergency contraception to survivors of sexual assault, based on the following guidelines:

- » Emergency contraception should be initiated as soon as possible after the assault. It is more effective if given within 3 days but can be given up to 5 days (120 hours).
- » Health-care providers should offer levonorgestrel (recommended: single dose of 1.5 mg).
- » If levonorgestrel is not available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics to prevent nausea, if available.
- » If oral emergency contraception is not available and it is feasible, copper-bearing intrauterine devices (IUDs) may be offered to women seeking ongoing pregnancy prevention. Taking into account the risk of STIs, the IUD may be inserted up to 5 days after sexual assault for those who are medically eligible, in line with the WHO medical eligibility criteria (WHO 2010a).

Safe abortion should be offered in accordance with national law, if:

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

HIV POST-EXPOSURE PROPHYLAXIS

Health care professionals should consider offering HIV post-exposure prophylaxis (HIV PEP) for women presenting within 72 hours of a sexual assault. Health professionals and the survivor should use shared decision-making in order to determine whether HIV PEP is appropriate. When discussing the HIV risk, the following factors should be taken into account:

- » HIV prevalence in the geographic area,
- » limitations of PEP,
- » the HIV status and characteristics of the perpetrator if known,
- » assault characteristics, including the number of perpetrators,
- » side-effects of the antiretroviral drugs used in the PEP regimen, and
- » the likelihood of HIV transmission.

If HIV PEP is used, health care professionals should:

- » start the regimen as soon as possible and before 72 hours,
- » provide HIV testing and counselling at the initial consultation,
- » ensure patient follow-up at regular intervals, and
- » provide adherence counselling. The latter is important, keeping in mind that many women survivors of sexual violence do not successfully complete the 28 days of the preventive regime required in order to be effective. This is because HIV PEP causes nausea and vomiting, may trigger painful thoughts of the rape and may be overtaken by other issues in the lives of the survivors.

Two-drug regimens (using a fixed dose combination) are generally preferred over three-drug regimens, prioritizing drugs with fewer side-effects. The choice of drug and regimens should follow national guidance. It is recommended that survivors of sexual violence undergo HIV testing prior to giving PEP, but should not preclude PEP from being offered. Persons with HIV infection should not use PEP; rather, they should receive care and antiretroviral therapy.

POST-EXPOSURE PROPHYLAXIS FOR SEXUALLY TRANSMITTED INFECTIONS:

Health care professionals should offer women survivors of sexual assault post-exposure prophylaxis for the following sexually transmitted infections:

- » chlamydia,
- » gonorrhoea,
- » trichomoniasis, and
- » syphilis, depending on the prevalence.

The choice of drug and regimens should follow national guidance. In order to avoid unnecessary delays, presumptive treatment is preferable to testing for STIs; therefore, testing prior to treatment is not recommended.

Hepatitis B vaccination without hepatitis B immune globulin should be offered according to national guidelines. Health care professionals should take blood for hepatitis B status prior to administering the first vaccine dose. If immune, no further course of vaccination is required.

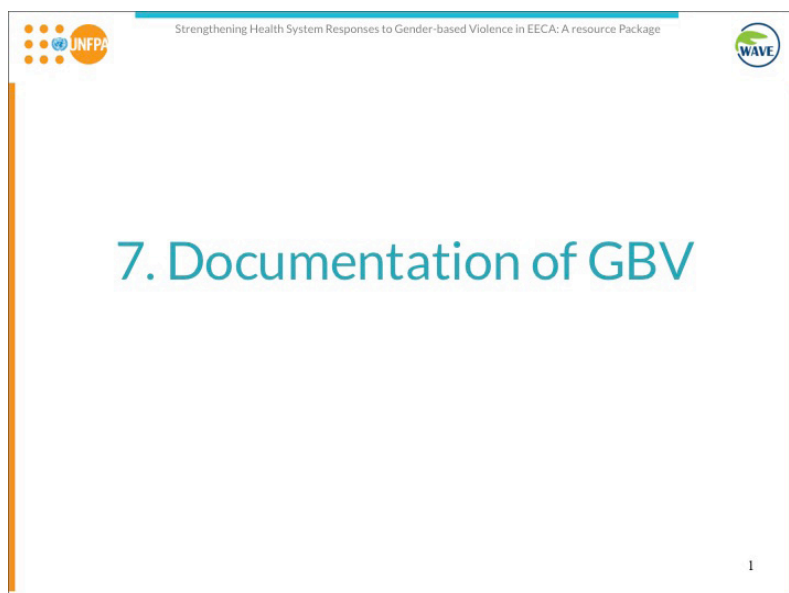
Source: WHO 2013, Rec. 13-20

3.7. MODULE 7: DOCUMENTATION OF GENDER-BASED VIOLENCE

3.7.1. OUTLINE OF THE MODULE

Duration of the module	1 hour
Aim of the module	<ul style="list-style-type: none"> To explain why is it necessary to document GBV. To provide participants with an overview of the different steps involved in <ul style="list-style-type: none"> » recording and classifying injuries, » documenting GBV, » providing medico-legal services (undertaking a forensic examination, providing evidence in court), and » storing patient data.
Key learning messages	<ul style="list-style-type: none"> Documentation of GBV is necessary from the perspective of the health care provider, the patient, and good clinical care. Health care professionals should carefully describe any injuries assessed, including the type, number and location of injuries, using a body map. Interpretation of injuries for medico-legal purposes should be done by trained forensic specialists. Mechanisms for documentation include hand-written notes, diagrams, body maps and photographs. Photographs may supplement, but should not replace other forms of documentation. Where a criminal offence has been committed, forensic specimens should be collected carefully and as early as possible. Patient records and information should be stored strictly confidentially and at a safe place.
Background readings for trainer	<p>UNFPA-WAVE Resource Package, Part I, chapter 3.3</p> <p>Further reading: WHO 2003</p>
Methods	<ul style="list-style-type: none"> Presentation by trainer (PPT slides 1-11, distribution of handouts 26-28, Annex 8) Presentation by trainer (PPT slides 12-18)
Notes for trainers	<p>When distributing the checklist for documentation of GBV on handout 26 and the templates on handouts 27-28, you may want to facilitate an exchange in the group to discuss participants' work practice. Possible questions for discussion include: Do you find the checklist useful for your work? Do you use similar documentation forms in your daily work? Are there any challenges in the documentation of GBV that you have experienced? How could they be overcome?</p>
Materials for training session	<p>Presentation: PowerPoint presentation Module 7</p> <p>Handouts: Handout 26: Checklist for documenting cases of gender-based violence Handout 27: Check-list for using photography to document gender-based violence Handout 28: Documentation form for cases of gender-based violence – example from Austria Annex 8: WHO sexual violence documentation form</p>

3.7.2. POWERPOINT PRESENTATION



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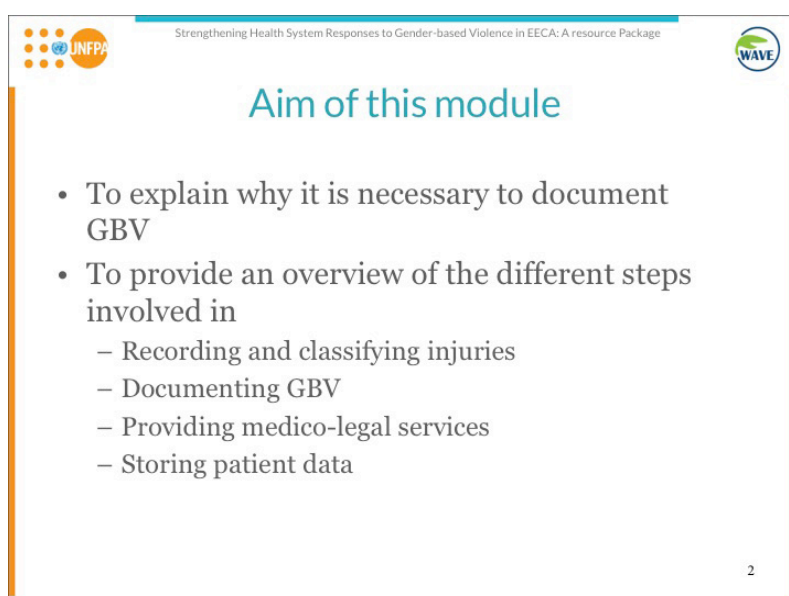
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WAVE

7. Documentation of GBV

1

This is the first slide of a PowerPoint presentation. It features a white background with a blue header bar. The UNFPA logo is on the left, and the WAVE logo is on the right. The title '7. Documentation of GBV' is centered in a large, bold, blue font. The number '1' is in the bottom right corner.



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Aim of this module

- To explain why it is necessary to document GBV
- To provide an overview of the different steps involved in
 - Recording and classifying injuries
 - Documenting GBV
 - Providing medico-legal services
 - Storing patient data

2

This is the second slide of the presentation. It has the same header as slide 1. The title 'Aim of this module' is centered in a blue font. Below the title is a bulleted list with two main points. The first point is 'To explain why it is necessary to document GBV'. The second point is 'To provide an overview of the different steps involved in', followed by a sub-list of four items: 'Recording and classifying injuries', 'Documenting GBV', 'Providing medico-legal services', and 'Storing patient data'. The number '2' is in the bottom right corner.

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Outlook

- Importance of documenting GBV
- Recording and classifying injuries
- How and what should be documented
- Forensic examinations
- Providing evidence in court
- Storage and access to patient records/info

3

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Importance of documenting GBV

4

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Uses of documentation

Health professional's legal issues	Patient's legal issues	For good clinical care
<ul style="list-style-type: none"> • Professional obligation to record details of any consultation with a patient • Notes should reflect what patient said, what was seen and done • Keep confidential 	<ul style="list-style-type: none"> • Medical records can be used in court as evidence • Documenting health consequences may help court in decision-making and provide info about past/ present violence • Lack of coordination between healthcare and police/ prosecutors can cause loss of evidence 	<ul style="list-style-type: none"> • Documentation can alert other health care providers, who may later attend the patient, to her experiences of GBV and thereby assist in providing appropriate follow-up care

5

Recording and classifying injuries

6

Recording and classifying injuries

- Recording - carefully describe any injuries
 - Type, number of injuries, and location using a body map
 - In case a survivor does not disclose, note whether the injuries are compatible with her explanations
- Interpretation involves determining age of an injury, how it was produced or the amount of force required to produce the injury (for forensic purposes)
- Without accurate documentation and expert interpretation, conclusions on how injuries occurred might be seriously flawed.

7

Don't interpret without training

- Health care professionals who are **not trained** in interpretation of injuries should
 - **document injuries**, using standard terminology as provided in the WHO medico-legal guidelines for victims of sexual violence (i.e. abrasions, bruises, lacerations, incisions, stab wounds or gunshot wounds)
 - **refer** the task of injury **interpretation** to a **forensic specialist**

8

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How and what should be documented

9

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What to document in cases of sexual violence

Information including:

- demographic information & patient education
- consents obtained
- history (i.e. general medical and gynaecological history)
- an account of the assault
- results of the physical examination
- tests and their results
- treatment plan
- medications given or prescribed
- referrals given

10

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How to document

- Hand-written notes
- Diagrams
- Body charts
- Photography
 - Should be used to document injuries, but not replace other methods of recording
 - Important evidence for criminal proceedings

Checklist for photography

- ✓ Consider the patient
- ✓ Identification
- ✓ Scales
- ✓ Orientation
- ✓ Chain of custody
- ✓ Security
- ✓ Sensitivity

**H26
H27
H28**

11

Forensic examinations

12

Forensic examination

“Medical examination conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion”

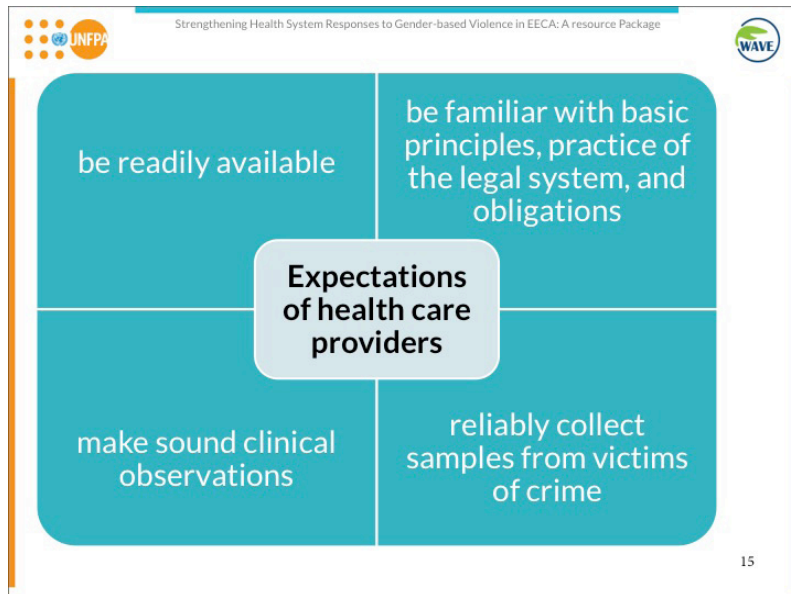
Principles for specimen collection:

- collect carefully, avoiding contamination
- collect specimens as early as possible (72 hours after assault, value of evidentiary material decreases)
- label all specimens accurately
- dry all wet specimens
- ensure specimens are secure and tamper proof
- maintain continuity
- document details of all collection/handling procedures

13

Providing evidence in court

14



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Guiding principles

Writing reports

1. Explain what you were told and observed.
2. Use precise terminology.
3. Maintain objectivity.
4. Stay within your field of expertise.
5. Distinguish findings and opinions.
6. Detail all specimens collected.
7. Only say or write what you would be prepared to repeat under oath.

Giving evidence in court

1. Be prepared.
2. Listen carefully.
3. Speak clearly.
4. Use simple and precise language.
5. Stay within your field of expertise.
6. Separate facts and opinion.
7. Remain impartial.

** Without specific training of medico-legal aspects of service provision, health professionals should not offer an opinion. The court can seek an expert for interpretation of observations.

16

Storage and access to patient data

17

Storage and access to patient data

Professional, legal and ethical duty to maintain and respect patient **confidentiality and autonomy.**

Records/ information should **not be disclosed** to anyone except those directly involved in the case or as required by local, state and national laws.

All patient records should be **stored in a safe place.** Biological evidence usually needs to be refrigerated or frozen; check with your laboratory.

18

3.7.3. HANDOUTS

HANDOUT 26: CHECKLIST FOR DOCUMENTING CASES OF GENDER-BASED VIOLENCE

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

Source: WHO 2003, Warshaw et al 1996

HANDOUT 27: CHECKLIST FOR USING PHOTOGRAPHY TO DOCUMENT GENDER-BASED VIOLENCE

- » **Consider the patient and obtain informed consent:** Many survivors will be uncomfortable, unhappy, tired or embarrassed. Communicate the role of photography and obtain informed consent for the procedure.
- » **Identification:** Each photograph must identify the subject, the date and the time that the photograph was taken. The photographs should be bound with a note stating how many photographs make up the set. Ideally, a new roll of film should be used for each subject; alternatively, there should be a clear indication of where a new series commences.
- » **Scales:** A photograph of the colour chart should commence the sequence of photographs. Scales are vital to demonstrate the size of the injury. They may be placed in the horizontal or vertical plane. Photographs should be taken with and without a scale.
- » **Orientation:** The first photograph should be a facial shot for identification purposes; this may not be required if the photographs have been adequately identified (see above). Subsequent shots should include an overall shot of the region of interest followed by close-up shots of the specific injury or injuries.
- » **Chain of custody:** This should be logged as for other forensic evidence.
- » **Security:** Photographs form part of a patient record and as such should be accorded the same degree of confidentiality. Legitimate requests for photographs include those from investigators and the court. If, however, a copy is made for teaching purposes, the consent of the subject or his/her parents/guardian should be obtained.
- » **Sensitivity:** The taking of photographs (of any region of the body) is considered to be inappropriate behaviour in some cultures and specific consent for photography (and the release of photographs) may be required. Consent to photography can only be obtained once the patient has been fully informed about how, and why, the photographs will be taken. The briefing should also explain how this material may be used (e.g. released to police or courts and cited as evidence).

Source: WHO 2003

HANDOUT 28: DOCUMENTATION FORM FOR CASES OF GENDER-BASED VIOLENCE – EXAMPLE FROM AUSTRIA

<p>Place of examination:</p> <p>Doctor: _____ Tel. _____</p> <p>Referred by: _____</p> <p>Beginning of examination: _____ : _____ (Date) (Time)</p>	<p>Patient:</p> <p>Date of Birth: _____ Tel. _____</p> <p>Address: _____</p> <p>Other people present: _____</p>
<p>PATIENT-BASIC DOCUMENTATION</p> <p>Height: _____ Weight: _____</p> <p>Psychological condition during examination:</p>	<p>Patient is: <input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed</p> <p>Consciousness: <input type="checkbox"/> clear <input type="checkbox"/> slightly impaired <input type="checkbox"/> clearly impaired <input type="checkbox"/> unconscious</p> <p>Impression of: <input type="checkbox"/> alcohol <input type="checkbox"/> drug consumption</p>
<p>communication:</p> <p><input type="checkbox"/> fluent <input type="checkbox"/> broken <input type="checkbox"/> translation necessary</p> <p>by whom:</p> <p>Dangerous situations for staff <input type="checkbox"/> yes <input type="checkbox"/> no</p>	
<p>DETAILS ABOUT OFFENSE (According to patient)</p> <p>Location: _____</p> <p>Time: _____ (Date) _____ : _____ (Time)</p> <p>(approx.) duration of the incident: _____</p>	<p><input type="checkbox"/> assailant known</p> <p><input type="checkbox"/> assailant(s) unknown How many: _____</p>
<p>Description of assault (According to patient), weapons used, details of assault, subjective complaints: (Basis for clinical examination and forensic data collection, no suggestive interrogation!)</p>	

<p>PATIENT STORY</p> <p>Are there witnesses of the offense (e. g. children, neighbours)? ↳ If yes, are they also concerned/hurt? Were objects (tools, weapons) used? Did the survivor try to defend herself? Did the patient scratch the assailant(s)?</p> <p>Was force used against the throat (strangle, choking)?</p> <p>Did the patient consume alcohol, drugs or medication before, during or after the offence??</p> <p>Has a similar offence happened before?</p>	<p><input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know</p> <p>↳ If yes, please wipe the lower surface of the fingernails with wet cotton (DNA!)</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know ↳ <input type="checkbox"/> signs of congestion <input type="checkbox"/> unconsciousness <input type="checkbox"/> deception <input type="checkbox"/> loss of urine or stool <input type="checkbox"/> pain in the throat, difficulty to swallow</p> <p><input type="checkbox"/> yes when, what, how much: <input type="checkbox"/> no <input type="checkbox"/> don't know</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> no answer</p>
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SAVING EVIDENCE		
<p>Damage on clothes (Photo!)? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Contamination of clothes (blood, soil etc.)? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other traces secured? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>Clothing secured</p> <p><input type="checkbox"/> yes</p> <p><input type="checkbox"/> no</p>	<p>↳ which:</p> <p>→ Packed separately in paper bags!</p>

PHYSICAL EXAMINATION		
<p>Head</p>	<p>Hairy skull (palpate, bald spots?):</p> <p>Forehead-/temporal region</p> <p>Eyes (incl. conjunctiva):</p> <p>Ears (backside):</p> <p>Nose (nostrils):</p> <p>Cheeks:</p> <p>Mouth (lips, teeth, vestibular mucosa):</p> <p>Chin:</p>	<p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p>
	<p>Are there signs of congestion?</p>	<p><input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>↳ <input type="checkbox"/> skin of eyelid</p> <p><input type="checkbox"/> conjunctiva</p> <p><input type="checkbox"/> skin behind ears</p> <p><input type="checkbox"/> facial skin</p> <p><input type="checkbox"/> vestibular mucosa</p>
<p>Throat</p>	<p>Front side:</p> <p>Neck:</p>	<p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p>
<p>Thorax</p>	<p>Mammae:</p> <p>Anterior rib cage:</p> <p>Back:</p>	<p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p> <p><input type="checkbox"/> NAD</p>

Arms	Shoulder: Upper arms (even inside): Forearms (wrists): Hands:	<input type="checkbox"/> NAD <input type="checkbox"/> NAD <input type="checkbox"/> NAD <input type="checkbox"/> NAD
Abdomen		<input type="checkbox"/> NAD
Buttock		<input type="checkbox"/> NAD
Genital area		<input type="checkbox"/> NAD
Legs	Thigh (inner thighs) Lower leg: Feet:	<input type="checkbox"/> NAD <input type="checkbox"/> NAD <input type="checkbox"/> NAD

Is an apparent pattern of injury visible? yes no
(grouped or shaped injuries, burns, prints, e.g. shoe print, tire prints, double bruise):

Gunshot wound excision of projectile, marked and documented

Provisional medical assessment:

Further measures (e. g. multidisciplinary consultation, psychological counselling, informing police etc.):

Information about services (shelter, helpline) given? yes comments:

End of examination: _____ time: _____ signature doctor: _____

TRANSMISSION OF EVIDENCE

Objects (clothing, instrumentalities, projectile, excised tissue etc.):

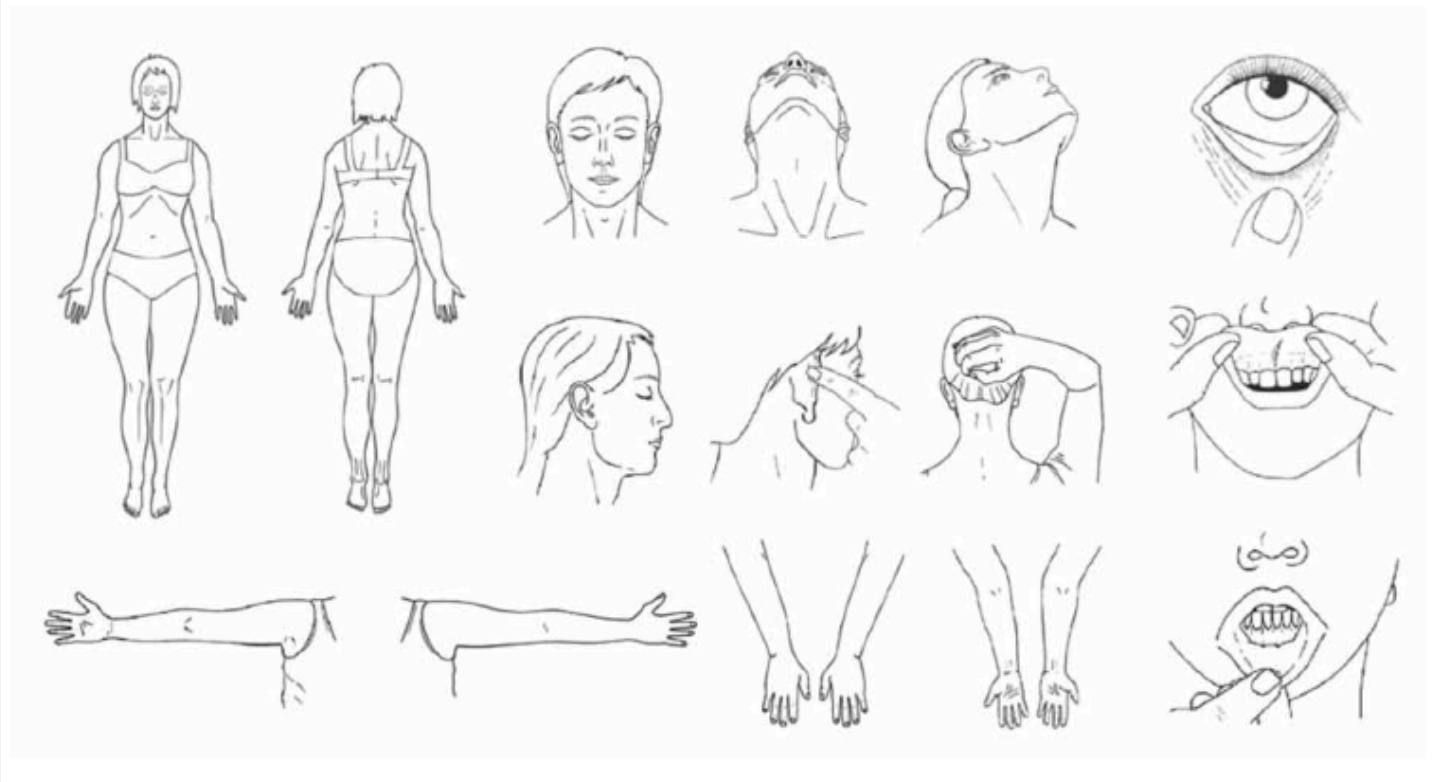
Transmitted by: _____ (capital letters)	Taken over by: _____ a (capital letters)
Date and signature: _____ , _____ a	Date and signature: _____ , _____ a a

PHOTO DOCUMENTATION

Was photo documentation made? yes no
↳ if „no“, why not:
↳ if „yes“, where archived:

Number of photos taken: _____ a

Recommendation for examination and photo basic documentation:



Source: Adapted from BMWFJ 2010 (translation from German to English by WAVE)

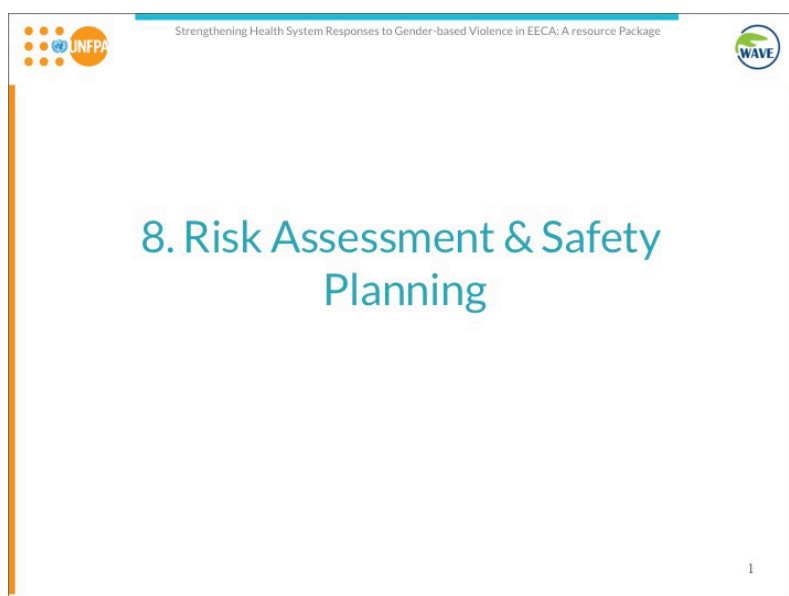
3.8. MODULE 8: RISK ASSESSMENT AND SERVICE PLANNING

3.8.1. OUTLINE OF THE MODULE

Duration of the module	2 hours
Aim of the module	To provide participants with knowledge and skills to <ul style="list-style-type: none"> • understand the importance of risk assessment and safety planning, and • support the patient in identifying risk factors for repeating or increasing intimate partner violence and in developing a safety plan.
Key learning messages	<ul style="list-style-type: none"> • Health care professionals play an important role in supporting a survivor of GBV through jointly assessing potential risks, supporting her in her safety planning and referring her to other services needed (e.g. shelter). • Risk factors for repeating or increasing intimate partner violence include previous acts of violence, threats, possession and/or use of weapons and extreme jealousy and possessiveness. • Separation and divorce are high times of risk. Therefore, health care providers should not encourage women to leave a violent partner, as this can put them at further risk. • Risk assessment should follow standardized tools and procedures, for instance the Danger Assessment developed by Jacqueline Campbell. Acronyms can be a practical tool to help health care professionals to memorize key risk factors in day-to-day work practice (e.g. SPECSS used in the UK); developing local acronyms that fit the respective context and language is recommended. • Developing a safety plan together with the patient can help her to leave the relationship in case the violence escalates. This should include precautions such as identifying neighbours, friends or relatives that can offer support or having a packed bag ready with essential items in case the woman needs to leave the home in a hurry. • Networking and establishing referral pathways with other service providers is important. In particular women's shelters may be specialized in risk assessment and safety planning and can make an important contribution to protecting the patient's safety. • In the absence of women's shelters, health facilities could consider practical solutions, such as offering women short-term stays in the facility.
Background readings for trainer	UNFPA-WAVE Resource Package, Part I, chapter 3.4 Further readings: WAVE 2013
Methods	<ul style="list-style-type: none"> • Presentation by trainer (PPT slides 1-6, handout 29) • Presentation by trainer (PPT slides 7-10, handout 30) • Individual exercise: Identifying risk factors – the case of Mrs. Y (handouts 30-31) – duration: 25 minutes • Presentation by trainer (PPT slides 11-13, handouts 32-33, handout 17 on victim support rooms/module 4) • Role play: Safety Planning – the case of Dilorom (handouts 32-34) – duration: 45 minutes

<p>Notes for trainers</p>	<p>Individual exercise: Identifying risk factors – the case of Mrs. Y (handout 31) – duration: 25 minutes</p> <p>Ask participants to read handout 31 and to identify risk factors, using the Danger Assessment by Campbell (handout 30). Allow 10 minutes for individual work and 15 minutes for discussion in the group. When wrapping up the exercise, explain that this case study is based on a true story.– Ms. Y, a woman of Turkish origin living in Austria was eventually killed by her husband because the criminal justice authorities had underestimated the risk. Her children took the case to the UN CEDAW Committee, which found that Austria had violated its obligations under the CEDAW Convention. You may also want to point out that it is very important that all agencies involved are aware of the risk factors, use the same standardized risk assessment tool and are trained on applying, are trained on using it, and that risk assessment becomes a routine standard in their everyday work.</p> <p>Role play: Safety Planning – The Case of Dilorom (handouts 30-32) – duration: 45 minutes</p> <p>Disseminate handout 34 with the instructions; ask participants to also refer to handouts 32 and 33. Ask for volunteers for the following three roles: patient, doctor/nurse, and observer. A bigger training group can be divided into small groups (factor in more time for the discussion). Allow 10-15 minutes for the role play. Parties can change roles, if there is enough time. After the role play, facilitate a discussion (15-20 minutes):</p> <ul style="list-style-type: none"> • Questions to the person playing the survivor: How did you feel in your role? Was the behaviour of the doctor/nurse useful? What could the doctor/nurse have done differently? • Questions to the person playing the doctor/nurse: How did you feel in your role? What did I handle well? What was the most difficult for me? What could I have done differently? What do I need to in my work practice to support a patient in safety planning? • Ask the observer to share her/his observations and feedback. <p>Then open the discussion to the group.</p>
<p>Materials for training session</p>	<p>Presentation: PowerPoint presentation Module 8</p> <p>Handouts:</p> <p>Handout 29: Risk factors indicating a high degree of dangerousness in case of intimate partner violence</p> <p>Handout 30: Example of a risk assessment tool: Danger Assessment by Jacquelyn C. Campbell</p> <p>Handout 31: Individual exercise: Identifying risk factors – the case of Mrs. Y</p> <p>Handout 32: Check list for developing a safety plan with the survivor</p> <p>Handout 33: Individual safety plan for women who experienced violence by intimate partners or other family members</p> <p>Handout 34: Role Play: Safety Planning – The Case of Dilorom</p>

3.8.2. POWERPOINT PRESENTATION



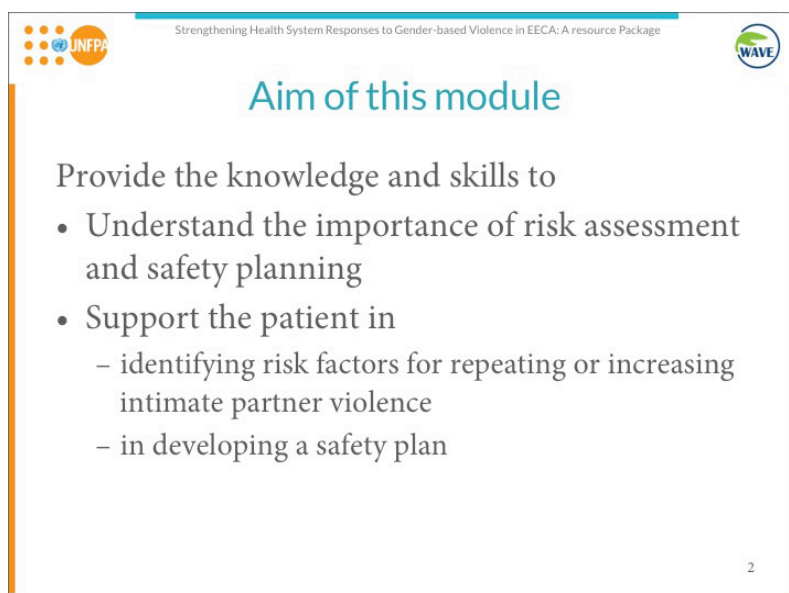
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8. Risk Assessment & Safety Planning

1



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Aim of this module

Provide the knowledge and skills to

- Understand the importance of risk assessment and safety planning
- Support the patient in
 - identifying risk factors for repeating or increasing intimate partner violence
 - in developing a safety plan

2

Outlook

- Risk factors for repeating/escalating violence
- Risk assessment
- Safety planning

3

Risk factors for repeating or escalating intimate partner violence

4

Risk factors

- IPV: Isolated occurrences of violence are rare
- Chances of repeated offenses are high
- Risk of violence increases during separation/divorce
- Most murders or serious acts of violence are committed when a survivor attempts to leave a violent partner
- So, understanding potential risk and supporting the survivor is paramount to her survival
- **The more factors that apply in a specific case, the higher the risk is that acts of violence will be repeated or that violence may increase/escalate.**

5

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Specific risk factors

- Previous acts of violence against the woman or family members
- Previous acts of violence outside the family
- Separation and divorce
- Acts of violence committed by other family members
- Possession and/or use of weapons
- Threats
- Extreme jealousy and possessiveness
- Extremely patriarchal concepts and attitudes
- Persecution and psychological terror (stalking)
- Danger for children
- Non-compliance with restraining orders by courts or police
- Possible triggers

H29

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Risk assessment

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Assessment tools

- Enables criminal justice authorities to decide on actions against the perpetrator
- Enables service providers to support the patient in identifying measures to increase her safety and to raise her awareness of the risk
- Many tools have been developed, e.g. Danger Assessment by Campbell (2004)
 - 1) a calendar, on which the woman should mark frequency and severity (on a scale from 1-5) of violent incidents that happened in the past year
 - 2) a list of 20 questions, to be answered with yes or no

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Risk assessment

- Undergo training on applying risk assessment tools.
- Ask the victim about her own assessment of the situation.
- Lower level risk cases should not be used as a basis to deny access to services.
- Adapt risk assessment tools to the local regional/ country context.

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Acronyms for risk factors – example from UK (SPECSS)

- S** • **Separation/child contact:**
 - In London, 76% of domestic abuse murder victims had recently ended the relationship.
- P** • **Pregnancy** (pre-birth and under 1s)
 - 30% of domestic violence and abuse starts in pregnancy.
- E** • **Escalation of violence**
 - Previous domestic violence: 35% of households have a 2nd incident within 5 weeks of the first.
- C** • **Cultural factors**
 - Language barriers, immigration status, isolation
- S** • **Stalking**
 - More dangerous behaviours by intimate relationship stalkers vs. non-intimate relationship.
- S** • **Sexual assault**
 - Where abusers use both physical and sexual violence, victims are at an elevated risk.

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Safety planning

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Safety planning assistance (1)

- Developing a safety plan may help the woman prepare to leave the relationship safely.
- Health providers should help the woman find affordable safe places to go to like
 - homes of friends or relatives
 - referral to women's shelters or women's organizations
- Low-income women and those from rural or ethnic minority communities often lack resources to leave the abuser or afford alternative places to stay.

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Safety planning assistance (2)

- Health facilities should network with such groups and establish referral pathways.
- In the absence of shelters, consider practical solutions like offering women short-term stays in the facility.

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3.7.3. HANDOUTS

HANDOUT 29: RISK FACTORS INDICATING A HIGH DEGREE OF DANGEROUSNESS IN CASE OF INTIMATE PARTNER VIOLENCE

- » **Previous acts of violence against the woman, the children or other family members, as well as former partners:** Look at the history of abuse, forms and patterns of violence used as well as former convictions or reports to police. Perpetrators who have committed frequent, severe acts of violence (such as using a weapon or strangling the victim) are particularly dangerous.
- » **Previous acts of violence outside the family**, e.g. against the staff of service providers or authorities, indicate a general tendency to use violence also within the home.
- » **Separation and divorce** are times of high risk.
- » **Acts of violence committed by other family members** of the perpetrator may be used to control the victim and result in making it impossible for her to flee.
- » **Possession and/or use of weapons:** Legal or illegal possession of weapons increases the risk of armed violence, especially when the perpetrator has used, or threatened to use weapons in the context of earlier episodes of violence.
- » **Abuse of alcohol or drugs** does not in itself cause violence, but may lower the threshold and thus contribute to an escalation of violence.
- » **Threats** should always be taken serious. It is wrong to assume that persons who “only” use threats are not dangerous – in fact, severe violence is often preceded by threats. In particular, threats of murder must be taken serious: In many cases of women being killed by intimate partners, they had been repeatedly threatened with murder before being killed.
- » **Extreme jealousy and possessiveness:** Perpetrators who kill or severely injure their partners are often possessed by the desire to own and control their partners, sometimes regarding every man around their partner as a rival and constantly accusing her of infidelity.
- » **Extremely patriarchal concepts and attitudes**, such as that a woman or girl must obey her husband or father who is the head of the family or comply with rigid concepts of honour and sexuality.
- » **Persecution and psychological terror (stalking):** Many perpetrators are not willing to accept a separation from their partner and try to prevent it by all means, including violence. This may lead to acts of violence and threats committed even many years after a separation.
- » **Danger for children:** Children are also at particular risk during separation and divorce. Abuser’s aggression against the partner may also extend to the children, and he may take revenge by abusing or killing them. Therefore, safety planning must always include the children.
- » **Non-compliance with restraining orders by courts or police** indicate a high-risk situation because it shows that the perpetrator is not willing to change his behaviour.
- » **Possible triggers** that may lead to a sudden escalation of violence include changes in the relationship, for instance when the woman takes a job against the partner’s will, seeks help or files for divorce.

Source: adapted from WAVE 2006

HANDOUT 30: EXAMPLE OF A RISK ASSESSMENT TOOL: DANGER ASSESSMENT BY JACQUELYN C. CAMPBELL

DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN, FAAN

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Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex-partner. Write on that date how bad the incident was according to the following scale:

- 1 Slapping, pushing; no injuries and/or lasting pain
- 2 Punching, kicking; bruises, cuts, and/or continuing pain
- 3 “Beating up”; severe contusions, burns, broken bones
- 4 Threat to use weapon; head injury, internal injury, permanent injury, miscarriage, choking
- 5 Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following.

(“He” refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

Yes	No	
		1. Has the physical violence increased in severity or frequency over the past year?
		2. Does he own a gun?
		3. Have you left him after living together during the past year?
		3a. (If have never lived with him, check here___)
		4. Is he unemployed?
		5. Has he ever used a weapon against you or threatened you with a lethal weapon?
		5a. (If yes, was the weapon a gun?___)
		6. Does he threaten to kill you?
		7. Has he avoided being arrested for domestic violence?
		8. Do you have a child that is not his?
		9. Has he ever forced you to have sex when you did not wish to do so?
		10. Does he ever try to choke you?
		11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, Meth, speed, angel dust, cocaine, "crack", street drugs or mixtures.
		12. Is he an alcoholic or problem drinker?
		13. Does he control most or all of your daily activities? (For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: ___)
		14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can").
		15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ___)
		16. Has he ever threatened or tried to commit suicide?
		17. Does he threaten to harm your children?
		18. Do you believe he is capable of killing you?
		19. Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?
		20. Have you ever threatened or tried to commit suicide?
		Total "Yes" Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

HANDOUT 31: INDIVIDUAL EXERCISE: IDENTIFYING RISK FACTORS – THE CASE OF MRS. Y

INSTRUCTIONS:

After another violent attack of her husband, Mrs. Y arrives at the hospital to seek medical help for injuries.

Please assess the level of danger faced by Mrs. Y, using the Danger Assessment Tool developed by Jacquelyn Campbell (handout 28). What is your assessment of the dangerousness of Mr. Y? Which risk factors can you identify in the case study?

CASE OF MRS. Y:

Mrs. Y has been married to her husband for one and a half years; for both of them it is the second marriage. Mrs. and Mr. Y live in country A but are originally from country B. Both have children from previous marriages; only the 5-year-old daughter of Mrs. Y lives with them.

Before they got married, Mr. Y was charming and polite to his wife. But soon after the wedding he becomes very controlling and tries to prevent her from visiting her family or going out with friends. He wants her to account for every minute she is out of the house and if she comes back from work later than usual he explodes and accuses her of being a bad wife and “whoring around” with her colleagues.

Mrs. Y does not put up with his behaviour and refuses to submit to his “orders”. As his controlling behaviour and possessiveness get worse, she tells him that she wants to divorce him. From this moment on he starts to threaten that he will kill her if she leaves him; he also threatens to kill her children. Mrs. Y has the citizenship of country A, but Mr. Y does not and depends on her for his visa.

Despite his threats Mrs. Y files a petition for divorce. When he finds out he beats her and threatens again to kill her if she does not withdraw the petition for divorce.

Mrs. Y reports the physical violence and the threats to the police. The police issues an expulsion and barring order obliging Mr. Y to leave the family home for 10 days. Despite the expulsion of her husband Mrs. Y decides to move out of the family home with her daughter because she is very afraid of her husband. She seeks counselling and support from a domestic violence counseling centre; the counselor advises her not to go back home.

Mr. Y continues to be violent; he follows Mrs. Y to her work place, and threatens her there as well. He says that he will kill her and flee to his home country and that her case will be in the newspaper. Mrs. Y calls the police but he flees before they arrive. She reports the threats to the police again; the police informs the prosecutor’s office, who however decides not to arrest Mr. Y.

With the support of the domestic violence counseling centre, Mrs. Y obtains a court order that prohibits her husband to come to her home, to her work place or to contact her. But Mr. Y continues to follow and threaten her.

Source: adapted from Committee on the Elimination of Discrimination Against Women, Views of 1 October 2007, Fatima Yildirim (deceased) against Austria, Communication No. 6/2005, CEDAW/C/39/D/6/2005

HANDOUT 32: CHECK LIST FOR DEVELOPING A SAFETY PLAN WITH THE SURVIVOR

- » Identify one or more neighbours you can tell about the violence, and ask them to help if they hear a disturbance in your house.
- » Are there any friends or relatives you can trust and who could give you and your children shelter for a few days?
- » Decide where you will go if you have to leave home and have a plan to go there, even if you do not think you will need to leave.
- » If an argument seems unavoidable, try to have it in a room or an area that you can leave easily.
- » Stay away from any room where weapons may be available. If possible, get the weapons outside your home.
- » Practice how to get out of your home safely. Identify which doors, windows, elevator or stairwell would be best.
- » Have a packed bag ready, containing spare keys, money, important documents and clothes. Keep it at the home of a relative or friend, in case you need to leave your home in a hurry.
- » Devise a code word to use with your children, family, friends and neighbours when you need emergency help or want them to call the police.
- » Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he wants to calm him down. You have the right to protect yourself and your children.
- » Remember, you do not deserve to be hit or threatened.

Source: adapted from Heise et al 1999

HANDOUT 33: INDIVIDUAL SAFETY PLAN FOR WOMEN WHO EXPERIENCED VIOLENCE BY INTIMATE PARTNERS OR OTHER FAMILY MEMBERS

Client _____ Health professional _____

Date _____ Re- evaluation (dates) _____

1 If my own or my children's safety is in danger at home, I can go to _____ or _____ or _____ (decide this although you would not expect another violent act anymore).

2 In a violent or threatening situation a safe way out is _____ (e.g. which doors, windows, elevator, stairs or emergency exit I could use).

3 I can talk about violence with the following persons and ask them to call the police if they hear suspicious noises in my house:

4 I can use (e.g. a sign, a word) _____ as a code with my children or friends so that they can call for help.

5 If my partner does not live with me anymore, I can ensure my safety at home (locks, keys, alarm system etc.) _____.

6 I can keep my handbag/safety bag (a place at home/at a friend's home): _____.

7 I need the following things in case of a quick departure from home (content of the safety bag):

- money/cash
- extra pair of home and car keys
- extra clothes
- personal hygiene items
- mobile phone, important phone numbers, phone card
- medical prescriptions
- important documents/cards (passport/identity card, health insurance card etc.)
- children's favorite toys
- other, _____

8 The health professional has told me that:

- I am not responsible for the violent behaviour of my partner but I can decide how to improve my and my children's safety.
- I deserve better than this: me and my children have the right to lead a safe life without fear.
- Violence is a crime and I can report it to the police.
- There are restriction/barring orders and I know how I can apply for them.
- There are places where to get support: _____

9 The health professional has suggested/we have agreed that I can continue dealing with the problem at the following help providers: _____

10 Together with health professional I have made a (written) assessment of violence. In my situation these answers mean that _____

11 I can keep this safety plan without endangering my own or my children's safety at: _____

Source: adapted from Perttu 2004, cited in Perttu/Kaselitz 2006

HANDOUT 34: ROLE PLAY: SAFETY PLANNING – THE CASE OF DILOROM

Please read the instructions. Then engage in a role play, according to the roles assigned.

INSTRUCTIONS FOR THE ROLE PLAY:

- » The aim of the role play to practice the safety planning in a case of GBV of and communication with survivors of GBV, according to the principles discussed in training.
- » The role play has three parties: Dilorom, a survivor seeking help, a doctor working at the health centre, and an observer.
- » Situation: Dilorom seeks medical help from a health centre in her hometown because of chronic stomach pain and sleeping problems. The doctor observes several bruises on her arms and neck. Dilorom reports that her husband repeatedly beats her and sometimes also the children. Several times, he forced her to have sexual intercourse. He also verbally abuses her and threatens to kill her if she leaves him. Dilorom wants to leave but she is afraid of what he would do if she does leave him. Together with her husband and children, she lives with her in-laws. From her husband's parents, she cannot expect any help – they regularly insult her and blame her for her husband's violent behaviour. Dilorom asks the doctor what she could do for her safety.
- » Maximum duration of the conversation between the doctor/nurse and the patient: 15 minutes.
- » After the role play, please come back to the bigger group for a feedback round (patient, doctor/nurse, observer), followed by comments from the larger group.

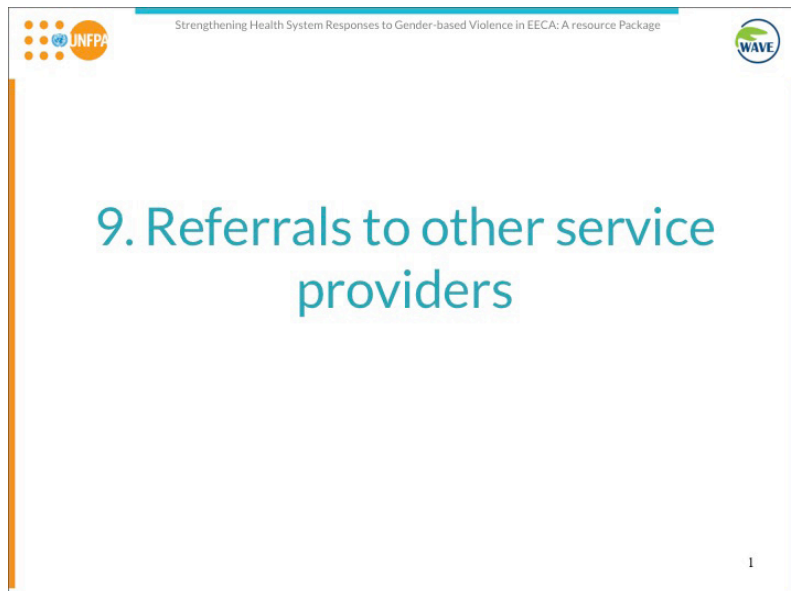
3.9. MODULE 9: REFERRALS TO OTHER SERVICE PROVIDERS

3.9.1. OUTLINE OF THE MODULE

Duration of the module	1 hr 45 minutes hours
Aim of the module	To provide participants with knowledge and skills to <ul style="list-style-type: none"> • understand the importance of referral systems in facilitating access of survivors of GBV to multi-sectoral services, • learn about the actors involved, the requirements for effective referrals, and the steps for developing and implementing referral systems, and • learn about practical resources for health care professionals and patients to facilitate referrals.
Key learning messages	<ul style="list-style-type: none"> • A referral system or mechanism provides a comprehensive institutional framework for multi-sectoral cooperation that connects various governmental, non-governmental and, as appropriate, international organizations, with the overall aim of ensuring the protection and assistance of survivors, the prevention of GBV and the prosecution of perpetrators (“3 p’s”). • Referral mechanisms benefit both the patient who experienced GBV and the health care professional: <ul style="list-style-type: none"> » Women who have experienced GBV have multiple and complex needs. Therefore, referrals to other services – medical and non-medical - are key to ensure that survivors of GBV have access to comprehensive care, support and protection. As health care professionals are often the first point of contact for survivors, they provide an important entry point for referrals. » Health care professionals are relieved from their work load as they can benefit from support from other partner organizations; they may feel more confident to ask about GBV, knowing that other needed services exist; they are in a position to adequately act upon the identification of a survivor. • In order to ensure sustainability and effectiveness, the operation of referral mechanisms should be grounded in legislation or standardized protocols that define the roles and responsibilities of all organizations involved. • Effective referrals require that health care professionals are able to identify and facilitate the disclosure of GBV; are able to assess the situation and needs of the individual patient as well as the risk of further violence; are knowledgeable about the existing referral system and services and support the patient in identifying the best options; are knowledgeable about national laws on GBV and obtain the consent of the patient before sharing her case with other organizations. • Key actors involved in referral systems besides the health sector typically include specialized women’s services (such as shelters or helplines), general support services (such as housing; financial support and other social services; employment services, public education or child welfare), police and judiciary. • In the absence of a formal referral system, health care professionals may use follow-up appointments to check the wellbeing of the patient, consider establishing basic services in-house, and refer to the patient to other known service providers, possibly using a referral directory.
Background readings for trainer	UNFPA-WAVE Resource Package, part I, chapter 4 Further readings: Istanbul Convention and Explanatory Report, UNFPA 2010, IPPF 2010
Methods	<ul style="list-style-type: none"> • Presentation by trainer (PPT slides 1-4) • Brainstorming: Defining Referrals • Presentation by trainer (PPT slides 5-9, handout 35) • Presentation by trainer (PPT slides 10-15, handout 36) • Presentation by trainer (PPT slides 16-17, Annexes 6-7) • Presentation by trainer (PPT slides 18-27)

<p>Notes for trainers</p>	<p>Brainstorming: Defining Referral Systems – duration: 10 minutes Ask participants to do a brainstorm in which they try to come up with a definition of a referral system. Write the answers on a flipchart. After the brainstorm, discuss the results before introducing the definition provided on GBV (PPT slides 5-6)</p> <p>The trainer may want to prepare a handout listing existing key providers of services to women survivors of GBV in the country, region or town of training participants, as appropriate. This should include in particular women’s shelters, women’s helplines and women’s centres.</p> <p>Before presenting slide 27, the trainer may want to collect suggestions from participants on what health care professionals can do in the absence of formal referral mechanisms.</p>
<p>Materials for training session</p>	<p>Presentation: PowerPoint presentation Module 9</p> <p>Handouts: Handout 35: Establishing a referral mechanism to prevent and respond to domestic violence at the local level – an example from Kyrgyzstan Handout 36: The role of specialized women support services in the multi-sectoral response to GBV Annex 6: Template for identifying and mapping potential referral partners Annex 7: Template for compiling a directory of referral organizations</p>

3.9.2. POWERPOINT PRESENTATION



Aim of this module

- To understand the importance of referral systems in facilitating access of survivors of GBV to multi-sectoral services
- To learn about the actors involved, the requirements for effective referrals, and the steps for developing and implementing referral systems
- To learn about practical resources for health care professionals and patients to facilitate referrals

2

Outlook

- Definition of a referral system
- Key actors involved in a referral system
- Developing and implementing an effective referral system - steps and recommendations
- What health care professionals can do in the absence of a referral system

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Definition of a referral system

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Defining referrals

Referrals are the processes of

- how a woman gets in touch with an individual professional or institution about her case
- how professionals and institutions communicate and work together to provide her with comprehensive support

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Defining referral systems

A **comprehensive institutional framework** that connects various entities with **well-defined and delineated mandates, responsibilities and powers** into a **network of cooperation** to ensure the **3 p's**:

(UNFPA 2010)

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    graph TD
      A[Protection and assistance of survivors] <--> B[Prosecution of perpetrators]
      A <--> C[Prevention of GBV]
      B <--> C
    
```

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Importance of referral systems

- Survivors of GBV have multiple and complex needs that require a comprehensive set of services
- One single organization cannot provide all these services

→ Coordinated multi-sectoral response is necessary

→ A referral system = institutional framework

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Benefits of referral systems

Patient:

- Access to comprehensive and specialized care and support, tailored to individual needs

Health care professional:

- First contact for survivors → important entry point
- Benefit from support and expertise from other partner organizations → relief from work load
- Knowing that other needed services exist → increase confidence to ask about GBV
- Able to adequately act upon the identification of a survivor

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Levels of referral mechanisms

❖ Example of setting up a local-level referral mechanism in Kyrgyzstan

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Requirements of effective referrals

Health care professionals	Health facilities/management
<ul style="list-style-type: none"> • Able to recognize GBV and facilitate disclosure • Able to assess the patient's individual situation & needs • Know about the existing referral system and services • Know about national laws on GBV • Obtain consent from patient before sharing information 	<ul style="list-style-type: none"> • Ensure ongoing capacity building of staff (e.g. IRIS intervention, UK) • Multi-sectoral trainings: first step to establishing partnerships • Put in place a coordinated mechanism to monitor services and improve quality

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Capacity building improves referrals – example: IRIS (UK)

- IRIS: Identification & Referral to Improve Safety
- 24 general practices in London and Bristol:
 - training of health care professionals and admin staff
 - establishment of simple referral pathway to specialist DV service provider
 - technical support to practice teams
- Evaluation: compared to 24 control practices
- Results: intervention practices showed
 - 3 times higher identification rate
 - 21 times more recorded referrals (compared to control practices)

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Key actors involved in a referral system

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Overview

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graph TD; A[Specialized women's support services] --- B[General support services]; A --- C[Police and judiciary]; B --- C;
```

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Standards for specialized women's services

- Run by independent women's organizations
- Receive adequate financial support from the state
- Be specialized in two ways:
 1. especially targeted at women survivors and their children
 2. specialized on VAW as a gender specific form of violence
- Apply a survivor-/women-centred, gender-sensitive & human rights-based approach
- Be run and provided by women
- Be provided by professional staff trained on working with survivors of GBV

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Types of providers of specialized women's services

- Women's helplines
- Women's shelters
- Women's centres
- Services specialized on supporting survivors of sexual violence



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General support services

- Funded and provided by state authorities
- Not designed for survivors of GBV – benefit public at large
- Examples: health services, housing, financial support, child welfare
- Complement, but not replace specialized women's services

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Police and judiciary

- Police, criminal justice system
 - Investigation and prosecution of GBV, determine criminal liability of defendant
 - Police restraining orders (in some countries)
- Civil courts
 - Divorce
 - Child custody
 - Protection orders (in some countries)

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Developing and implementing an effective referral system - steps and recommendations

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Step 1: Situation analysis and mapping of services

- Obtain a comprehensive picture on the scope of GBV, the legal framework on GBV and available services – including gaps
- Identify entry points and potential referral partners
- Look at national, regional, local levels
- Use a mix of sources and methodologies:
 - official data and NGO reports
 - desk research, qualitative interviews, focus group discussions

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Step 2: Setting up a referral directory

- Organize information collected on service providers in a referral directory
 - Contact information
 - Types of service provided, population served
 - Criteria for eligibility/admission
- It's a useful reference document for health care providers when making referrals to other services (also in the absence of a formal referral system)
- Management should
 - provide copies to all staff (or at least one copy in a convenient, accessible place)
 - gather feedback from staff and ensure regular updates

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Step 3: Formalizing the partnership (1)

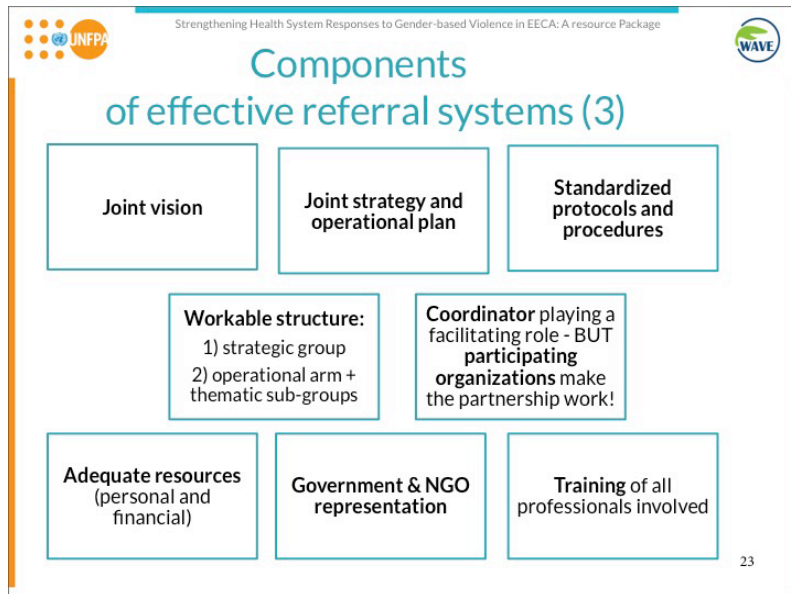
- **How:** Memorandum of Understanding (MoU), inter-agency protocol
- **Why:** Provide an institutionalized basis for effective coordination → sustainability
- **What:** Formalize cooperation
 - Define roles and responsibilities of actors involved
 - Common principles for service provision
 - Devise referral pathway (to whom to refer the survivor, when, where, how)

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Step 3: Formalizing the partnership (2)

- **Prerequisites:**
 - Develop work relationship based on trust
 - Common understanding of GBV and vision of how to respond, shared by all partners
 - Willingness to share information on how cases are handled on to accept feedback

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Step 4: Providing staff with information resources (1)






- Informing the patient of available services is key to help her identify the most suitable options
- Written information for patients need to be discreet
- Examples:
 - What: posters with tear-off slips, pamphlets, brochures
 - Where: examination rooms, women’s toilets

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Step 4: information resources (2)

- Examples (continued):
 - Pocket-size lists of phone numbers
 - Phone numbers in form of barcodes (stickers, lip balms)
 - Key rings with hidden information
 - Key rings with personal alarms

Source: Standing Together against Domestic Violence (UK)

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What health care professionals can do in the absence of a formal referral system

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Some ideas

- Use follow-up appointments to check on patient's well-being
- Consider establishing basic services in-house
 - e.g. crisis intervention, support groups, overnight accommodation in hospitals
 - example: victim-support rooms (Tajikistan)
- Establish a referral directory and refer patient to known service providers

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3.9.3. HANDOUTS

HANDOUT 35: ESTABLISHING A REFERRAL MECHANISM TO PREVENT AND RESPOND TO DOMESTIC VIOLENCE AT THE LOCAL LEVEL – AN EXAMPLE FROM KYRGYZSTAN

Since 2010, UNFPA has been partnering with NGOs, the government of Kyrgyzstan to set up a system of multi-sectoral cooperation for the prevention of and response to GBV at the municipal level. At the outset, the following steps were undertaken:

- » A Coordinating Council was set up by the mayors' office in capital city Bishkek; it approved local level work plans for the prevention of and response to domestic violence.
- » Models for inter-agency cooperation were developed and tested in specified pilot districts/sub-districts in Bishkek. The pilot was coordinated by the municipal administration in the respective pilot district/sub-district.
- » Sector-specific action plans and departmental instructions for health care and the municipality administration (including police, health, education and local self-governance including social services) on how to work with survivors of domestic violence were adopted.
- » All involved professionals were trained on understanding GBV, relevant local and international laws, and how to effectively respond to GBV. Training of health care providers targeted both, doctors and nurses.
- » Standard forms for reporting and tracking domestic violence for use by health care institutions and municipal administration were adopted.
- » Quarterly coordination meetings of all sectors involved have been organized and facilitated by the deputy mayor and UNFPA. These meetings served to register identified cases of women and children survivors of domestic violence; further, service providers discussed and agreed on further support measures.
- » A number of public awareness raising activities were held. For example, health facilities organized information stands to inform patients and health care professionals on available services for survivors and contact information of organizations providing support. Education departments organized a series of activities in schools among students and children, those who have experienced domestic violence were provided with psychosocial support.
- » Local self-governance bodies worked on identification and prevention of domestic violence in their respective communities.

In 2012, this model cooperation framework developed at the capital city level was then translated into action at the sub-national level, through a pilot in the cities of Osh and Jalal-Abad:

- » Participating organizations formalized their cooperation based on a Memorandum of Understanding (MoU) which also includes implementation of GBV Standard Operating Procedures at the national level. The MoU was initiated under the IASC GBV sub-cluster during the interethnic conflict that occurred in June 2010, in order to set up a national network to respond to and prevent GBV in the aftermath of the conflict. The MoU was signed by the Ministries for Labour, Employment and Migration; Social Protection; Internal Affairs; Justice; and Health, as well as UNICEF, UNFPA and UN Women.

- » In both cities, the mayor's offices set up Multi-sectoral Coordinating Councils; they approved local level work plans for the prevention of and response to domestic violence. Members include the deputy mayors, representatives of women crisis centres, women's NGOs, NGOs providing legal support, health departments, local self-governance bodies, and municipal law enforcement bodies.
- » Municipal workers and service providers underwent training on the implementation of the MoU and the SOPs, based on the 2003 Law on Social and Legal Protection against Domestic Violence.

These efforts have resulted in identification and referrals of survivors of GBV, as follows:

- In 2012, 500 cases of domestic violence were registered at the Emergency Medical Care Center (Osh), which included 329 women and 171 men.
- 117 complaints of instances of physical domestic violence were registered in 2012 at the trauma unit of the City Hospital (Osh) and received medical support.
- From August 2012 to March 2013, three women survivors of domestic violence sought help at the emergency room of Family Medical Center №1 (Osh). Two of them were referred to the Police Department of Osh.

While some progress has been made, more work still needs to be done to ensure that GBV survivors have access to comprehensive support. It is necessary to continue strengthening the capacity of local providers of health, psychosocial, legal and protection services, with a view to setting up a sustained and well-functioning referral pathway. For the health sector, emphasis should be put on sensitizing doctors to address GBV as a public health issue, rather than a family/private matter, in order to improve the identification of survivors. Further, improvements in the infrastructure of health facilities are urgently needed. Currently, many health facilities lack separate rooms for psychosocial consultations provided to patients who experienced GBV. This prevents doctors from asking confidential questions, and survivors from disclosing GBV due to shame and fear. Furthermore, sector-specific instructions on the response to GBV should be institutionalized through capacity building of ministerial workers on gender equality and GBV.

Lessons learned:

- » Political will on the part of central-level authorities that ensure accountability of local governments are important prerequisites to ensure that laws, policies and action plans documents are actually implemented and that appropriate financial and human resources are in place at the local level.
- » Political and financial support from the municipal administration not only helped to secure funds needed for the implementation of action plans but also serve to create a sense of ownership among those responsible for implementation.
- » Coordinating bodies need to meet regularly, in order to ensure ongoing implementation and monitoring of action plans and to enable them to address emerging issues in a timely manner. Ensuring broad-based membership of governmental, non-governmental and international organizations in coordination structures is desirable.

The added value of setting up a multi-sectoral cooperation mechanism and getting to know each other's counter parts in the partner organizations is illustrated in the following statement from a district police inspector in Osh: *"After we started working together, I realized that we are all doing the same job. Not only us, but others also work on resolving domestic violence. Now that we know each other, it's easier. You can't just send someone off to another agency without that."*

Source UNFPA 2013, information provided by UNFPA Country Office Kyrgyzstan, June 2014

HANDOUT 36: THE ROLE OF SPECIALIZED WOMEN SUPPORT SERVICES IN THE MULTI-SECTORAL RESPONSE TO GBV

Participation of women's organizations in the multi-sectoral response to GBV is of particular importance. These organizations often possess long-standing experience in the response to GBV. Further, because of their mandates as direct and specialized service providers they are well positioned not only to provide many services themselves, but also to accompany survivors throughout the entire process. They complement, but cannot be replaced by, general support services offered by public authorities, such as housing, financial support and other social services, employment services, public education or child welfare.

Specialized women's support services for survivors of GBV may provide a broad range of services, including in particular women's shelters, women's helplines, women's centres, providing various types of non-residential support, as well as services specialized for survivors of sexual violence. These organizations might serve survivors of GBV more broadly, or concentrate on survivors who have experienced specific forms of violence (such as intimate partner violence, trafficking or sexual violence) or belong to specific groups (such as migrant women, adolescent girls or sex workers).

Women's helplines may be the first contact point for survivors to receive information about available services and legal options. Therefore, helplines, which are widely-advertised public numbers that provide support, crisis interventions and referrals to face-to-face services such as shelters or the police, provide an important cornerstone of a multi-sectoral response to GBV. Women's helplines should operate 24/7, be free of charge and anonymous, and serve survivors of all forms of GBV. All women in the country should have access to a helpline, so at least one national helpline should exist and provide support in all the main languages spoken in country, at least for a considerable amount of hours per week (WAVE 2013, CoE 2008, Article 24 Istanbul Convention and Explanatory Report).

Women's shelters are specialized in providing immediate and safe accommodation to women survivors of violence and their children. Furthermore, they provide comprehensive support and empowerment to help survivors to deal with their traumatic experience, to regain their self-esteem and to lay the foundations for a self-determined life. Shelters should be accessible 24/7. They need to apply special safety precautions, which includes risk assessment and safety planning in each individual case, keeping locations secret and technical security of the building in order to protect clients and staff, but also neighbours from violent attacks by perpetrators. Shelters should be available in a sufficient number in the country (Article 23 Istanbul Convention and Explanatory Report, WAVE 2013). A commonly referred benchmark is one family place per 10 000 inhabitants (CoE 2008). An important part of the work provided by shelters is follow-up or after-case support, in order to assist women and girls in their reintegration after leaving the shelter. This requires consideration of existing risks, the client's income generation and livelihood skills, alongside other factors. The reintegration process should be well managed, ensure safety to the woman and her children, and subsequently monitored by the caseworker.

Women's centres (in some countries, also referred to as "women's crisis centres" or "women's counseling centres") encompass all women's services that provide non-residential support of any kind (psychosocial counseling, legal or other information and advice, practical support, court accompaniment, etc.) to women survivors of GBV and their children. These organizations play an important role in countries or regions where women's shelters do not exist. Moreover, they provide advocacy and counselling to women that might not need accommodation but require other specialist support and advocacy (WAVE 2013).

Specialized support services for survivors of sexual violence are necessary in light of the traumatic nature of sexual violence, requiring a particularly sensitive response by trained and specialized staff. These services include immediate medical care and trauma support, complemented by medium- and long-term psychological counselling, as well as immediate forensic examinations to collect evidence needed for prosecution. It is a good practice to carry out forensic examinations regardless of whether the matter will be reported to the police and to offer the survivor the possibility to have the samples taken and stored, so that the decision as to whether or not to report the rape can be taken at a later date.

Service providing organizations typically include (Article 25 Istanbul Convention and Explanatory Report):

» Sexual violence referral centres specialized in immediate medical care, forensic practice and crisis intervention. These centres can be part of a hospital setting to respond to recent sexual violence and refer the survivor to specialized organizations for further support or specialist care.

»

» Rape crisis centres offering long-term help. Services may take the form of face-to-face counseling, support groups and contact with other services. They also accompany support during court proceedings.

A commonly referred benchmark is one specialized support centre per every 200 000 inhabitants (CoE 2008, cited in Istanbul Convention - Explanatory Report).

Specialized support services for survivors of sexual violence might not exist in all countries in EECA. Where they do not exist, it is of particular importance that healthcare professionals, particularly gynecologists and forensic doctors, are trained to provide the required immediate medical care and trauma support (see chapter 3.2).

3.10 MODULE 10: EVALUATION AND CLOSING OF THE TRAINING

3.10.1. OUTLINE OF THE MODULE

Duration of the module	45 minutes
Aim of the module	<ul style="list-style-type: none"> • To evaluate the usefulness of the training • To close the training
Methods	<ul style="list-style-type: none"> • Completion of evaluation questionnaires • Feedback round
Notes for trainers	<ul style="list-style-type: none"> • Disseminate handout 35 and allow 15 minutes for completion. • After administering the evaluation form, allow for an informal feedback round to close the training. Ask each participant to share with the group one thing that they learned and will take home from the training. • Disseminate certificate of attendance (optional).
Materials for training session	Handouts: Handout 37: Training evaluation questionnaire

3.10.2. HANDOUTS

HANDOUT 37: TRAINING EVALUATION QUESTIONNAIRE ²⁰

<p>1. How do you evaluate the training overall?</p> <p><input type="checkbox"/> very good <input type="checkbox"/> good <input type="checkbox"/> not so good <input type="checkbox"/> not good</p>				
<p>2. What were the three most important things that you learned in this training?</p> <p>A.</p> <p>B.</p> <p>C.</p>				
<p>3. Anything in the course of this training that you found less useful for your work?</p>				
<p>4. Please assess the following aspects of the training (structure, content, methodology).</p>				
	yes, very much	rather yes	no, rather not	not at all
The training was well structured.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There was appropriate time allocated to each module.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The time for discussion was sufficient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The methods were suitable to support my learning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The handouts and materials were useful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The training was relevant for my daily work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The training opened new perspectives to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I learnt new skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I now feel more confident to address the issue of GBV in my daily work with patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The training enabled me to learn about experiences and practices from other colleagues/countries (<i>Note: specify in line with geographical focus of the training</i>).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The training made me aware of new ideas for cooperation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The training enabled me to find new cooperation partners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20 This questionnaire was adapted by WAVE from a questionnaire prepared by Sabine Bohne, University of Osnabruck, for WAVE in 2011.

Any comments or suggestions for improving structure, content, methodology of the training?				
5. How do you assess the performance of the trainer?				
	yes, very much	rather yes	no, rather not	not at all
<i>(Note: for more than one trainers, add more cells and insert the names of the trainers)</i>				
I found the trainer knowledgeable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I found the trainer ensured good interaction and exchange with and among participants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I found the trainer had good presentation skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would recommend this trainer for similar trainings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other comments or suggestions?				
6. Any topics about which you would have liked to learn in greater detail?				
Any topics that have been missing?				
7. How do you assess the overall organization/logistics of the training?				
	Excellent	Good	Not so good	Bad
Before the training				
Pre-training information from and communication with the organizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel and accommodation arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the training				
Accommodation (hotel room)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Coffee breaks, lunches and dinner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Place of training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Location of the venue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any comments or suggestions for improving the overall organization/logistics?				
8. Please provide one example on how the learnings from this training will benefit your work practice.				
9. Any other comments or suggestions to help us further improving the training?				
Thank you very much for supporting our evaluation!				

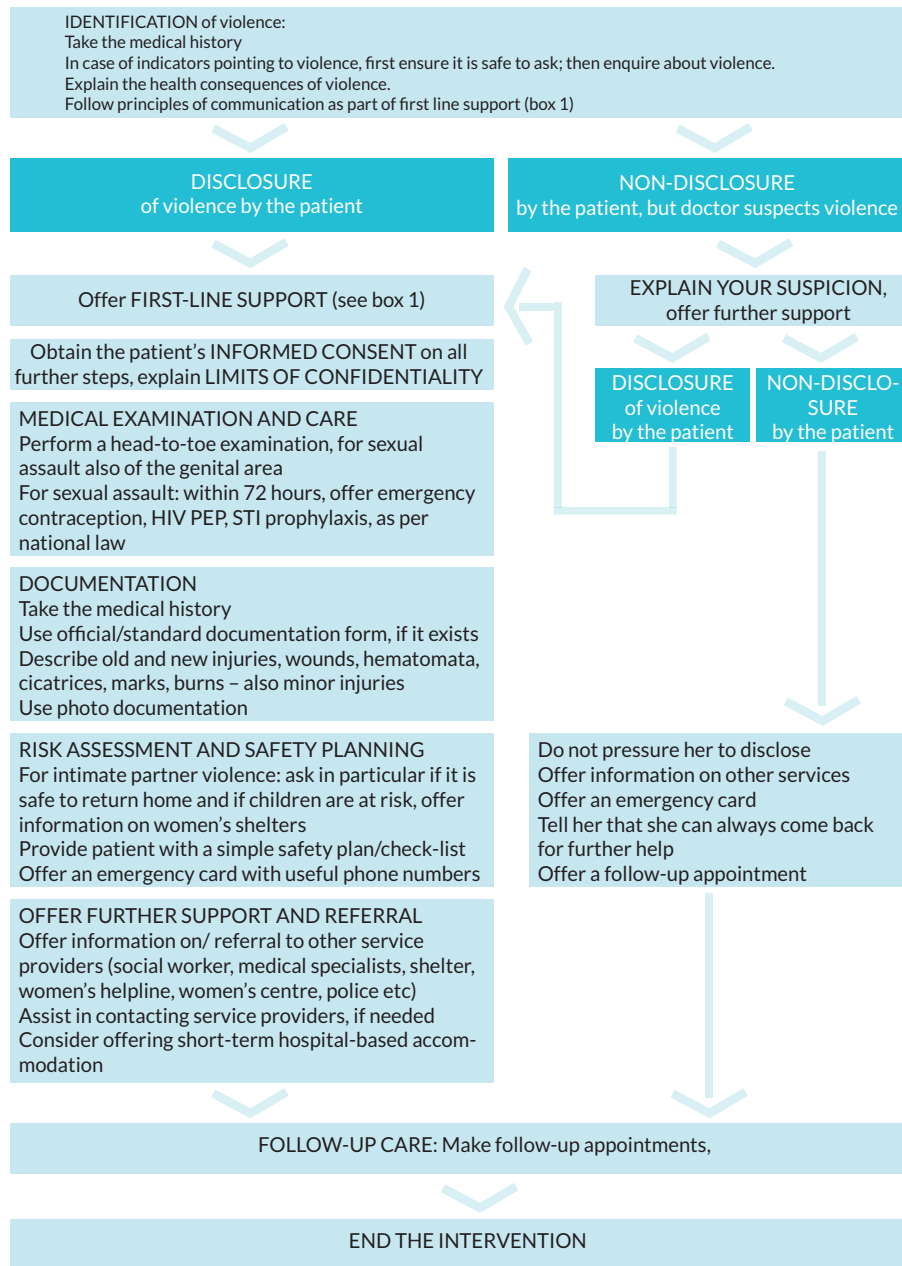
ANNEX 1: KEY ELEMENTS OF QUALITY HEALTH CARE FOR WOMEN SURVIVORS OF GENDER-BASED VIOLENCE

Key elements	Why this element is important
Institutional values and commitment	The values, mission and overall commitment of an institution can have an enormous influence on the professional culture of frontline providers in any organization. Heise et al. and others have argued that the most effective way for health services to respond to violence against women is for the whole institution to make a commitment to the issue (a “system’s approach”) rather than simply letting the responsibility fall on the shoulders of individual providers. Ideally, senior managers should be aware of gender-based violence as a public health problem and a human rights violation, and they should voice their support for efforts to improve the health service response to violence.
Alliances and referral networks	Before encouraging staff to discuss violence with patients, health programs have an obligation to investigate what referral services exist in the local community and to compile this information into a format that health care providers can use. This manual contains a series of recommendations and tools for developing referral directories and networks (section e of this chapter). Networks and alliances with other organizations are important for other reasons as well. For example, they allow the health sector to play a role in the broader policy debate by raising awareness of violence against women as a public health problem.
Privacy and confidentiality	Privacy and confidentiality are essential for women’s safety in any health care setting given that providers can put women’s safety at risk if they share sensitive information with partners, family members or friends without consent. A breach of confidentiality about pregnancy, rape, contraception, HIV status, abortion, or a history of sexual abuse can put women at risk of additional emotional, physical or sexual violence. Moreover, women who have already experienced violence need privacy in order to disclose those experiences to providers without fear of retaliation from a perpetrator. To protect confidentiality and privacy, health programs need adequate infrastructure and patient flow, as well as clear policies outlining when and where providers are allowed to discuss sensitive information.
Understanding local and national legislation	Educating providers about laws related to gender-based violence can prepare them to inform women about their rights and can alleviate their concerns about getting involved in legal proceedings when a patient discloses violence. Both managers and service providers need to be 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. Health care providers also need to understand their obligations under the law, including legal reporting requirements (for example, in cases of child sexual abuse) 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).

Ongoing provider sensitization and training	Providers' attitudes, knowledge, and skills about gender-based violence can have a major impact on quality of care. When patients disclose experiences of physical or sexual violence, providers who respond inadequately can inflict great emotional harm, for instance when expressing a judgmental or blaming attitude. Moreover, providers who fail to consider the possibility of violence while counseling women about contraception, STIs, HIV prevention or health issues may be ineffective. Ignorance about links between health and violence may lead health workers to misdiagnose certain conditions and overlook the risks that some women face. Each institution must decide how much sensitization and training it can afford to provide. At a minimum, staff should be aware of the health dimensions of violence, a human rights framework for understanding violence, and a basic understanding of local legislation. They should be able to respond to survivors in a compassionate way and be prepared to care for women in crisis.
Protocols for caring for cases of violence	Protocols for identification, care, and referral of gender-based violence cases can be essential tools for health services. Developing protocols in a participatory way allows managers to engage staff in a dialogue about the best way to improve the health care response in resource-poor settings. Having written protocols readily available to health care providers can make it easier for staff to respond in an appropriate way. Moreover, anecdotal evidence suggests that clear policies and protocols can diminish the risk of harm to patients posed by negative attitudes from staff.
Emergency contraception and other supplies	Emergency contraception is an essential service for women who experience rape and other forms of non-consensual, unprotected sex. Research suggests that women who live in a physically violent relationship often experience sexual violence, have difficulty negotiating contraceptive use, and may experience higher rates of unwanted pregnancy than women who do not live in situations of violence. Health programs have an obligation to ensure that clinics not only stock emergency contraception, but that their staff members know how to provide it to women.
Informational and educational materials	Displaying and distributing information in the clinic about gender-based violence (for example, in the form of posters, pamphlets, and cards) is an important way to indicate the organization's commitment to combating violence. These materials can raise awareness of the problem, educate patients about the unacceptability of gender-based violence, and inform women about their rights and local services where they can turn for help.
Medical records and information systems	Information systems play an important role in the response to violence in several ways. For example, health organizations have an obligation to ensure that providers know how to record sensitive information about cases of gender-based violence. Documenting information about violence in medical records may be important to complete a woman's medical record and in some cases may provide evidence for future legal proceedings. In order to protect women's safety and wellbeing, medical records need to be securely stored. Information systems are also important for monitoring a health organizations' work in the area of gender-based violence. For example, health care organizations can gather service statistics on the number of women identified as survivors of violence, information that can help them determine the level of demand for other services.
Monitoring and evaluation	Monitoring and evaluating the quality of care is another essential way to ensure that health services are responding to violence in acceptable and supportive ways. At the level of management, administrators should receive ongoing feedback from providers to identify any problems and ways to improve the services. The input of women who have experienced violence can also be crucial for successfully refining the design of health services.
Regular opportunities for providers and managers to exchange feedback	Practice has shown that it is essential for managers to maintain an ongoing dialogue with front-line providers. In the experience of IPPF/WHR, the changes made throughout the organizations worked best when providers were allowed to participate in those decisions and to make improvements as the changes were put into practice. An ongoing challenge for many of the clinics, however, was to find enough ways to provide ongoing feedback to providers about the outcome of specific cases. Health care providers are often the first step in the referral process, and they may find it frustrating when there is no formal system for following-up with women who disclose violence.

Source: IPPF 2010

ANNEX 2: CARE PATHWAY FOR SURVIVOR OF GENDER-BASED VIOLENCE



Box 1 – First-line support (WHO 2013): Women who disclose any forms of violence by any perpetrator should be offered immediate support: This includes:

- Ensuring consultation is conducted in private
- Ensuring confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting)
- Being non-judgmental, supportive and validating what the woman is saying
- Providing practical care and support that responds to her concerns, but does not intrude.
- Asking about her history (for sexual assault: time of since assault and type of assault, risk of pregnancy, risk of HIV and other STIs, mental health status), listening carefully, helping her access information about resources, including legal and other services that she might think helpful.
- Assisting her to increase safety for herself and her children.

Source: adapted from BMWFJ 2010, WHO 2013

ANNEX 3: SELECT HEALTH CARE POLICIES AND PROTOCOLS ON THE HEALTH SECTOR'S RESPONSE TO GENDER-BASED VIOLENCE

Country	Name of Protocol or Guidelines	Published by	Year	Link	Content
The Former Yugoslav Republic of Macedonia	Ministry of Health – Protocol for Dealing with Domestic Violence Cases (part of Umbrella Protocol for Dealing with Domestic Violence Cases)	Government of the Republic of Macedonia	2010	http://www.beznasilstvo.mk/en/communities/community-support-services	Form(s) of violence: domestic violence; special provisions addressing intimate partner violence, abuse and neglect of children, violence against older persons, violence against women, violence against persons with disability. Applies to: health care workers Topics covered: role of health care institutions, documentation, health care, referrals, prevention, identification/screening documentation, safety planning, reporting.
Ireland	Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examinations in Ireland	National SATU Guidelines Development Group	2010	http://www.rcni.ie/wp-content/uploads/NationalSATUGuidelines.pdf	Form(s) of violence: sexual violence Applies to: health care professionals Topics covered: referral, forensic clinical examination guidelines, psychological support guidelines, sexually transmitted infection guidelines, forensic science laboratory guidelines and general practitioners guidelines.
Serbia	Special Protocol for the Protection and Treatment of Women Victims of Violence	Ministry of Health of the Republic of Serbia	2010	http://www.unpd.org/content/dam/serbia/Publications%20and%20reports/English/UNDP_SRB_TirkizniTekst.pdf	Form(s) of violence: all forms of GBV Applies to: all health professionals Topics covered: acknowledging and identifying violence, responding to the health consequences of violence, risk assessment and safety planning, referrals and ending the interview.
Spain	A Common Protocol for Healthcare Response to Gender-Based Violence	Ministry of Health and Consumers Affairs of Spain	2007	http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/com-monProtocol.pdf	Form(s) of violence: all forms of GBV Applies to: health professionals of primary and specialized care Topics covered: definition of GBV, its health consequences, the role of health professionals, detection (indicators of GBV and identification), assessment (medical history, psychosocial situation, experiences of violence, risk of further violence), intervention (information about GBV, medical care and follow-up, recording medical history, referral and documentation), interventions for sexual assault.

Sweden	Guide to care following sexual assault	National Center for Knowledge on Men's Violence against Women	2010	http://viewer.zmags.com/publication/3afabbe8#/3afabbe8/1	Form(s) of violence: sexual assault Applies to: health care professionals Topics covered: principals to respect during all interventions, instructions for examination, body pictograms and template for a forensic medical report.
Sweden	Handbook: National Action Programme for Health Care and Medical Service's Reception and care of Victims of Sexual violence	National Center for Knowledge on Men's Violence against Women	2008	http://viewer.zmags.com/publication/2f30d828#/2f30d828/1	Form(s) of violence: sexual assault Applies to: health care professionals and reception staff at health facilities Topics covered: background information about sexual assault, principles for medical care, how to ask about sexual assault, the responsibility of the health care and medical services, medical care, crisis counselling and psychosocial follow-up, documentation, forensic medical reports and work of the judicial system.
UK	Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively	National Institute for Health and Care Excellence	2014	http://publications.nice.org.uk/domestic-violence-and-abuse-how-health-services-social-care-and-the-organisations-they-work-with-ph50/about-this-guidance#status-of-this-guidance	Form(s) of violence: domestic violence and abuse (child abuse is not included) Applies to: health and social care commissioners, specialist domestic violence and abuse staff and others whose work may bring them into contact with people who experience or perpetrate domestic violence and abuse. Topics covered: the context of domestic violence including the different forms of domestic violence and resulting public sector costs, identification of DV, programmes for perpetrators, trainings, prevention, children witnesses, specialist support, advocacy, advice and skills building.
UK	Sexual Assault Referral Centre (SARC)- Policy	Gloucestershire Constabulary	2012	http://www.gloucestershire.police.uk/foi/Information%20Classes/Policies/item8023.pdf	Form(s) of violence: sexual violence Applies to: SARC staff Topics covered: legislative requirements as a national guideline or legal framework, training, code of practice in management of police information, consultations, procedures and monitoring.

ANNEX 4: ASSESSMENT TOOL 1 - SITUATION ANALYSIS ON GENDER-BASED VIOLENCE AND MAPPING OF STATE RESPONSES²¹

Aim of this questionnaire: to provide health care facilities with a tool to map the prevalence of GBV, the legal and institutional state response to GBV, as well as entry points to improve the health system's response to GBV in their country. The data collected provides valuable background information to inform initiatives to strengthen the response of health care professionals to GBV.

Target group: The main target group for this assessment tool is the management of health care facilities. This tool can also be used by governmental organizations (in particular Ministries of Health, regional or local health administration), non-governmental or international organizations planning an intervention to improve the response of the health system to GBV.

Methodology for collecting data: Desk research. Optional: to be complemented with interviews of organizations working on GBV, either through oral interviews or asking counterparts to provide responses in writing.

PART I: SCOPE OF GENDER-BASED VIOLENCE IN THE COUNTRY

1. Have any surveys been done in your country to measure the prevalence of GBV?²²

Yes No

If yes, summarize the results:

- a) Which forms of GBV have been studied?
- b) How prevalent are they?
- c) What are the consequences of GBV, especially on women's health?

2. Is there any other research data (qualitative studies, administrative data,) on GBV in your country?

Yes No

If yes, please summarize the results:

- a) Which forms of GBV exist?
- b) What are the consequences of GBV, especially on women's health?

²¹ This questionnaire has been prepared by WAVE, building on IPPF 2010 and a set of questionnaires that were prepared by Sabine Bohne in 2011 for WAVE, based on PRO TRAIN 2009 and the official monitoring tool for monitoring the implementation of CoE Recommendation (2002) 5 on the protection of women against violence in Council of Europe Member States (CoE 2007).

²² Refer to Part I, chapter 1 for a table summarizing prevalence studies from the EECA region (table 4).

PART II: THE LEGAL AND POLICY RESPONSE TO GBV

A) LEGAL FRAMEWORK

3. What forms of GBV are criminalized in your country's criminal law?

- Rape and sexual violence
- Domestic violence
- Intimate partner violence
- Sexual harassment at the work place
- Female genital mutilation
- Violence in conflict/post conflict situations
- Violence in institutional environment
- Forced sterilization
- Forced abortion
- Forced marriage
- Bride kidnapping
- Gender-biased sex-selection in favour of boys
- Child marriage
- Crimes in the name of honour
- Other (please specify)

4. For each form of violence that is criminalized,

- a) How is the criminal offense defined?
- b) What are the sanctions?

5. Are there any legal measures in place to protect survivors of GBV?

- Yes No

If yes, please specify.

6. Does the law provide for protection orders in favour of survivors of GBV?

- Yes No

If yes, please specify the requirements and procedures for obtain a protection order.

7. Are there any other laws in place regulating the response to GBV?

- Yes No

If yes, please specify.

8. Overall, are these laws (questions 1-6) effective?

- Yes Somewhat No

If somewhat or yes, what are the obstacles and challenges in implementation?

B) NATIONAL ACTION PLANS OR STRATEGIES

9. Has your government established a national action plan or strategy for combating GBV?

Yes No

If yes,

a) please specify the form(s) of GBV covered

- Rape and sexual violence
- Domestic violence
- Intimate partner violence
- Sexual harassment at the work place
- Female genital mutilation
- Violence in conflict/post conflict situations
- Violence in institutional environment
- Forced sterilization
- Forced abortion
- Forced marriage
- Bride kidnapping
- Gender-biased sex-selection in favour of boys
- Child marriage
- Crimes in the name of honour
- Other (please specify)

b) please list and further the types of interventions foreseen:

- Prevention
- Protection and support
- Investigation and prosecution
- Other (please specify)

10. Does the plan/strategy address the role of the health system in GBV?

Yes No

If yes, which measures are foreseen?

PART III: MAPPING THE DIFFERENT ACTORS IN THE FIELD OF GBV

A) OVERVIEW

11. What general service providing organizations work directly with survivors of GBV in your region and municipality?

List the organizations here and provide further details in question 14.

12. What organizations other than direct service providers work in the area of GBV in your region and municipality?

List the organizations here and provide further details in question 14.

13. Are there networks of organizations working on the problem of GBV in your municipality, region or country?

Yes No

14. For each of these organizations or networks (Q11-13), please list:

a) Status of organization

Public institution

Civil society organization/NGO

Private institution (for profit)

Private institution (non- profit)

Other , please specify

b) Mandate and main activities

c) How long have they been working in the field of GBV?

d) If they provide direct services, please specify the type of services.

B) MAPPING OF SPECIALIZED WOMEN SUPPORT SERVICES**1) Women's shelters****15. Do women's shelters exist in your country?**

Yes No

If yes,

1) How many shelters do exist?

2) What are their names and phone numbers?

3) In which cities are they located?

4) Do they operate free of charge? Are there any requirements for accessing the shelter?

5) Who is the main target group of these shelters?

2) Women helplines

16. Is there a national women's helpline?

Yes No

If yes,

1) Is it free of charge?

Yes No

2) Does it operate 24/7?

Yes No

3) What is the phone number?

17. Is there a local helpline?

Yes No

If yes,

1) Is it free of charge?

Yes No

2) Does it operate 24/7?

Yes No

3) What is the phone number?

3) Perpetrators programmes

18. Are there specifically designed intervention programmes, conducted by professionals, offered to men perpetrators of violence against women?

Yes No

If yes,

1) How many are there?

2) Are these programmes offered to perpetrators on a voluntary basis?

Yes No

C) NATIONAL REFERRAL MECHANISM

19. Is there a referral system for survivors of GBV exist at the national level?

Yes No

If yes, please describe it: who are the main actors, what are their roles, what coordination mechanism is in place, how is the cooperation formalized, etc.

20. Does a referral system for survivors of GBV at the local level exist?

Yes No

If yes, please describe it: who are the main actors, what are their roles, what coordination mechanism is in place, how is the cooperation formalized, etc.

21. Have you already established any contacts or work relationships with any organizations working in the field of GBV (refer to questions 11-17)?

Yes No

If yes, please specify. If no, please specify why not.

22. Have you met with representatives from other organizations working in the area of GBV (refer to questions 11-17) to identify how you can collaborate in providing care and support to survivors of GBV?

Yes No

ANNEX 5 ASSESSMENT TOOL 2 - ASSESSING A HEALTH FACILITY'S RESPONSE TO GENDER-BASED VIOLENCE²³

Aim of this questionnaire: to provide health care facilities with a tool to assess the extent to which the GBV response is integrated in their institution. The data collected can be used as a starting point by management of health facilities when developing an intervention program to strengthen the response to GBV in their respective facilities.

Target group: Management of health care facilities.

Methodology for collecting data: Desk research. Optional: to be complemented with interviews of organizations working on GBV, either through oral interviews or asking counterparts to provide responses in writing.

PART I: BACKGROUND - THE HEALTH SYSTEM

1. How is the health care system funded?

- General taxation to the State, country or municipality
- Social health insurance
- Voluntary or private health insurance
- Out-of-pocket payment
- Donations to charities
- Other (please specify)

2. Which of the following health units do women or girls in your region regularly attend?

- General practitioners/ physicians
- Gynaecologists/obstetricians
- Nurses/ public health nurses
- Midwives
- Mental health professionals, psychiatrists, psychologists
- Emergency staff in ambulance
- School or company doctors
- Other (please specify)

3. Do patients need to visit a general practitioner first in order to see a specialist?

- Yes No

³ This questionnaire has been prepared by WAVE, building on IPPF 2010 and a set of questionnaires that were prepared by Sabine Bohne in 2011 for WAVE, based on PRO TRAIN 2009 and the official monitoring tool for monitoring the implementation of CoE Recommendation (2002) 5 on the protection of women against violence in Council of Europe Member States (CoE 2007).

4. What are some of the obstacles for women to see a health care professional in your region?

- Lack of transportation
- Far distance
- Fear of stigmatization, fear of a bad reputation, shame
- Partner/husband/family may not allow woman to seek help
- Lack of services in the region
- Financial restrictions
- Sex (not allowed to see a male doctor)
- Other (please specify)

5. Are there any national health sector policies, plans and/or programs in place to address GBV?

- Yes No

If yes, please list them:

6. Are these policies/plans/ programs implemented?

- Yes Somewhat No

If somewhat or no, explain why?

7. What are the legal obligations for health service providers in your country with regard to situations of GBV?**8. Are health service providers required to report cases of GBV to the police?**

- Yes No

If yes, please describe the requirements (e.g. circumstances/severity of the offense, forms of violence)?

9. Who is allowed to collect forensic, documentary and photographic evidence in ways that can be presented as legal evidence in court?**10. With whom are health care professionals allowed by law to share information with about his/her patient?**

PART II: THE RESPONSE OF THE HEALTH FACILITY

A) POLICIES AND PROTOCOLS

11. Is there a written policy and/or protocol in your institution that addresses GBV?

Yes No

If so,

a) What is the main focus of the policy/protocol? (chose all options that apply)

Forms of Violence	Interventions
<input type="checkbox"/> Rape and sexual violence <input type="checkbox"/> Domestic violence <input type="checkbox"/> Intimate partner violence <input type="checkbox"/> Violence committed by a non-partner <input type="checkbox"/> Sexual harassment at the work place <input type="checkbox"/> Female genital mutilation <input type="checkbox"/> Violence in conflict/post conflict situations <input type="checkbox"/> Violence in institutional environment <input type="checkbox"/> Forced sterilization <input type="checkbox"/> Forced abortion <input type="checkbox"/> Forced marriage <input type="checkbox"/> Bride kidnapping <input type="checkbox"/> Gender-biased sex-selection in favour of boys <input type="checkbox"/> Child marriage <input type="checkbox"/> Crimes in the name of honour <input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Identify the symptoms of GBV <input type="checkbox"/> Ask questions about GBV in case of suspicion <input type="checkbox"/> Provide the patient with information on GBV and its consequences on women's health <input type="checkbox"/> Create a friendly and confidential environment <input type="checkbox"/> Care and examination of the survivor <input type="checkbox"/> Documentation of GBV <input type="checkbox"/> Risk assessment and safety planning <input type="checkbox"/> Referrals <input type="checkbox"/> Other (please specify)

b) Are they accessible for all staff?

12. Is there a process in place for monitoring and evaluating the implementation of these documents and for collecting feedback from those who apply them?

Yes No

If yes, who is in charge for monitoring, evaluating and feedback collection?

If not, describe why?

13. Has the facility distributed written information about legal issues (e.g. confidentiality rules, laws on criminalization of GBV) to all staff members?

Yes No

If not, describe why?

B) CAPACITY BUILDING OF STAFF ON GBV

14. Has your facility undertaken any efforts to sensitize management about GBV as a public health and human rights issue?

Yes No

If yes, please describe it

15. Does your facility offer training to the staff in the area of GBV, gender equality and human rights?

Yes No

If yes, what are the main topics of the training?

16. Do these trainings provide both theoretical knowledge and practical skills to identify, examine and provide care to women survivors of GBV?

Yes No

17. Who was the target group of the training?

- General practitioners/ physicians
- Gynaecologists/obstetricians
- Nurses/ public health nurses
- Midwives
- Mental health professionals, psychiatrists, psychologists
- Emergency staff in ambulance
- School or company doctors
- Other (please specify)

18. Was the training only for health professionals or multi-disciplinary professionals?

Only health Multi-disciplinary

If it was a multi-disciplinary training, who were the other professionals besides health?

19. What was the duration of the training?

20. Was it a one-time event or are trainings held regularly?

One-time Regularly

If the training is held regularly, how often is it organized?

21. Who provides the training?

- Health professionals from the facilities
- External health professionals
- External experts working on GBV (please specify)
- Others (please specify)

22. Have you identified individuals and/or organizations that could support your efforts to sensitize and train health care providers on issues related to GBV?

- Yes No

If yes, please specify

If no, describe the obstacles and how you can address them?

23. Even if your facility does not provide trainings, did any of your staff undergo training on GBV by another way?

- Yes No

If yes, identify these staff members (they are possible resource persons for further trainings)

C) HEALTH CARE STAFF RESPONSES TO GBV

1) Ensuring safety

24. Do medical staff establish safety planning with the women survivors?

- Yes No

If no, specify why?

25. Is your medical staff aware of the protection measures available under the country's legislation?

- Yes No

If no, specify why?

2) Ensuring the patient's dignity and providing a supportive and validating environment

26. Do medical staff ask women patients about GBV when they have suspicions that she is a survivor?

- Yes No

27. Do medical staff receive trainings on how to communicate with women survivors of GBV?

- Yes No

3) Ensuring privacy and confidentiality

28. What are the rules of your facility about confidentiality?

29. With whom is medical staff allowed to share information with about a patient?

30. Does the facility have enough space to ensure private consultations?

Yes No

If no, explain why?

31. Can the patient be heard or seen from outside of the consultation room?

Yes No

32. Are other persons authorized in the consultation room (partner, husband, young children or other relatives)?

Yes No

33. Are the medical records stored in a secure place?

Yes No

If no, please explain why?

34. Which staff has access to the medical records?

4) Ensuring the patient's empowerment, autonomy and participation

35. Are there any written documents displayed in the waiting rooms to inform patients about GBV, such as pamphlets or posters?

Yes No

36. Do medical staff at your facility have a list of organizations to refer survivors of GBV to?

Yes No

5) Referrals

37. Do medical staff refer survivors of GBV to any other organizations?

Yes No

If yes, to which one(s)?

ANNEX 6: TEMPLATE FOR IDENTIFYING AND MAPPING POTENTIAL REFERRAL PARTNERS

Name of institution:	Type of institution:
Director of institution:	Hours and Days Open:
Address:	Phone Numbers:
	Fax Numbers:
	E-mail Address:
What type of population do you serve?	Do you specifically see survivors of GBV? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is the profile of the survivors you serve? Does your organization have any criteria that a potential client/patient would have to meet?	
Do you provide direct care or do you make referrals?	If you do provide direct care, what type is it? (Legal, medical, social, psychological, educational, etc.)
If you make referrals, where do you refer?	Do you charge a fee? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, do you have a fixed fee or can you make accommodations?
What is the profile of your staff who see survivors of violence?	Are there other activities that your institution offers?
Are you aware of any other institutions that offer care to victims of GBV? If so, can we have this information so we can contact them?	Would you be interested in our two institutions making cross-referrals? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you be interested in being a part of a network of groups that work in the area of GBV? <input type="checkbox"/> Yes <input type="checkbox"/> No	

INSTRUCTIONS

- » Get names of potential referral resources from non-governmental organizations (NGOs), hospitals, community leaders, and people at the district level.
- » If possible, request a face-to-face interview with the possible referral resource. Above is a sample set of questions that can be used to evaluate each group that is interviewed.
- » Offer to keep in contact and work together on creating a network, if they are interested.
- » Write up the resource list using the information that has been gathered. Divide the referral book up into different types of referral topics, putting all relevant referrals together under each area, i.e., legal, social, housing, medical, and psychological. Put it into a book with one referral per page, including relevant information about this institution that could be useful when deciding what institution could best help a particular client/patient.

Source: Adapted from UNFPA 2001

ANNEX 7: TEMPLATE FOR COMPILING A DIRECTORY OF REFERRAL ORGANIZATIONS

CONTACT INFORMATION	
Full name of the institution:	
Acronym of the institution:	
Type of institution:	
Address:	
Telephone:	
Fax:	
Email:	
Name of director:	
Information source – name and title (the person in the institution who provided this information):	
Date of last update of information:	
Overview of the institution (mandate, area of work):	
DESCRIPTION OF SERVICES RELATED TO GENDER-BASED VIOLENCE	
Characteristics of the population served (such as sex, age, other specific characteristics, such as minority or disability status, geographical area covered):	
Types of services provided:	
Hours:	
Procedures/requirements for obtaining services:	
Costs of the services, if any :	
Organizations to which your organization refers clients/patients to:	
Type of staff who provide services to survivors of violence:	
Other activities related to violence:	

Source: adapted from IPPF 2010

ANNEX 8: WHO SEXUAL VIOLENCE DOCUMENTATION FORM

World Health Organization SEXUAL VIOLENCE EXAMINATION RECORD

PATIENT DETAILS

FAMILY NAME		
GIVEN NAME(S)		
DATE OF BIRTH	AGE (in years)	SEX
ADDRESS (or other identification)		

EXAMINATION

DATE	TIME
PLACE	
HEALTH WORKER'S NAME (or identification details)	
OTHER PERSONS PRESENT DURING CONSULTATION (and relationship to patient)	

REPORT

DATE SENT

SENT TO

¹ This record should be used in conjunction with the WHO *Guidelines for Medico-legal Care for Victims of Sexual Violence*, which contain much of the background information about the conduct of the examination.

Notes on completing the Consent Form

Consent for an examination is a central issue in medico-legal practice. Consent is often called “Informed consent” because it is expected that the patient (or his/her parent(s) or guardian) will be “informed” of all the relevant issues to help the patient make a decision about what is best for him/her at the time.

The patient needs to understand:

- » What the history-taking process will involve.
- » The type of questions that will be asked and the reason those questions will be asked.

For example:

“I will need to ask you for details of the assault. I will need to know where your attacker’s body touched yours so I will know where to look on your body for signs of injury or for traces of evidence from your attacker.”

- » That the examination will be done in circumstances of privacy and dignity. The patient will lie on an examination couch and an extensive examination will be required.
- » That a genito-anal examination will require the patient to lie in a position where this area can be adequately seen with the correct lighting.

For example:

“I will ask you to lie on your back on the examination couch with a sheet draped over your knees. I will ask you to draw your knees up, keep your ankles together and flop your legs apart so that I can look carefully at your pelvic area with the help of this light.”

- » That the genito-anal area will be touched by the examiner’s gloved hands to allow internal structures to be better seen. A device designed for looking inside the vagina or the female birth canal, called a speculum, may be used. A device for looking inside the anus, an anoscope, may be used.
- » That specimen collection involves touching the body and body openings with swabs and collecting body materials such as head hair, pubic hair, genital secretions, blood, urine and saliva. Clothing may be collected. Not all of the results of the forensic analysis may be made available to the patient.

It is crucial to inform the patient that the information told to the health worker and found on examination will be conveyed to investigators for use in the pursuit of criminal justice if the patient decides to pursue legal action or in jurisdictions with mandatory reporting requirements. This means that anything told to the health worker may not be kept private between patient and health worker, but may be discussed in an open court at some time in the future.

The patient should also be given an explanation as to how photographs may be used. Photography is useful for court purposes and should NOT include images of genital areas.

All of the above information should be provided in a language that is readily understood by the patient or his/her parent/guardian.

CONSENT FOR A MEDICAL CONSULTATION¹

..... (*insert health worker's name*) has explained to me the procedures of examination, evidence collection and release of findings to police and/or the courts.

I (*insert patient's name*) agree to the following:

(Mark each n that applies)

Examination, including examination of the genitalia and anus.

Collection of specimens for medical investigations to diagnose any medical problems. Collection of specimens for criminal investigation.

Photography.

Providing a verbal and or written report to police or other investigators. Treatment of any identified medical conditions.

Patient's (or parent's or guardian's) signature or mark

Witness' signature

Date

¹ In cases involving children, a parent or guardian can sign on behalf of the child. Similarly, if an adult is not competent to provide consent, the next of kin or guardian should sign on his/her behalf.

MEDICAL HISTORY

1. RELEVANT MEDICAL/SURGICAL/PSYCHIATRIC HISTORY

For children include:

- relevant antenatal/postnatal and developmental history;
- history of behavioural problems (if considered relevant to allegations);
- family history.

2. RELEVANT GYNAECOLOGICAL HISTORY

First day of last normal menstrual period (DD/MM/YY):

Average number of days between menstrual periods:

Age at menarche (for children):

Was patient menstruating at the time of the assault?	Yes	No	Not applicable
--	-----	----	----------------

Is the patient currently pregnant?	Yes	No	Not applicable
------------------------------------	-----	----	----------------

Pregnancy history:

Methods of contraception currently in use:

History of genital trauma, surgery or bleeding:

3. ALLERGIES

4. MEDICATIONS/IMMUNIZATION STATUS (e.g. hepatitis B, tetanus)

HISTORY OF OFFENCE

5. DETAILS FROM OTHER PARTIES (e.g. police, family, witnesses)

Details provided by (name):

6. DETAILS FROM PATIENT

Date(s) of assault (or period over which assaults occurred, number of assaults and date of last assault):

Time: Location:

Assailant(s) (number and relationship to patient, if any): Alcohol consumed:

Drugs consumed:

Weapons used, threats made:

Relevant details of assault:

7. CURRENT SYMPTOMS

SUMMARY OF SEXUAL ASSAULT

VAGINAL PENETRATION	Assailant 1	Assailant 2	Assailant 3	Assailant 4	Assailant 5
Attempted/completed?					
Ejaculated Yes/No?					
ANAL PENETRATION	Assailant 1	Assailant 2	Assailant 3	Assailant 4	Assailant 5
Attempted/completed?					
Ejaculated Yes/No?					

ORAL PENETRATION	Assailant 1	Assailant 2	Assailant 3	Assailant 4	Assailant 5
Attempted/completed?					
Ejaculated Yes/No?					

	Assailant 1	Assailant 2	Assailant 3	Assailant 4	Assailant 5
EJACULATED ON BODY If 'Yes' list site					
SALIVA ON BODY If 'Yes' list site					
CONDOM USED (Yes/No/?)					
LUBRICANT USED (Yes/No/?)					

OBJECTS¹ USED FOR PENETRATION	Assailant 1	Assailant 2	Assailant 3	Assailant 4	Assailant 5
VAGINA					
ANUS					
MOUTH					

¹ Include body parts (e.g. digits).

8. POST ASSAULT

Detail clothing worn at time of assault:

Changed clothes	Yes	No
Cleaned clothes	Yes	No
Bathed/showered	Yes	No
Had sexual intercourse	Yes	No

9. RECENT INTERCOURSE

Intercourse during the past week Yes No

Details (date/time/with whom):

Was condom/spermicide/lubricant used? Yes No

Details:

Notes on the forensic examination

The extent of the examination will be largely directed by the history and clinical observations. If there is any doubt, a complete external inspection is preferable.

When describing wounds, consider: site, size, shape, surrounds, colour, contours, course, contents, age, borders and depth.

Classify wounds:

- » Abrasion: disruption of the outer layer of the skin.
- » Bruise: an area of haemorrhage beneath the skin.
- » Laceration: splitting or tearing of tissues secondary to blunt trauma.
- » Incision: a cutting type of injury with (usually) clear, regular margins.
- » Stab: a wound of greater depth than length, produced by a sharp object.

A speculum (or proctoscope) examination may be required for adults or post-pubertal sexually active children. Indications include:

- » genital pain;
- » bleeding;
- » foreign body (used during assault and possibly still present);
- » assaults > 24 hours earlier. In such cases, a cervical canal specimen is required.

The speculum should be warmed and lubricated with water. A bimanual examination is rarely indicated post sexual assault.

Photography (including colposcopic photography) provides a useful addition to wound documentation. Consider the following:

- » self, police or hospital photographers may be appropriate;
- » careful labelling of film/photos is vital;
- » photography of the genital region may cause considerable embarrassment for the patient; it should only be performed when the patient provides specific consent and if it is considered essential to the case.

Notes on methods of collecting forensic specimens are provided on pages 19–20. Advice should be sought from the forensic laboratory on any variations to this methodology.

EXAMINATION

10. PERSONS PRESENT

Name(s):

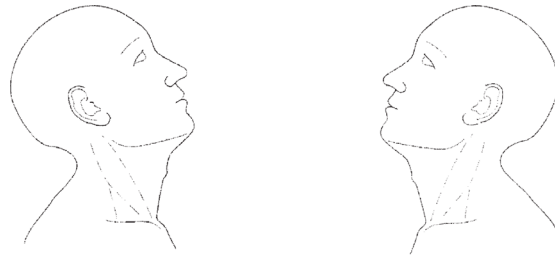
.....

.....

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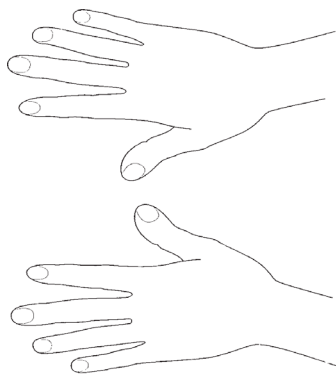
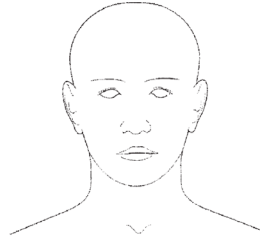
11. INITIAL APPEARANCE (e. g. intellect, physical, sexual development, clothing, emotional state, effects of alcohol/drugs)

12. FINDINGS (place notes here; use body charts for diagrams)



Right

Left

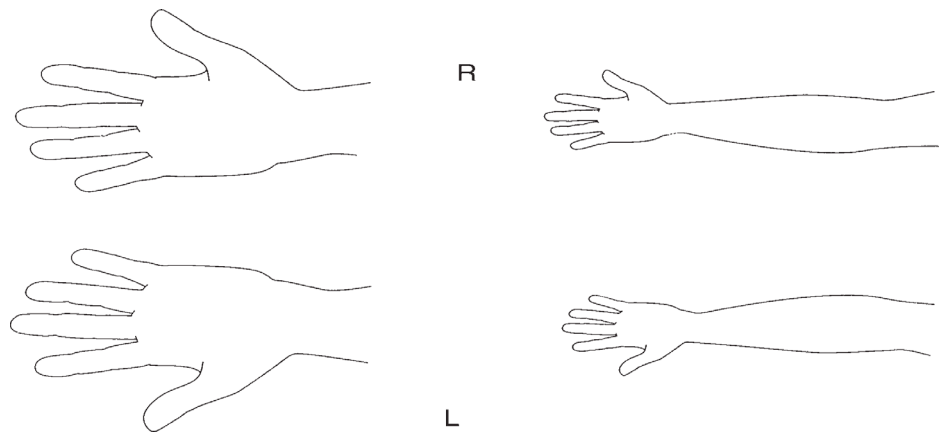


R



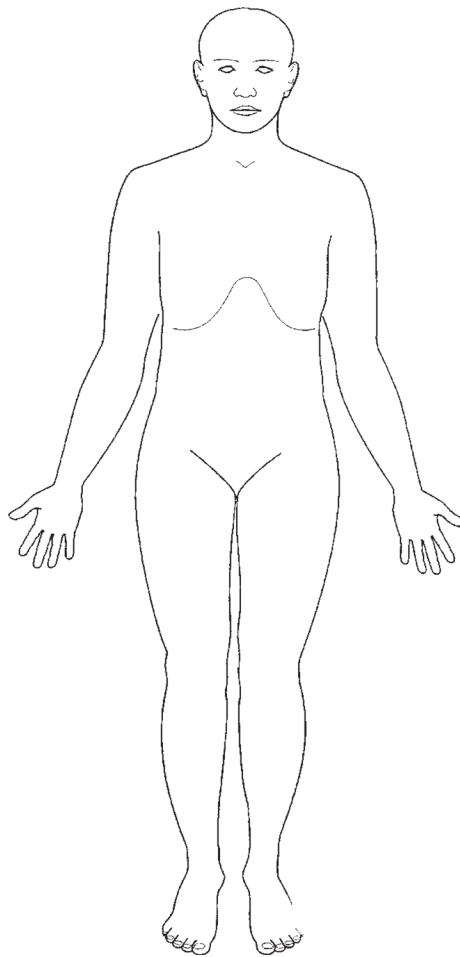
L





Right

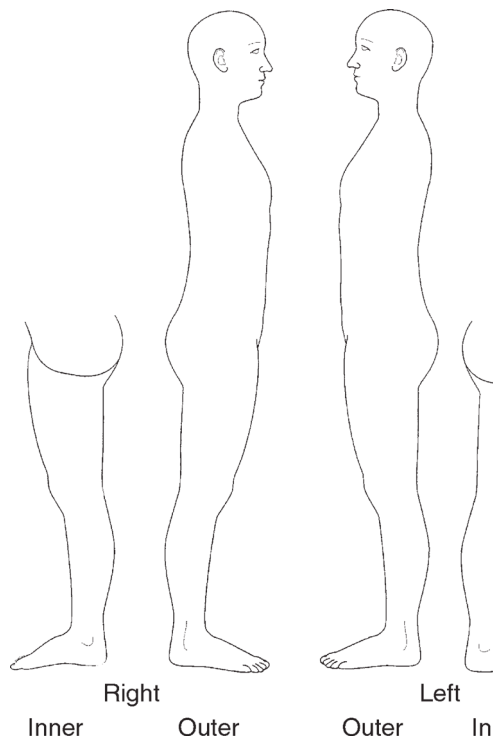
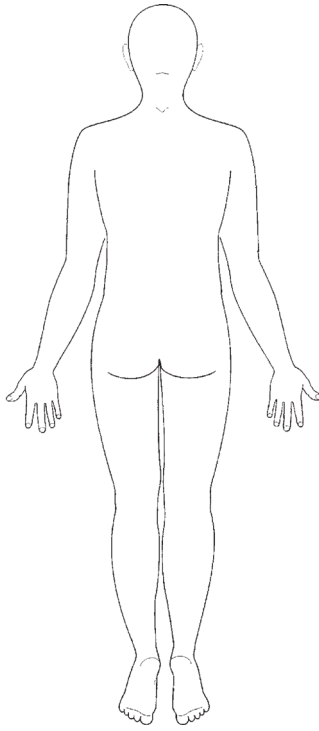
Left

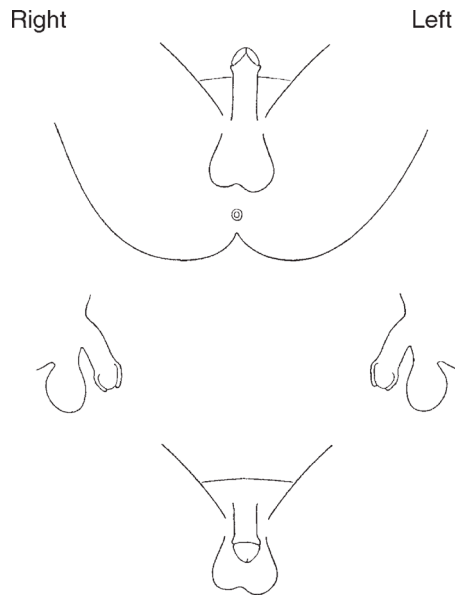


Draw in outline of breasts as required.

Left

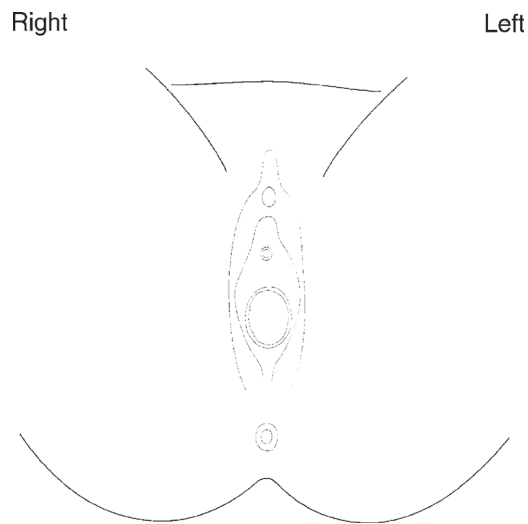
Right





Proctoscopy conducted
Findings:

YES NO



Speculum examination conducted

YES NO

Proctoscopy conducted

YES NO

Findings:

OTHER DETAILS

13. PHOTOGRAPHY

No Yes

By whom?

Date and time:

14. MEDICATION PROVIDED

Emergency contraception	No	Yes	Details:
STI prophylaxis	No	Yes	Details:
HIV prophylaxis	No	Yes	Details:
Other	No	Yes	Details:

15. HOSPITAL PATHOLOGY

No Yes

Details:

16. FOLLOW-UP ARRANGEMENTS (e.g. medical, counselling)

17. CONTACT MADE WITH OTHER HEALTHWORKERS

Letter Yes No

Telephone call Yes No

Details:

COLLECTION OF FORENSIC SPECIMENS

Informed consent specifically for specimen collection should be obtained, and documented.

Explain that the specimens may be used for the criminal justice process should a legal action go ahead. If a report of the assault has not been made (i.e. to the police) there may still be some benefit in collecting the specimens (and holding them for a time). This should be explained to the patient.

Some results of the tests may not be available to the patient (unlike diagnostic tests done by medical practitioners).

Consult with your local laboratory regarding appropriate types and handling of specimens. For example, do not collect DNA evidentiary material if your laboratory does not perform this test.

Once collected, the specimens should not be out of the doctor's sight until handed to the police. This process is called "continuity of evidence" and is designed to avoid allegations of specimen tampering. Record the name of the police officer to whom the specimens are handed, and the date and time of transfer, on the second to last page of this proforma (page 21).

INSTRUCTIONS TO THE PATIENT

If the patient alleges oral penetration with possible ejaculation in the mouth, drinking and toothbrushing should be postponed until oral forensic specimens are collected. If the patient is thirsty, the oral specimen can be collected prior to history taking and examination (see below).

Use words like "gather" and "collect", as opposed to "take" and "scrape". A calm demeanor is helpful.

GENERAL PRECAUTIONS

Wear gloves for examination and specimen collection.

All forensic swabs are dry to begin with and should be dry to end with!

Recap dried swabs and seal with a patient label, if available.

In order to find spermatozoa, the laboratory will need a slide and a swab.

The slide is used to look for sperm (the adjacent diagram shows how to plate the specimen).

The sperm are then extracted from the swab for DNA typing.

Specimens should be sealed into a bio-hazard bag.



SAMPLE LABEL	
Name of patient	Ada Wells
Date & time of collection	01.10.02 0400 hrs
Specific type of specimen	Endocervical swab
Name of doctor	Dr A Welborn

Every specimen should be labelled with identifying data (see example).

ORDER OF COLLECTION

Clothing

Trace evidence from the patient's clothes will not be lost if the patient is instructed to undress over a large sheet of paper (drop sheet). One way of doing this is to ask the patient to stand on a sheet of paper, behind a screen and hand out the items of clothing one by one, to be placed in individual paper bags. Note which items of clothing have been collected. Check with the police which items of clothing are required.

Drop sheet

The drop sheet could have evidence from the offender such as pubic hairs, head hairs and clothing fibres.

The drop sheet could have evidence from the scene such as sand, fibres or vegetation.

The drop sheet is folded in such a way so as to retain any evidence, placed in a paper bag and sealed with a patient label.

Sanitary pad/tampon

These items should be dried and sealed in a double paper bag.

Fingernail scrapings

An allegation of the victim scratching the assailant may leave foreign DNA or fibres under the patient's fingernails. A wooden swab stick may be broken in half, one used for each hand, and the remnants placed in a sterile urine jar. Alternatively, the fingernail(s) can be cut and the clippings placed in the container.

Head hair for comparison purposes

Twenty representative hairs should be cut from over the head, placed on a piece of paper, folded as the drop sheet, sealed and bagged.

Oral swab

Spermatozoa in the mouth collect in the same places as saliva. The best reservoirs are therefore the gingival margins of the lower teeth and under the tongue. This swab should be done if there is allegation of oral penetration within the last 12–24 hours. Alternatively, have the patient his/her mouth with 20–30 ml of sterile water and collect the rinsings in a sterile container.

Saliva on skin

Assailant DNA can be recovered. The double swab technique involves (a) swabbing the affected area with a swab moistened with tap water, followed by (b) swabbing with a dry swab. Both swabs should be air dried and submitted.

Semen on skin

The double swab technique can be also be used for skin where dried semen may be present. Both the first moist swab and the second dry swab should have slides made from them. Use this technique wherever ejaculation may have occurred, including the vulva and anus.

Pubic hair combing

Performed infrequently and only if foreign hair is noted on examination. Submit comb and products. Collect foreign materials with a swab stick and submit in a sterile container.

Vaginal swab

A swab taken with or without the use of a speculum, depending on patient/doctor preference.

Endocervical swab

Can be collected with the use of a speculum for direct visualization of the cervix. Use warm water to lubricate the speculum.

Anal and rectal swab

An anoscope may be used, or the anus can be swabbed under direct vision.

Victim / Assailant DNA for comparison

If there is no allegation of oral penetration, a buccal swab may be taken. Otherwise, blood will provide DNA (see below).

Blood for DNA

Should be collected into an appropriate tube.

Blood for drugs

Use a plain tube.

Urine for drugs

Instruct the patient to provide a full sterile container of urine.

SAMPLES

FORENSIC SAMPLES

Health Worker's Copy

Clothing(bags)
Drop sheet
Sanitary pad/tampon

BODY EVIDENCE

Oral swab and slide
Foreign material on body
Semen-like stains on body
Semen-like material on head hair
Semen-like material on pubic hair
Combings of pubic hair
Fingernail evidence
Body swab (for saliva) (note site)
Other (specify)

GENITO-ANAL EVIDENCE

Foreign material
High vaginal swab and slide
Endocervical swab and slide
Anal swab and slide
Rectal swab and slide
Other (specify)

COMPARISON SAMPLES

Pubic hair
Head hair
Buccal swab for DNA
Blood for alcohol and drugs (plain tube or fluoride/oxalate vial)
Urine for drugs

OTHER

Other samples (list)
.....

TOTAL NO. OF SEALED BAGS

The samples listed were handed to:

Name: Rank/number:
Station/squad:
Date and time:
Signed:

FORENSIC SAMPLES

Laboratory Copy¹

Date and time collected:hours on / /

SAMPLES

- Clothing(bags)
- Drop sheet.....
- Sanitary pad/tampon

BODY EVIDENCE

- Oral swab and slide
- Foreign material on body
- Semen-like stains on body
- Semen-like material on head hair
- Semen-like material on pubic hair
- Combings of pubic hair
- Fingernail evidence
- Body swab (for saliva) (note site)
- Other (specify).....

GENITO-ANAL EVIDENCE

- Foreign material
- High vaginal swab and slide.....
- Endocervical swab and slide
- Anal swab and slide.....
- Rectal swab and slide
- Other (specify).....

COMPARISON SAMPLES

- Pubic hair
- Head hair
- Buccal swab for DNA
- Blood for alcohol and drugs (plain tube or fluoride/oxalate vial)
- Urine for drugs

OTHER

- Other samples (list).....
-
-

HEALTH WORKER'S NAME:

¹ This copy to be enclosed with specimens. These should be taken to the laboratory.

List of acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AKH	General Hospital of the City of Vienna
APA	American Psychiatric Association
BIH	Bosnia and Herzegovina
BMWFJ	Bundesministerium für Wirtschaft, Familie und Jugend
CAADA	Coordinated Action against Domestic Abuse
CBT	Cognitive behavioural therapy
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CHANGE	Center for Health and Gender Equity
CHEC	Cambodia HIV/AIDS Education and Care
CIDA	Canadian International Development Agency
CoE	Council of Europe
CoE PA	Council of Europe Parliamentary Assembly
CSW	Commission on the Status of Women
DALY	Disability-adjusted life year
DEVAW	Declaration on the Elimination of Violence against Women
DV	Domestic violence
EECA	Eastern Europe and Central Asia
EECARO	Eastern Europe and Central Asia Regional Office of UNFPA
EMDR	Eye movement desensitization reprocessing
ESE	Association for Emancipation, Solidarity and Equality of Women of Republic of Macedonia
FRA	European Union Agency for Fundamental Rights
GBV	Gender-based violence
GR	General Recommendation
HIV	Human Immunodeficiency Virus
HIT	Health system in Transition
HRBA	Human rights based approach
HRW	Human Rights Watch
IASC	Inter-Agency Standing Committee
ICMPD	International Centre for Migration Policy Development
ICPD	International Conference on Population and Development
IDRC	International Development Research Centre
IEC	Information, education & communication
IGWG	Interagency Gender Working Group
ILO	International Labour Office
IPPF	International Planned Parenthood Federation
IPV	Intimate partner violence
IRIS	Identification & Referral to Improve Safety
IUD	Intrauterine device
LFA	Logical framework approach
LSHTM	London School of Hygiene & Tropical Medicine
MDF	Management for Development Foundation
M&E	Monitoring & Evaluation
mhGAP	Mental Health Gap Action Programme (WHO mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings)

MSC	Most significant change
MoU	Memorandum of Understanding
MoV	Means of verification
MWIA	Medical Women's International Association
NGO	Non-governmental organization
OECD-DAC	Organization for Economic Cooperation and Development, Development Assistance Committee
OHCHR	Office of the High Commissioner for Human Rights
OSCE	Organization for Security and Cooperation in Europe
OVI	Objectively verifiable indicators
PAHO	Pan-American Health Organization
PATH	Program for Appropriate Technology in Health
PEP	Post-exposure prophylaxis
PICUM	Platform for International Cooperation on Undocumented Migrants
PPT	PowerPoint presentations
PROI	Association PROI (Bosnia-Herzegovina)
PTSD	Post-traumatic stress disorder
RBM	Results-based management
RK	Republic of Kazakhstan
SC	Significant change
SMART	Specific and simple, Measurable, Appropriate and achievable, Realistic, Time-bound
SOP	Standard operating procedures
SPECSS	Separation, Pregnancy, Escalation of violence, Cultural factors, Stalking, Sexual assault
SPICED	Subjective, Participatory, Cross-checked and compared, Empowering, Diverse and disaggregated
STI	Sexually transmitted infections
SV	Sexual violence
UK	United Kingdom
UN	United Nations
UN DESA	United Nations Department for Economic and Social Affairs
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNDPI	United Nations Department of Public Affairs
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNSCR 1244	United Nations Security Council Resolution 1244 on the situation related to Kosovo
VAW	Violence against women
WAVE	Women against Violence Europe
WHO	World Health Organization
WHPC	Women's Health Promotion Center (Belgrade)
WHR	Western Hemisphere Region

Glossary

BRIDE KIDNAPPING

The act of taking a woman or girl against her will through deception or force and using physical or psychological coercion to force her to marry one of her abductors (HRW 2006).

COGNITIVE BEHAVIOURAL THERAPY

Cognitive behavioural therapy (CBT) is based on the concept that thoughts, rather than external factors such as people or events, are what dictate one's feelings and behaviour. People may have unrealistic or distorted thoughts, which if left unchecked, could lead to unhelpful behaviour. CBT typically has a cognitive component (helping the person develop the ability to identify and challenge unrealistic negative thoughts), as well as a behavioural component. CBT varies, depending on the specific mental health problems (WHO 2013).

CHILD

Every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier (CRC 1989).

CHILD MARRIAGE (OR EARLY MARRIAGE)

The union of two persons at least one of whom is under 18 years of age (CoE PA 2005).

CLINICAL ENQUIRY (OR CASE-FINDING)

In the context of intimate partner violence, this refers to the identification of women experiencing violence who present to health-care settings, through use of questions based on the presenting conditions, the history and, where appropriate, examination of the patient. These terms are used as distinct from “screening” or “routine enquiry” (WHO 2013).

DOMESTIC VIOLENCE

“All acts of physical, sexual, psychological or economic violence within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim” Article 3 Istanbul Convention). The two main forms of domestic violence are intimate partner violence between current or former spouses or partners and inter-generational violence which typically occurs between parents and children (Istanbul Convention Explanatory Report).

EARLY MARRIAGE (SEE CHILD MARRIAGE)

ECONOMIC VIOLENCE

Economic violence is used to deny and control a woman's access to resources, including time, money, transportation, shelter, insurance, food or clothing. Acts of economic violence include: prohibiting a woman from working; excluding her from financial decision making in the family; withholding money or financial information; refusing to pay bills or maintenance for her or the children; and destroying jointly owned assets (adapted from Warshaw/Ganley 1996).

EYE MOVEMENT DESENSITIZATION REPROCESSING

This therapy entails standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions and bodily sensations, and (b) bilateral stimulation, most commonly in the form of repetitive eye movements. Unlike CBT with a trauma focus, eye movement desensitization reprocessing therapy involves treatment that is conducted without detailed descriptions of the event, without direct challenging of beliefs, and without extended exposure (WHO 2013).

EMPOWERMENT

The process of helping women to feel more in control of their lives and able to take decisions about their future, as articulated in Dutton's empowerment theory. Dutton notes that battered women are not "sick", rather they are in a "sick situation" and responses need to demonstrate an understanding, and take into account, their differing needs for support, advocacy and healing. Empowerment is a key feature of advocacy interventions and of some psychological (brief counseling) interventions (Dutton 1992, cited in WHO 2013).

EVALUATION

The systematic collection and analysis of data in order to assess the relevance, effectiveness and impact of activities in light of project objectives. It involves assessing the strengths and weaknesses of projects, programs, strategies and/or policies to improve their effectiveness. It involves giving feedback about the progress to donors, implementers and beneficiaries of the project. Evaluations are generally done either during the span of a program (mid-term evaluation) to measure and allow for mid-stream program adjustments or upon completion of programs (ex-post evaluation) (ICMPD 2010).

FORCED MARRIAGE

The union of two persons at least one of whom has not given their full and free consent to the marriage (CoE PA 2005).

GENDER

The socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women. While sex and its associated biological functions are programmed genetically, gender roles and the power relations they reflect are a social construct – they vary across cultures and through time, and thus are amenable to change. Gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationship between women and men, girls and boys (adapted from MWIA 2002, WHO undated).

GENDER-BASED VIOLENCE

Violence “that is directed against a woman because she is a woman or that affects women disproportionately” (CEDAW GR 19, Article 3 Istanbul Convention). This manual uses the terms “gender-based violence” and “violence against women” interchangeably.

GENDER-BIASED SEX SELECTION

Gender-biased sex-selection in favour of boys may take place before a pregnancy is established, during pregnancy through prenatal sex detection and selective abortion, or following birth through infanticide or child neglect (OHCHR/UNFPA/UNICEF/UN Women/WHO 2011). Pre-natal sex selection refers to the practice of using medical techniques to choose the sex of offspring. This term “sex selection” encompasses a number of practices including selecting embryos for transfer and implantation following in vitro fertilization, separating sperm, and selectively terminating a pregnancy (WHO Genomic resource centre).

HEALTH-CARE PROVIDER

An individual or an organization that provides health-care services in a systematic way. An individual health-care provider may be a health-care professional, a community health worker, or any other person who is trained and knowledgeable in health. This can include lay health-care workers who have received some training to deliver care in their community. Organizations include hospitals, clinics, primary care centres and other services delivery points. In these guidelines, the term “health-care provider” usually refers to the primary care provider (nurse, midwife, doctor or other) (WHO 2013).

HARMFUL PRACTICES

All practices done deliberately by men on the body or the psyche of other human beings for no therapeutic purpose, but rather for cultural or socio-conventional motives and which have harmful consequences on the health and the rights of the victims. Examples of harmful practices include early/forced marriages, female genital mutilation/cutting, gender-biased sex-selection and widowhood rites (adapted from UN Women Virtual Knowledge Centre).

HEALTH SYSTEM

A health system is the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction to provide services that are responsive and financially fair, while treating people decently. A good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well maintained facilities and logistics to deliver quality medicines and technologies. Who identified the following building blocks for health system strengthening: service delivery; health workforce; information; medical products, vaccines and technologies financing and leadership and governance (stewardship) (WHO 2005b, WHO health topics)

“HONOUR” KILLINGS

A practice in which women and girls suspected of defiling their family’s honour by their misconduct can be killed by their brother, father, uncle or another relative who thus restores the said honour. Honour killings are executed for instances of rape, infidelity, flirting or any other instance perceived as disgracing the family’s honour, and the woman is then killed by a male relative to restore the family’s name in the community. The allegation of misconduct alone is considered enough to defile a man’s or family’s honour, and is therefore enough to justify the killing of the woman. The men who commit the murder typically go unpunished or receive reduced sentences (UN Women Virtual Knowledge Centre).

INTERVENTION

Any action undertaken with the aim to eliminate GBV. Interventions can be preventive or reactive and can have different formats, such as laws, policies, large-scale programmes, or single projects. In the context of health system responses to GBV, interventions are understood as any actions set by health care professionals vis-à-vis a survivor of GBV, aimed at identifying GBV, providing first-line support and other medical care as well as referring the survivor to other services.

INTIMATE PARTNER VIOLENCE

Behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. It covers violence by both current and former spouses and other intimate partners (WHO 2013).

MANDATORY REPORTING

Refers to legislation passed by some countries or states that requires individuals or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence (WHO 2013).

MEANS OF VERIFICATION

Sources of qualitative or quantitative information, which can measure whether the indicators and results have been achieved (ICMPD 2010).

MONITORING

The continuous, regular, systematic and purposeful observation, gathering of information, and recording of activities, projects, programs, strategies and/or policies. To monitor is to check on how planned activities are progressing, to identify operational difficulties and to recommend actions. Monitoring is aimed at improving the efficiency and effectiveness of an initiative and at ensuring that activities are transformed into results/outputs. It involves giving feedback about the progress to donors, implementers and beneficiaries of the project. Monitoring is always undertaken during the implementation of activities, projects, programs, strategies and/or policies (ICMPD 2010).

OBJECTIVE

The intended physical, financial, institutional, social, environmental, or other results to which an intervention is expected to contribute (OECD-DAC 2009).

OUTCOMES

The likely or achieved short-term and medium-term effects of an intervention's outputs (OECD-DAC 2009).

OUTPUTS

The products, capital goods and services which result from an intervention; may also include changes resulting from the intervention which are relevant to the achievement of outcomes (OECD-DAC 2009).

PERPETRATOR

A person, group, or institution that directly inflicts, supports and/or condones violence against a person or a group of persons.

PHYSICAL VIOLENCE

The use of physical force that results in bodily injury, pain, or impairment. The severity of injury ranges from minimal tissue damage, broken bones to permanent injury and death. Acts of physical violence include: slapping, shoving, pushing, punching, beating, scratching, choking, biting, grabbing, shaking, spitting, burning, twisting of a body part, forcing the ingestion of an unwanted substance; restraining a woman to prevent her from seeking medical treatment or other help; and using household objects to hit or stab a woman, using weapons like knives or guns (adapted from Warshaw/Ganley 1996).

POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder (PTSD) may develop after a person is exposed to one or more traumatic events, such as sexual assault, serious injury, or the threat of death. The diagnosis may be given when a group of symptoms, such as disturbing recurring flashbacks, avoidance or numbing of memories of the event, and hyper arousal continue for more than a month after the traumatic event (APA 2013).

PSYCHOLOGICAL VIOLENCE

An action or set of actions that directly impair the woman's psychological integrity. Acts of psychological violence include: threats of violence and harm against the woman or somebody close to her, through words or actions (e.g. through stalking or displaying weapons); harassment and mobbing at the work place; humiliating and insulting comments; isolation and restrictions on communication (e.g. through locking her up in the house, forcing her to quit her job or prohibiting her from seeing a doctor); and use of children by a violent intimate partner to control or hurt the woman (e.g. through attacking a child, forcing children to watch attacks against their mother, threatening to take children away, or kidnapping the child). These acts constitute both, violence against children as well as violence against women (adapted from Warshaw/Ganley 1996).

PREVALENCE

The number of persons having a specific characteristic or problem, divided by the number of persons in the study population who are considered to be at risk of having the problem, usually expressed as a percentage (WHO/PATH 2005).

PREVALENCE STUDY

In the context of GBV, prevalence studies seek to measure the scope of GBV. Usually, prevalence research is undertaken through population-based surveys. These surveys use randomly selected samples; therefore, their results are representative of the larger population (UN Secretary-General 2006).

RAPE

The physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object, although the legal definition of rape may vary and, in some cases, may also include oral penetration (WHO 2002, cited in WHO 2013).

REFERRAL

The process of how a woman gets in touch with an individual professional or institution about her case and how professionals and institutions communicate and work together to provide her with comprehensive support. Partners in a referral network usually include different government departments, women's organizations, community organizations, medical institutions and others (UNFPA 2010).

REFERRAL SYSTEM

A comprehensive institutional framework that connects various entities with well-defined and delineated (albeit in some cases overlapping) mandates, responsibilities and powers into a network of cooperation, with the overall aim of ensuring the protection and assistance of survivors, to aid in their full recovery and empowerment, the prevention of GBV and the prosecution of perpetrators (the so-called 3 p's). Referral mechanisms work on the basis of efficient lines of communication and establish clearly outlined referral pathways and procedures, with clear and simple sequential steps (UNFPA 2010).

RESULTS

Umbrella term for the output, outcome (medium-term change), or impact (long-term change) -intended or unintended, positive and/or negative - of an intervention.

RESULTS-BASED MANAGEMENT

A management strategy focusing on performance (inputs, activities) and achievement of outputs, outcomes, and impacts. Results-based management identifies strategic elements, such as results, outcomes, impact and outputs and their causal relationship, following a number of assumptions and risks identified. It involves the formulation of relevant indicators to measure success and performance (OECD-DAC 2009).

RESULTS CHAIN

The causal sequence for a development intervention that stipulates the necessary sequence to achieve desired objectives beginning with inputs, moving through activities and outputs, and culminating in outcomes, impacts, and feedback (OECD-DAC 2009).

ROUTINE ENQUIRY (OR UNIVERSAL SCREENING)

Sometimes used to refer to investigating intimate partner violence without resorting to the public health criteria of a complete screening programme; it can also be used to denote a low threshold for women being routinely asked about abuse in a health-care setting, but not necessarily all women (WHO 1968, Taket et al 2003, all cited in WHO 2013).

SEXUAL ASSAULT

A subcategory of sexual violence, sexual assault usually includes the use of physical or other force to obtain or attempt sexual penetration. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object, although the legal definition of rape may vary and, in some cases, may also include oral penetration (WHO 2002, cited in WHO 2013).

SEXUAL HARASSMENT

“Any form of unwanted verbal, non-verbal or physical conduct of a sexual nature, with the purpose or effect of violating the dignity of a person, in particular when creating an intimidating, hostile, degrading, humiliating or offensive environment” (Article 2 Directive 2006/54/EC). At the work place, sexual harassment often takes two forms: when the harasser makes a job benefit - such as a pay rise, a promotion, or even continued employment - conditional on the person acceding to demands to engage in some form of sexual behaviour; or when the harasser’s conduct creates a hostile and intimidating working environment for the person concerned (adapted from ILO undated).

SEXUAL VIOLENCE

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person’s sexuality, using coercion, by any person, regardless of their relationship to the victim, in any setting, including, but not limited to, home and work (WHO 2002, cited in WHO 2013).

SUICIDES FOLLOWING EXPERIENCES OF DOMESTIC VIOLENCE

Suicides committed by women to escape violence and oppression, sometimes prompted by pressure from family members for in adherence to “proper” or “honourable” conduct. In some cases, recorded suicide cases may also be disguised murders (UN Special Rapporteur VAW 2007).

SURVIVOR/VICTIM

Refers to a woman or girl who has experienced any form of GBV. International law defines “victim” as “any natural person who is subject to [violence against women or domestic violence]” (Article 1 Istanbul Convention). Both terms are often used synonymously. In order to underline that women and girls who experienced violence are not “passive” victims but are actively trying to stop violence and seeking protection and support (WAVE 2008), the present publication uses the term “survivor”, with the exception of references to terminology used in international human rights standards or context-specific terminology (for instance when referring to homicide).

TRAFFICKING IN WOMEN²⁴

The recruitment, transportation, transfer, harbouring or receipt of a woman, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over a woman, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered “trafficking in persons” even if this does not involve any of the coercive means listed above (adapted from UN 2000).

TRIANGULATION

The use of three or more theories, sources or types of information, or types of analysis to verify and substantiate an assessment. By combining multiple data sources, methods, analyses or theories, evaluators seek to overcome the bias that comes from single informants, single methods, single observer or single theory studies (OECD-DAC 2009).

UNIVERSAL SCREENING (SEE ROUTINE ENQUIRY)

VIOLENCE AGAINST WOMEN

“Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Article 1 DEVAW). Violence against women encompasses, among others: (a) Physical, sexual and psychological violence occurring in the family; including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; (b) Physical, sexual and psychological violence occurring within the general community; including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs” (Article 2 DEVAW). This manual uses the terms “gender-based violence” and “violence against women” interchangeably. t

²⁴ the UN publication uses the term trafficking in person but due to the specificity of our publication the term trafficking in women is used.

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