A Practical Approach to Gender-Based Violence:

A Programme Guide for Health Care Providers & Managers

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Foreword

In 1998, UNFPA published a Programme Advisory Note, Reproductive Health Effects of Gender-Based Violence, which described the serious long-term effects of gender-based violence (GBV). It also identified a number of strategic entry points where UNFPA could begin work on the problem of GBV. One strong recommendation was that reproductive health (RH) services integrate the treatment of GBV into their services. As mentioned in the State of the World Population, Lives Together, Worlds Apart in a Time of Change 2000. GBV is a serious impediment to women's reproductive health, and a violation of basic human rights.

We know that a sizeable proportion of women, worldwide, have experienced GBV. However, many women will not mention violence unless asked directly. Yet, few health care providers have been trained to address these difficult issues with their clients and few clinics have activities that specifically address the needs of victims of GBV. Women suffer in silence for lack of someone they can trust with whom they could discuss the violence in their lives – someone who could listen sensitively and give a helpful response.

To help break this silence we are embarking on an innovative strategy to assist victims of violence by integrating the assessment and treatment of GBV into RH services. RH facilities are an ideal place for such activities, since these are facilities where many women already go, and where they talk about their lives.

A Practical Approach to Gender-based Violence: A Programme Guide for Health Care Providers and Managers, offers step-by-step guidance on how RH facilities can begin their own GBV projects. Three project options are presented in this Programme Guide.

- Project A involves displaying material about GBV (including information about where women can get help) in the public and private rooms of the facility.

- Project B includes displaying GBV material and also asking all clients about GBV. If clients say that they have experienced GBV, they are then referred to an outside group that provides the necessary care and support.

- Project C includes all of the activities of Projects A & B, and also offers on-site treatment for survivors of GBV.

These project models allow a facility to choose the one that will best fit their physical plant, financial and referral resources and capability. The Programme Guide also helps prepare the facility by guiding the clinic through the different practical steps needed to integrate their particular GBV project choice into their existing activities. The Projects are modular, and a facility may begin with Project A and later expand it into B or C.

UNFPA is very pleased and proud to be inaugurating this practical approach to recognising and helping women who are victims of gender-based violence. We know that women's lives can start to change when they are given permission to speak about the violence in their lives and are offered sensitive care and assistance. This can then allow them to take the first steps to begin to heal from the effects of the abuse.

Mari Simonen, Director Technical Support Division

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Executive Summary

Until recently gender-based violence (GBV) was viewed as a private or family matter. However, there has been a shift in thinking in the last few years about this topic and it is now viewed as both a public health problem and a human rights violation. Numerous studies have been published that document the prevalence of GBV and its serious effects on women. From these studies we know that one out of every three women have experienced GBV (Heise, Ellsberg & Gottemoeller, 1999). Women's groups have spoken out about GBV and have advocated for viewing GBV as a societal problem rather than a private matter. Legislators have been lobbied to enact and implement laws that criminalise GBV. Global conferences have passed resolutions condemning GBV. The United Nations has defined it and recognised it as a problem that effects individuals, families, communities and nations.

Yet, with all this progress what has been missing is a lack of co-ordinated services for the victims of GBV. Although women who go to health care facilities often have symptoms related to GBV, they are generally not asked about GBV in their lives. Thus, in reproductive health settings victims of GBV are often the women who are labelled (and further stigmatised) as "difficult" clients. These victims are considered "failures" because they often do not use the family planning methods prescribed to them, do not follow behavioural or health recommendations, fail to return for follow-up visits and fail to get treatment for their STDs. Their symptoms may worsen and/or they may continue to suffer from the same symptoms for years. But the real problem is that these women don't get the help that they need for what often underlies their behaviour and symptoms is undiagnosed GBV. Thus GBV, if undetected and untreated, can reduce the effectiveness of women's health care programmes.

We know that even though health care providers often do not address GBV, many of their clients are GBV victims. Health care providers see clients suffering from the effects of the GBV on a daily basis with problems such as undiagnosable, escalating pain, repetitive episodes of STDs, and unintended pregnancies. Faced with such problems, staff may feel powerless, even feel like failures themselves because they do not know what to do. Staff may even realise that

the effects of the GBV are undermining the services they provide. However, because they are not trained to recognise and address GBV and because there is no institutional base to support them in this area, health care providers feel helpless to intervene.

What now needs to be done is to begin to address the effects of GBV on the victims. In developing countries, a visit to a reproductive health facility may be the only health care visit that a woman makes. This visit thus becomes a timely and unique opportunity to assess clients for GBV. Staff, especially those in women's health settings such as reproductive and sexual health, maternal child health and prenatal settings have a critical role to play when dealing with victims of GBV. However, in order for victims of GBV to talk about the violence in their lives they first need to trust their health care providers to understand and respond properly to this disclosure. Sensitising staff about GBV is key to increasing victims' level of trust.

This programme guide addresses these important gaps in services to women. The programme guide applies what we know about GBV and its effects and offers a step-by-step guide for designing and implementing a GBV Project in any part of the world. This Project does not have to be one that offers victims of GBV everything in the way of services. It can be a modest programme which, for example, both assists victims by educating them about GBV and gives them a list of places to get help.

The three GBV project options that are presented in this programme guide then allow a health facility to choose the one that will be the best fit, given their infrastructure, financial and referral resources and capability. The programme guide also helps prepare the health facility to begin their Project by guiding them through the different practical steps needed to integrate their particular GBV Project choice into their health programme.

Project A involves displaying material about GBV (including referral information) in the public and private rooms of the facility. Project B includes displaying GBV material and asking all clients about GBV. If clients disclose GBV, they are then referred to an outside facility that provides the necessary care and support. Project C includes all of the first two but also offers on-site treatment for victims of GBV. The Projects are modular, and a facility may begin with Project A and later expand it into Project B or C.

Figure 1. Steps for Implementing a GBV Project

- Assessments for choosing the most appropriate GBV project for their facility
- Development of planning and monitoring tools, GBV material and forms
- Setting up of referral mechanisms, protocols and policies
- Re-routing of clients, continuity of care and follow-up mechanisms
- Education of staff through sensitisation, training and supervision
- Expansion of staffing and services
- Education of the community

Whichever project a facility chooses, it will be providing crucial care and services. Although the project may not have an impact on the overall level of GBV in the country, it will serve as a place where victims of GBV can get the care they need in an environment that supports and validates them.

Chapter

2

A Practical Approach to Gender-Based Violence:

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Introduction

Although there are many stereotypes about victims of gender-based violence (GBV), in reality it can happen to any woman. Victims of GBV can be wealthy or poor, educated or illiterate, and married, widowed or single. The World Health Organization (WHO) estimates that at least one in five women have experienced violence in their lives (WHO, 1997). Other studies estimate the statistic to be one in three women (Heise et al., 1999). GBV can have long-term psychological and physical consequences and effect many aspects of women's lives.

- **Women who have been sexually abused as children are at greater risk of having unprotected sex as adolescents and adults and therefore at risk for contracting HIV/AIDS (Zierler, Feingold, Laufer, Velentgas, Kantrowitz-Gordon & Mayer, 1991).**

- **Women who are physically abused have more unplanned pregnancies than other women (Eby, Campbell, Sullivan & Davidson, 1995).**

- **Many rape victims suffer severe injuries and/or unconsciousness including mental illness and death following the rape (Shamin, 1985). Rape victims are nine times more likely than non-victims to have attempted suicide (Kilkpatrick & Best, 1990).**

The staff at health care facilities often know that they are treating victims of GBV and they would like to help these women. The question that they often ask is, "What can we do?" This programme guide responds to this question by saying that there is much that can be done and that health care facilities are in an ideal position to act. The programme guide offers a map to follow and this map has three routes. Each facility can choose one of the three GBV Project options and depending upon their choice, they will reach a slightly different destination. However, all facilities will be able to offer some level of services that will help victims begin to heal from the trauma of GBV.

A number of conferences and conventions have addressed physical, mental and sexual violence against women as one of the emerging issues. The Convention on the Elimination of All Forms of Discrimination (CEDAW) sets the agenda for a proactive approach to women's empowerment and contains specific recommendations to address violence against women (General Recommendation No. 19, A/47/38, 1992). In addition, General Recommendation No. 24, (A/54/38, May 1999) requires States to prevent

and impose sanctions for violations of human rights, with particular attention to gender-based violence, including sexual abuse. The Programme of Action (PoA) adopted at the International Conference on Population and Development in 1994 noted that "human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives." (Para 7.34). The PoA went on to say: "Violence against women, particularly domestic violence and rape, is widespread, and rising numbers of women are at risk from AIDS and other sexually transmitted diseases as a result of high-risk sexual behaviour on the part of their partners." (Para 7.35) The Special Session of the UN General Assembly on the Beijing+5 Review (2000) recognised gender-based violence as a crime and recommended specific actions to be taken inter alia within the judicial and health systems in paragraphs 103a-103i.

In addition, a variety of reports have been published documenting and discussing GBV including the Programme Advisory Note on GBV, Reproductive Health Effects of GBV: Policy and Programme Implications published by UNFPA in 1998. In 2000, the UNFPA published the State of the World Population. Lives Together, Worlds Apart: Men and Women in a Time of Change recognising GBV as both a public health concern and violation of human rights plus an impediment to women's reproductive health. Although there are not yet studies from as wide a group of countries as we would like, the data we do have has expanded our awareness of this problem and documented the magnitude of the problem and the extent to which victims can be affected by GBV. Yet, there has been a gap in applying this information and using it to create programmes that address victims of GBV. Specifically, what has been missing is the guidance that can help people apply this knowledge in a practical manner to help victims of GBV. This programme guide hopes to fill this gap, complementing what we already know about GBV, with the goal of assisting health care facilities in starting their own GBV services. The objectives of this guide are to provide guidance, support and information on what facilities can offer victims of GBV in terms of mainstreaming GBV services into their programmes.

Although there are many types of gender-based violence, this programme guide's focus will be on the three most common forms of GBV: adolescent and adult victims of childhood sexual abuse, domestic violence and rape or sexual assault.

This programme guide is addressed to district health administrators, managerial teams, health clinic teams and community advocates. These people can make a difference in whether and how GBV is addressed in women's health care settings. Staff, especially whether in reproductive health, maternal child health, prenatal and antenatal settings have a critical role to play when dealing with victims GBV. Studies show that victims of GBV need to trust their health care providers for them to be able to tell them about the violence in their lives. Sensitising the staff on this topic will help this begin to happen.

Health care providers are the people with whom women already talk to about many intimate matters (Heise, Moore, & Toubia, 1995). Added to this special relationship, in developing countries, a visit to a reproductive health facility may often be the only health care visit for a woman. This visit is a unique opportunity to assess clients for GBV.

Health care facilities must directly acknowledge that many women who attend family planning, prenatal care or maternal and child health clinics are victims of GBV and that this is an important topic to bring up with all female clients. Because GBV can happen to any woman, assessing every client for GBV is critical. Although some individual staff may have had training in the identification of GBV, they usually have no context to do this, as they have not had the support of a GBV project that was a part of the facilities' services. Some providers at facilities are supposed to ask about violence but often they do not. When asked about this omission, they state they are uncomfortable bringing up this topic, fearful that asking about GBV will antagonise clients or feeling they do not know how to respond if the woman answers "yes."

Some administrators, when asked about this, say they fear that if this topic were opened up, the needs and problems of the victims would overwhelm the staff. Consequently, they would not be able to complete the work they are already required to do. Nevertheless, there are ways to integrate this topic into already existing programmes without overwhelming the facility or the staff. Actually, integrating the assessment of GBV can enhance other programmes in the facility. Experience has shown that in the context of an organised project, including training and support, asking about GBV can be beneficial to the facility, staff and clients.

For clients who are victims of GBV, such a project can help end the isolation they have experienced as holders of this secret, lessen or ameliorate their guilt and self-blame, and increase their knowledge by educating them about the connections between their symptoms and GBV. All of these interventions assist victims in feeling more in control of their lives, thus empowering them.

For staff, being trained in the assessment and treatment of GBV can add to their repertoire of skills. It not only offers them information about GBV but it also teaches them techniques to use in discussing other sensitive topics with clients and helps to develop interpersonal skills that can enhance provider-client relationships. Such training can thus make a huge difference, empowering not only the client but the staff as well.

Some administrators think GBV is such a complex problem that it would require an enormous amount of resources to tackle GBV at their facility. That is not true. A project does not have to offer victims of GBV everything in the way of services. It can be a modest project, which for example, assists victims by educating them about GBV plus offers them a list of places to get help.

This programme guide is designed to assist you in choosing one of the three GBV Project options described herein.

Your group can choose the one that will be the best fit, given your particular facility and capability. This programme guide helps you conceptualise and actualise your Project. It also helps to prepare your staff for integrating your GBV Project option into your existing programme by guiding them through the different practical steps.

Before getting to those concrete steps, the programme guide first helps readers understand the connections between reproductive and sexual health and GBV, the myths and barriers to effectively tackling the topic and ways of overcoming them. Key to any programme that helps victims of GBV is the need for staff to look at their own responses, beliefs and biases about GBV. The section on myths and barriers covers some of these. Additional ones can be discussed at staff sensitisation and training sessions.

This is a programme guide about providing services. Part of knowing if you are meeting the objectives of these services is to develop a monitoring and evaluation plan. The research questions that you will answer while developing your project will inform you further about the problem of GBV in the population you serve. While some problems outlined in this programme guide can be addressed internally at the facility level, others may require outside assistance. For instance, if the staff is to be trained to assess, intervene, and refer GBV victims, then the facility would need to find a person who is knowledgeable about GBV and can offer the clinical staff the appropriate training and/or work as a consultant.

This programme guide includes sample forms that can be adapted to your particular facility, project choice, culture and language. Chapter 9 provides sample outlines on sensitisation and training topics that must be covered for staff to achieve a level of competence.

Forms in this programme guide can be used to:

- Assess the facility prior to commencing your GBV Project
- Develop a monitoring and evaluation plan
- Identify referral resources
- Screen clients about GBV
- Document GBV in the client's chart
- Gain an in-depth assessment of the effects of the GBV
- Summarise data that has been collected on GBV

This programme guide is written primarily for clinics providing reproductive and sexual health and maternal child health facilities but it can be adapted to other types of facilities that treat women, such as public and private agencies who are often the first to act. It is important to remember that women need to get help with the effects of GBV at whatever facility they attend.

Chapter 9 discusses the importance of involving men in any discussion of GBV and of providing treatment for men who abuse women. This programme guide, though, will focus on adolescent and adult women and what they need in order to begin to heal from the violence.

GBV is unfortunately a part of many women's lives. Victims of GBV have been waiting a long time to have the opportunity to name what has happened to them and get the help they need in a supportive environment, with caring people who will listen, support and assist them. Creating your GBV Project offers victims such a place.

Chapter

3

A Practical Approach to Gender-Based Violence:

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Definitions

As stated in the Introduction, this programme guide's focus will be on the three most common forms of GBV: adolescent and adult victims of childhood sexual abuse, domestic violence and rape or sexual assault. The definitions of each of these types of violence as well as an overarching definition of GBV taken from the United Nations Assembly are given below.

Gender-based violence includes the word **gender** because most victims of interpersonal violence are women. Violence is directed against women because they are female and have unequal power in relationships with men and low status in general in the world. This lack of power and status make women vulnerable to acts of violence.

Gender-Based Violence

"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 private life." (United Nations Declaration on Violence Against Women, b.)

The overall **goal** of the perpetrator of GBV is to control and dominate. GBV usually involves a pattern of abuse. This is particularly true when the perpetrator knows the victim, which has been documented to be true in the majority of the cases of GBV (Russell, 1986). Victims of GBV state that the closer their relationship with the perpetrator, the more traumatic they have experienced the abuse to be (Zierler et al., 1991). The **pattern** of abuse can be episodic, recurrent or chronic.

Perpetrators use a number of **tactics** as part of the abuse and thus may abuse the victim not only sexually but also physically, psychologically and emotionally/verbally. This can have serious consequences for the victim, causing her physical injury, psychological pain and an on-going high level of fear.

3.1 Childhood Sexual Abuse

WHO defines **childhood sexual abuse** as "an abuse of power that encompasses many forms of sexual activity between a child or adolescent (most often a girl) and an older person, most often a man or older boy known

to the girl. This activity may be physically forced, or accomplished through coercive tactics such as offers of money for school fees or threats of exposure. At times, it may take the form of a breach of trust in which an individual, who has the confidence of the child, uses that trust to secure sexual favours.

“Incest, sexual abuse occurring within the family, although most often perpetrated by a father, stepfather, grandfather, uncle or brother or other male in a position of family trust, may also come from a female relative...Incest takes on the added psychological dimension of betrayal by a family member who is supposed to care for and protect the child.” (WHO, 1997).

Sexual abuse can involve fondling, masturbation, oral, vaginal or anal contact. It is not necessary for sexual intercourse to occur for it to be considered sexual abuse. Sexual abuse is also the use of the child for prostitution, pornography and exhibitionism.

"A general unwillingness to acknowledge the extent of child sexual abuse exists in many societies. Attempts to downplay the prevalence and nature of child abuse often blame the victim or the victim's mother for the violence. Accusations against the child include the idea that the child invites the abuse or that she imagines it. The mother may be blamed for "causing" the abuse by refusing to have sex with the abuser, or for "colluding" by not realising or reporting what was going on." (WHO, 1997).

3.2 Domestic Violence

Domestic violence is the physical, verbal, emotional, psychological and/or sexual battering of a woman by her partner or spouse. This type of GBV can involve the use of threatening or intimidating words and acts, hitting, use of a weapon, rape, imprisonment, financial control, cruelty towards her or other people and things she cares about and abusive and/or demeaning language.

Figure 2. Categories of Domestic Violence

Physical Abuse is a pattern of physical assaults and threats used to control another person. It includes punching, hitting, choking, biting, and throwing objects at a person, kicking and pushing and using a weapon such as a gun or a knife. Physical abuse usually escalates over time and may end in the woman's death.

Sexual Abuse is the mistreatment or the control of a partner sexually. This can include demands for sex using coercion or the performance of certain sexual acts, forcing her to have sex with other people, treating her in a sexually derogatory manner and/or insisting on unsafe sex.

Emotional and Verbal Abuse is the mistreatment and undermining of a partner's self-worth. It can include criticism, threats, insults, belittling comments and manipulation on the part of the batterer.

Psychological Abuse is the use of various tactics to isolate and undermine a partner's self-esteem causing her to be more dependent on and frightened of the batterer. It can include such acts as:

- Refusing to allow the woman to work outside the home
- Withholding money or access to money
- Isolating her from her family and friends
- Threatening to harm people and things she loves
- Constantly checking up on her

Physical abuse need only happen once. Having experienced a beating, the victim is fearful of a reoccurrence. The batterer may only need to verbally threaten her now or look at her in an intimidating manner to get her to obey.

3.3 Rape or Sexual Assault

Rape is the use of physical force, or threat of force or emotional coercion, to penetrate an adult woman's vaginal, oral or anal orifices without her consent. In the majority of cases, the perpetrator is someone the woman knows. Rape can be a one-time occurrence or it can be ongoing. It may also involve the use of alcohol and drugs therefore making the victim more vulnerable.

Sexual Assault is non-consensual sexual contact that does not include penetration.

3.4 Other commonly used terms

Victim and survivor are words used interchangeably throughout the programme guide to describe a woman who is now or has in the past experienced GBV.

Perpetrator and batterer are words used throughout the programme guide to describe a person who abuses a woman. Men make up the majority of the people who abuse women and most of these men know their victims.

Staff and provider are words used interchangeably in this programme guide to denote people who work in a health care facility.

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Gender-Based Violence and Reproductive and Sexual Health

Until recently there has been silence surrounding GBV and so victims of violence have not been able to put their pain into words. But the body “speaks” even if the survivor cannot, and her body can tell her story even if her voice still can’t.

Victims have, through their behaviour, indirect ways of telling health care providers about their GBV experiences. Past or present day GBV can have an enormous effect on behaviour and interpersonal relationships. For example, women who were sexually abused as children often feel guilty and shameful about the abuse and blame themselves. These negative feelings about themselves can cause women to take more sexual risks, which make them more vulnerable to unplanned pregnancy, STDs (including HIV/AIDS) and infertility (Wyatt, Gutherie, & Notgrass, 1992). Studies have shown that these women are also more vulnerable to re-victimisation as adolescents and as adults, compounding the level of trauma and health effects (Wyatt et al., 1992).

Rape victims’ bodies may "speak" through their increased visits to health care providers. For rape victims, in the year following the rape there is more than a 50% increase in the number of visits to health providers (Koss, 1993). Yet, most of these women do not disclose the sexual trauma to their providers, nor do providers ask them about this.

We know that even though health care providers may not be addressing GBV with their clients, they are in reality treating GBV victims all the time. Victims often present with problems such as undiagnosable, escalating pain, repetitive episodes of STDs or unintended pregnancies. Faced with such problems, providers may feel powerless, sometimes even like failures, because on a daily basis they see clients suffering from the effects of GBV, but they themselves do not know what to do. Furthermore, they may realise that the effects of GBV are actually undermining the services they provide clients, but because they have not been trained to recognise or address GBV, they feel helpless to intervene.

GBV has many reproductive and sexual health effects. It is important to be able to recognise these. Figure 3 highlights the reproductive, behavioural and social health effects that adolescent and adult victims of

childhood sexual abuse, rape and domestic violence may experience.

In medical settings, victims are often the women who are considered "difficult" clients. They are often labelled "failures" because they fail to: use family planning methods prescribed to them, follow behavioural or health recommendations, return for follow-up visits and get treatment for any sexually-transmitted diseases.

They may get worse or continue to complain of symptoms such as undiagnosable, escalating pain, headaches, pelvic and back pain and gastrointestinal problems.

What often underlies this type of behaviour and these physical symptoms is undiagnosed GBV. The real problem is that these women do not get the help that they need. Thus GBV, if undetected and untreated, can reduce the effectiveness of reproductive and sexual health programmes.

Figure 3. Health Effects of Gender-Based Violence

Types of Violence	Reproductive, Behavioural and Social Health Effects
Childhood Sexual Abuse (For adolescent and adult victims)	Gynaecological problems, STDs, HIV/AIDS, early sexual experiences, early pregnancy, infertility, unprotected sex, unwanted pregnancy, abortion, re-victimisation, high-risk behaviours, substance abuse, suicide, death.
Rape	Unwanted pregnancy, abortion, pelvic inflammatory disease, infertility, STDs including HIV/AIDS, suicide, death.
Domestic Violence	Poor nutrition, exacerbation of chronic illness, substance abuse, brain trauma, organ damage, partial or permanent disability, chronic pain, unprotected sex, pelvic inflammatory disease, gynaecological problems, low-birth weight, miscarriage, adverse pregnancy outcomes, maternal death, suicide, death.

Chapter

5

A Practical Approach to Gender-Based Violence:

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The Importance of Asking Clients about GBV

Addressing GBV is the first critical step in getting victims of GBV the help that they need in order to begin to heal. Since we know that all women are vulnerable to GBV, asking all women who visit the health care facility about GBV is crucial.

Most victims will not spontaneously disclose that they are victims of GBV. Often they have not told anyone about these experiences. Studies show that most victims are never asked about GBV by their providers (Mazza, Dennerstein, & Ryan, 1996). Yet, in studies that have asked women whether they would, for example, disclose sexual assault to their provider if they were asked about it, 70% said "yes" but only six per cent of the women in this study said they had been asked. Ninety per cent of the women said they felt their physicians could help them with problems they were experiencing because of the sexual assault (Friedman, Samet, Roberts, Hudlin, & Hans, 1992). Victims report that although this disclosure would initially be difficult they would be willing to talk about this, in private, with a health care provider who asked them questions about GBV in a caring, non-judgmental manner. The reality is that many of these women have been waiting a long time to be asked about the violence in their lives.

GBV is a public health issue. Addressing GBV in a health care facility is one important means of intervening in this public health problem. In this context, the focus for the assessment, intervention and treatment of GBV is on secondary and tertiary prevention. This can involve screening for early intervention (secondary prevention) and intervening to minimise the severity of long-term abuse (tertiary prevention). Health care providers at women's health programmes see women who are both at present in violent relationships and women who have in the past been abused. Yet, it is clear that even though some clients may no longer be involved in violent relationships they may be still experiencing the long-terms effects. There are also women who as children or adolescents were sexually abused and although this occurred many years ago, they may still be experiencing the effects of the earlier trauma. In addition, women who have been raped do not on their own disclose this for many years (if ever) yet may be suffering from many

physical and psychological problems as a result of the rape.

Talking about such topics as family planning, pregnancy, reproductive health problems, sexuality concerns and physical symptoms a woman is experiencing can easily move into a discussion of GBV. Actually, asking about GBV can have many benefits. Victims often feel alone and isolated in their experiences of abuse. Just asking the client about GBV can be the first step in her beginning to release the secrets and shame that she has carried with her. Asking the client about GBV is an important intervention. Breaking the silence about this topic can offer her hope.

Health care providers can open a door for the client just by asking questions about violence in women's lives. Some women when they answer "yes" will immediately be able to walk through that door. Other women will answer "no" to the questions about GBV although they are actually victims of GBV. They need more time and trust in the provider and in the project before they can honestly answer the questions. But that door has been opened nonetheless, and they may be more ready to discuss it if questioned again at a later time. By giving clients who say "no" the message that the provider wants to know, the door stays open.

Health care providers are often concerned about what to do if a woman were to answer "yes" to their questions about GBV. Their actual role is crucial but limited. The appropriate response for the provider is to give the survivor support, understanding, validation and information. The provider does <u>not</u> have to listen to the whole story. What the provider <u>can do</u>, which is of enormous importance for women who answer "yes", is to be both sensitive and non-judgmental.

Providers must be sensitive and non-judgemental

- When the provider brings up the topic
- If the client says "yes"
- As they tell the client, for example, that no one deserves to be hurt and abused
- When they educate clients about possible physical and psychological consequences that they may be experiencing
- When referrals are discussed with clients

Clients, who have answered "yes" can then be seen on-site for an in-depth assessment if this is part of the Project and can be given an appropriate referral.

There are additional benefits to asking about GBV for both providers and provider-client relations. For example,

- It can deepen the relationship between the client and the provider, making it a more honest and open one.
- The facility can be a place where the client feels understood and where the client gets the help she needs.
- It will allow the client to have more trust in the provider and the facility as a whole.

- It can teach providers new skills by increasing their ability to raise difficult topics with clients and talk about them in a sensitive way.

- Lastly, it can increase the provider's sense of truly being able to respond to their clients.

Chapter

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Barriers to Talking about GBV

Many factors have contributed to the silence that has long surrounded GBV. Many people believe GBV is a "private" matter, one that should not be discussed publicly. It has certainly been seen as improper for outsiders to intervene in or even question violence perpetrated against women. GBV has even been rationalised as something that is acceptable, under certain conditions, for men to do to women (Friedman et al., 1992).

Victims of GBV themselves have been silenced, not only by the perpetrators of the violence but also by society. They are told by society that, for instance, the violence is their fault, that they must have done something to deserve it, that no one will believe them if they do tell or else they are frightened into silence by threats of more harm.

6.1 Effects on the Survivor

Figure 4 shows how the perpetrator's abuse can effect victims' beliefs about themselves and others, thereby making it difficult for them to initiate a discussion about the GBV in their lives.

Figure 4. The Survivor's Experience

What a perpetrator communicates to the survivor	The survivor's interpretation of this	The effects on the survivor
I hit you because I love you	This is what love is	Confusion, re-victimisation
The abuse is your fault	I'm bad and to blame	Self-blame, confusion, helplessness
No one will love you like I do	Without this person I'm alone forever	Dependent, fearful of leaving
This is for your own good	Other people know what's good for me	Doubts judgement
You don't own your body, I do	I have no control over what people do to me	Poor boundaries, re-victimisation
No one will believe you if you tell	I'm all alone and no one cares	Silence

Despite all these pressures not to tell, victims do want to break the silence about the violence in their lives. A few women might be able to speak out on their own but most need to be asked about it. But, unfortunately, providers, even when aware that GBV is occurring, rarely ask their clients about it. The common scenario is an impasse where two people remain silent about GBV, one person afraid to tell and the other person afraid to ask.

6.2 Staff Attitudes about GBV

Figure 5 lists some common attitudes that administrators, managers and providers have about GBV. These can inhibit them from addressing this topic and thus stop them from assisting women who are victims of GBV. Sensitisation and training plays an important part in gaining the skills needed to get past these barriers in order to feel a level of comfort about addressing GBV. This chart can later be used as a training tool to assist staff in understanding their responses to this topic.

Breaking down the barriers that stop providers from talking about GBV is crucial. Knowing what these barriers are and overcoming them is key to successfully intervening with GBV victims. Because of their role as healers, providers are one of the few people in the survivor's life who are in the position to identify, assess and treat GBV. Providers, most importantly, have the opportunity to heal with their words and attitude. Studies show that victims of GBV are capable of healing from the trauma, and one of the most important parts of this healing is having another person name and validate their experience in a concerned, knowledgeable manner (Heise et al., 1995). There are many kinds of help that a survivor may need, such as counselling groups, shelter, legal help, etc. But being heard and believed, possibly for the first time, is the crucial beginning of this process. Without this, she may not be able to take those next help-seeking steps.

6.3 Denial

Denial is a common response to GBV. GBV is an upsetting topic and can bring up feelings in providers that can make them feel powerless. One way that people react to experiencing these emotions is to distance themselves by acting as if it were not occurring. Denial on the provider's part can cause a survivor to feel that she is the only person this is happening to or she is making it up.

If staff have not been educated, they often do not know any other way to handle these emotions. But with training they can better understand the dynamics of GBV and their appropriate roles with victims.

Figure 5. Staff Members' Barriers to GBV

Defense	Myths / Barriers	Responses
Denial	This only happens in other places in the world, to other kinds of people.	GBV happens in just about every country, to all kinds of people.
	This type of thing does not happen to our clients.	It happens to women of all races, ethnic groups and classes.
	I don't want to acknowledge this when I see it.	GBV is a difficult topic to approach but with training you will have the skills to do this well.
	This happened to me and I do not want to admit it.	It is painful to admit this has happened but you can help others and may need to get help for yourself.
Rationalisation	It's a private matter.	This is a human rights issue.
	It's not my job.	GBV is a public health problem.
	No time to do this.	Addressing GBV takes a bit more time but may save providers time in the future.
	If I ask it could cause me legal problems.	This is something to look into before beginning the GBV Project.
	Victims don't really want to talk about it.	Women do want to talk about the GBV in their lives.
	Clients will get upset if asked about GBV.	Studies show that clients want to tell their heath care providers about violence in their lives.
	She must have done something to provoke it.	No one deserves to be hit or sexually abused.
	There is nothing I can do anyway.	There is much that you can do and asking about GBV is the first step in helping women begin to heal.
Minimisation	This happened in the past and could not be affecting her now.	The past, especially one that includes GBV, can affect someone's well-being in the present.
	She doesn't have a lot of marks so this couldn't have been too bad.	GBV can cause psychological, health and behavioural damage that may not be visible, yet is very serious.
Identification	This could never happen to me so it could not be happening to a woman like me.	GBV can happen to any woman although it is hard to think about being vulnerable to this.
	I could see why her partner would beat her.	Be aware that men and women can identify with the perpetrator.
Intellectualisation	A woman who is being hit should leave.	This is a complex situation and it may actually be dangerous for her to leave. We cannot make these decisions for clients.
	People get over these things in a short time.	Even when the physical bruises go away, the survivor is not necessarily over the other effects.
	We only deal with medical problems.	GBV is a public health problem. Victims of GBV often present with physical symptoms such as headaches, pelvic pain, gastrointestinal problems, etc. These are symptomatic of the underlying problem, GBV.

Also, research in the United States has shown that approximately 40% of health care providers report having experienced physical and/or sexual abuse at some point in their lives (deLahunta & Tulsky, 1996). If providers who have been victims of GBV have not disclosed this and have not gotten the support and help they need, it may make it more difficult for them to then address this topic with their clients.

6.4 Rationalisation

Rationalisation occurs because staff don't yet know how to intervene with victims. Providers often do not know how to respond to hearing traumatic stories about violence. Although they may be competent in giving the necessary medical treatment to a woman who has obvious bruises on her body, they are uncomfortable looking at and acknowledging the context of her injuries.

Providers can find reasons for not addressing the violence in her life by stating that this is not something they deal with in their roles. This response cannot only leave clients feeling hopeless about ever getting any help, it also serves to normalise the abuse to her. Although providers may have to spend a longer amount of time with a client, asking about and assessing GBV may ultimately save time because this woman may not need to repeatedly make visits to a provider because of symptoms related to the GBV. Taking the time to ask about GBV may in the end also save her life.

6.5 Minimisation

Minimisation serves to take what may feel to the staff like an overwhelming problem and translate it into something that is minor. The seriousness of the GBV is ignored as is the important connection between the victim's past and the present day physical and psychological symptoms. Faced with someone who minimises their pain and problems, victims can feel upset and confused because they may be experiencing a number of GBV related symptoms but no one is helping them by educating them as to these connections.

6.6 Identification

Identification happens when people feel a connection to another person because of something they have in common, such as a shared ethnicity, class background, gender, sibling order or some other characteristic. It can cause people to feel an immediate bond. But in some circumstances the identification can feel uncomfortable. So, for instance, if this bond occurs between a staff member and a client and then the staff member hears from this client a story about a threatening and frightening experience, such as a rape or having being sexually abused as a child, it can have a powerful effect on the staff member. In response to hearing this, the provider may find that s/he then distances her/himself from the victim. This response is an attempt to feel safe when listening to stories about GBV, stories that cause feelings of vulnerability.

Female providers, in particular, may experience this identification (although male providers may experience identification regarding their partners, daughters, mother, etc). It is frightening to realise that all women are vulnerable to violence. When this occurs, providers may attempt to find ways to distance themselves from this feeling by, for example, blaming the survivor and finding reasons why the survivor deserved to experience this trauma. This response on the provider's part can cause the victim to feel very isolated and guilty.

Staff members too may find they are identifying with the perpetrator and need to be aware of this break in their empathy toward with the client. If this break were to occur the client might feel re-traumatised, what is also called a second injury, as she is again experiencing an abusive situation.

6.7 Intellectualisation

Intellectualisation is a defense used when the staff feels uncomfortable because the situation seems out of control to her/him. The provider (trained in the medical model and taught to "fix" or cure others) then takes on the role of the "expert" who diagnoses what is going on and tells this woman what she should do. This behaviour leaves little room for listening to the victim's experience and what she can and cannot do now regarding the violence (and what may in actuality be dangerous for her to do now). If this occurs, the client may actually feel more to blame for the GBV after such an encounter.

Chapter

7

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Choosing a Project Design

Figure 6. Choosing a GBV Project

Project Choices	Components to Each GBV Project
Project A	• Assess the availability of suitable local programmes to which victims of GBV can be referred • Sensitise all staff about GBV • Develop or purchase materials about GBV • Give out GBV material including referral information • Support staff by on-going sensitisation
Project B	In addition to what is listed for Project A: • Train health care providers • Ask all clients who attend the facility about GBV in their lives • Document the answers to these questions • Refer victims of GBV • Support and supervise staff
Project C	In addition to what is listed for Projects A and B: • Hire new staff or train existing staff to administer the in-depth assessment form to victims • Facilitate psychological treatment and other types of care of victims of GBV by offering external referral and/or on-site treatment

Programme Examples

The following are examples of groups that have integrated GBV into their health care programmes. There are not many of them yet, as this is something that is just beginning to happen. We hope that in the final version of the programme guide, after it has been is piloted in a few countries, there will be more examples to add here.

✸ In Caracas, Venezuela, the Associacion de Planificacion Familiar (PLAFAM), an IPPF/Western Hemisphere Region affiliate gives each client who attends their reproductive health clinic written material about GBV when they sign in with the receptionist. Each new client is asked about GBV (childhood sexual abuse, rape and domestic violence) by the health worker and if a client discloses she is a victim of GBV she is offered an in-depth assessment and a referral. In 2000, PLAFAM won the Sasakawa Health Prize from the World Health Organisation for innovations in health care for the work they are doing on GBV.

✸ In India, the Family Violence Prevention Fund is working with a hospital in Bombay, offering them technical assistance so that women who come to the hospital will be asked about experiences of childhood sexual abuse and domestic violence. If a woman answers "yes" to any of these questions she is then sent to a trained staff member, who will then assess the client and refer her. If a client is afraid to return home, she is offered the option of staying at the hospital in a special area created for victims of violence.

✸ In the Philippines, Project Haven (Hospital Assisted Crisis Intervention for Women in Violent Environments) located in a hospital in Quezon City provides a crisis center for victims of violence. There are a number of entry points for women in this project including the department of obstetrics and gynaecology, the emergency section, different outpatient departments and the counselling department. Health care providers in the Philippines including midwives, nurses and doctors have been trained to identify and assess domestic violence. Some of this training is now integrated into the medical and nursing school curricula.

✸ In Brazil, women who attend the Medical School Health Centre Samuel Pessoa-University of Sao Paulo, which offers reproductive health care (and also other primary health care including mental health treatment) are screened for domestic violence if the staff suspects them of being a victim. If a woman discloses that she is in an abusive relationship, she then speaks to a staff person who asks her more questions about the violence and offers her a referral.

✸ In Queensland, Australia, a Domestic Violence Initiative began in 1999. Women at a number of participating sites, which included antenatal care clinics, gynaecology clinics and emergency departments, were screened for domestic violence. Staff was trained to ask women these questions, counsel them if they answered "yes" and offer them a referral. An evaluation of the women served at these health care facilities showed that 97% of the clients supported the routine screening for domestic violence.

Chapter

8

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Role of the Facility and Staff

In order to successfully integrate GBV into your programme, certain changes must be made at the facility level. The project your facility chooses will, of course, help you decide what specific changes need to be implemented facility-wide and what roles the staff need to take on in the GBV project. Quality of care issues, which are so important, will be mentioned throughout this chapter.

8.1 The Facility's Role

8.1.1 To Advocate, Network and Co-ordinate

It is important to network with other groups that are also addressing the topic of GBV. Building coalitions of different groups that are working on the same issue can enhance the possibility of change. This change may need to occur legislatively so that laws can be implemented or changed regarding GBV, to get government support for basic services to assist victims of GBV and/or to create or expand NGOs in the community. Not only can these groups in the coalition be potential referral sources for the GBV Project, but also there is the possibility of cross-referring clients. Working together can also help to avoid duplication of services to victims of GBV. These groups may also have material that can be used as prototypes for the development of the facility's material. In addition, your project and these groups may be able to form a coalition that can work together funnelling and exchanging information on GBV. There may also be local groups that have GBV expertise and they may be able to assist in you facility's GBV sensitisation.

Changing laws and making sure they are enforced also makes it harder:

For a perpetrator to say, "this is normal behaviour," "this is okay for me to do to my partner," or

For victims to say, 'this is what is supposed to happen to women," "no one says this is wrong," or

For the police to say "your partner can do this to you," and " there is nothing we can do."

8.1.2 Sensitising the Staff

Creating an environment that communicates to clients that "GBV is discussed here" is of primary importance. Most clients will not have previously experienced such an environment and victims may first need to test out whether it really is safe to discuss what until now they have

probably never said aloud. It is important for the facility to pass this test. One way to make sure this happens is to involve the whole staff in the GBV Project, sensitising them to this topic and to ways of interacting with victims of GBV. In addition, the staff needs to be sensitised to the local context of this problem and needs to discuss the issue. For example: How is GBV viewed in their community? How do people talk about GBV? What are the words or euphemisms people use when they discuss it? What are the underlying concerns of people about GBV? (See Chapter 9 for a sample staff sensitisation outline.) This will allow staff members to be prepared if they are at some point approached by a victim. If staff feel competent to discuss GBV, this communicates to clients that there really is openness here. A facility that is open to the reality of GBV in women's lives lets victims know that they no longer need to be silent about this.

8.1.3 Privacy and Safety for Clients

In order to ask clients about GBV there must be a private room with a door where these discussions can take place. In addition, to facilitate women feeling safe disclosing GBV, there needs to be a clearly stated clinic policy that ensures privacy when women are being asked about GBV. That means that a woman's partner cannot be allowed in the room while this is going on. Only she and the person asking her about GBV can be in the room. Asking a victim of domestic violence about GBV in front of her partner can put her in danger. The facility needs to create such a policy if there is not one already. If need be, this policy can then be explained to the partner by saying that there is a facility policy that states that each client is seen alone for part of her visit.

In terms of the role of the staff and the ambience of the facility, safety for victims of GBV includes a policy of not medicalizing or psychologizing the GBV or the victim. Doing otherwise could feel blaming and cold rather than understanding and caring.

8.1.4 Confidentiality

There can be serious health and welfare consequences to victims of GBV if their disclosures of GBV were to be made public. There needs to be a policy about confidentiality at the facility that is clear to both staff and clients. Just like with other health problems such as HIV/AIDS, STDs, etc. this is information that needs to remain confidential and thought through in terms of how to avoid breaks of confidentiality. So, if there is no locked cabinet to keep records that include information about GBV, the facility must, before implementing Project B or C, think through how they will be able to ask clients questions about GBV, record their answers and keep this information confidential.

Include in the rationale of why questions about GBV are being asked of all clients (just prior to asking them questions about GBV) a short sentence about confidentiality. The level of confidentiality at the clinic will no doubt effect her answers to the questions about GBV. But to not clarify the level of confidentiality before asking about GBV means possibly betraying this woman's trust, something which, if she

has experienced GBV, has already occurred. Confidentiality also means that clients' responses to the questions about GBV must neither be discussed professionally in public spaces in the clinic because this then might be overheard, nor should any of this confidential information be gossiped about amongst staff.

If for any reason, recording the client's positive answer to the questions about GBV in her chart is not possible, it can effect the facility's ability to keep accurate data summaries of the women who do disclose GBV. As an alternative, it may be possible to just keep anonymous data (which will offer some statistics on how many clients at the facility are disclosing GBV) if staff, when asking clients about GBV, record this on a common piece of paper without putting down any identifying information. This would then limit the continuity of care that would allow health care providers to be able to see from looking in her chart that she was a victim of GBV and therefore follow-up on this by giving her specialised care when she returns to the facility.

If it is possible to have confidentiality then use the documentation stamp, (the sample documentation stamp is located in Appendix 6) putting the stamp on the inside cover of each client's chart for easy access and quick awareness by staff.

8.1.5 Sensitivity to the Person and the Problem

It is also important for staff to be knowledgeable about the laws in their country regarding GBV. This information can be helpful in terms of understanding the problem and in disseminating this information to clients at the clinic.

Basic materials in the relevant language, and at different reading levels need to be available in the waiting room, consulting rooms and bathrooms, both for women to read there and take home with them. A video monitor in the waiting room can show tapes about GBV, focusing on both its effects and solutions. Posters can adorn the walls with photos and written messages communicating to clients that GBV is not acceptable, that women do not deserve this type of treatment, and it is not the woman's fault if this does happen. The posters and reading material can present ways they can get help if they currently are or have in the past been victims of GBV. Creating a small card for battered women that they can put in their shoe and that contains both educational information as to what kinds of behaviours constitute abuse and addresses and phone numbers of places they can call to get assistance is helpful. This will allow them to have important information that can be hidden from the batterer.

For non-literate women the videos, mentioned above, could assist them, or printing or purchasing descriptive comic books and/or hanging up posters with icons that have a clear message about GBV are alternative ways to transmit this information. Also, if possible, holding groups in the waiting room where a staff person could facilitate an educational discussion about GBV in women's lives with clients would be another option for

educating both non-literate and literate women.

8.2 The Staff's Roles

Most health care providers' education and practices are based on a medical model that seeks to diagnose and "fix" clients. But there are other parts to medical treatment. "The 'practice of medicine' can instead be defined as "diagnosing, healing, treating, preventing, prescribing or removing any physical, mental or emotional ailment…of an individual." (Civic Research Institute, 2000.) The staff need to learn a different model that encompasses an understanding of the many psychosocial factors that effect someone's life and health, ones such as culture, gender, family, religion, poverty, drugs and alcohol and education. There are many benefits to this broader model. If providers can use this model and offer victims what they need, i.e., understanding, support, openness and respect, they can truly offer victims the help that they need.

With the facility's support, the staff need to examine and expand their roles. The role of the provider within this project is to identify and assess GBV and to assist the survivor in getting the help that she needs to deal with the effects of the violence. The staffs' specific roles in the GBV Project are:

8.2.1 To Witness

Most women who have experienced GBV have never disclosed this to anyone. Having the encouragement to do so now allows them, probably for the first time, to tell someone about their private pain. She can now put into words what has never before been heard by another human being. The provider does not need to hear the whole story but does need to understand the injustice of what they are hearing and communicate this to the client. Along with this, the provider can help this woman get the assistance she needs.

8.2.2 To Listen and to Validate

Many victims say that the experience of being listened to by the provider is in itself very beneficial. (Family Violence Prevention Fund, 2000). If the survivor responds affirmatively to the questions about GBV, the provider can respond, not with suggestions or prescriptions, but with understanding. The survivor needs the provider to be supportive by showing the client empathy, sensitivity and belief in what the client is telling her/him.

8.2.3 To Educate

When women disclose histories of or present day experiences of GBV, the provider can help educate clients about the connections between their symptoms and the GBV, ways they can take better care of themselves, and very importantly, that they are not alone. Knowledge is power and this may be new and important information for the survivor as she may never have made a connection between her symptoms and the GBV or known of anyone else who has gone though what she has gone through.

8.2.4 To Document

When asking clients about GBV it is important for the provider who sees her

to document the answers in the client's chart. Depending upon the project model that has been chosen, this documentation can include entering information into the chart about what type of GBV she has experienced, when this occurred, filling out the in-depth assessment information, noting what referrals were made and, if there is physical evidence, such as bruises or scars, filling out a body map. (The sample documentation stamp in Appendix 6, the in-depth assessment is located in Appendix 9, and the body map is located in Appendix 10).

If there is a confidentiality policy at the facility and it is possible to document the client's answers to the questions about GBV, put the GBV stamp documentation box on the inside cover of each client's chart thereby making it very visible to any staff member. The other information about the GBV, such as the answers to questions about who the abuser is, forms such as the danger assessment, and the in-depth assessment could all be put at the back of the chart.

8.2.5 To Support

Providers need to be able to respond appropriately when clients disclose GBV. The provider needs to be non-judgmental, caring and sensitive. This means not telling the client what she should do but rather assisting her in thinking through her options and what, if anything, she is ready to do now. Supporting clients means respecting their decision-making and believing that they best know what they need. Clients, after disclosing GBV, may fear the provider's negative judgement and it would be helpful to let victims know that they are not being judged but that, for example, the disclosure is a brave gesture on their part.

8.2.6 To Be A Team Member

The provider needs to work with other staff at the facility who are also involved with the client. The staff needs to work as a team by co-ordinating the survivor's care and, after getting permission from the client, sharing necessary information about her.

8.2.7 To Refer

Victims of GBV need to be offered referrals to various types of agencies depending upon their specific needs. The staff needs to be trained in how and when to make a referral to a survivor of GBV. Providers must assist clients in getting the services they need. Knowledge of what resources are available, helping clients connect with these resources and following-up with clients on whether they used the referral, and if so, their feedback about the quality of the referral agency, is important.

8.2.8 To Provide Related Services

If the facility offers on-site services - such as psychological counselling, support groups, legal advice and assistance - the staff needs to know how victims can access these services at the facility, assist them in doing so and have contact with the other staff members who treat victims of GBV at the facility.

Chapter

9

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Starting Your GBV Project

There are a number of steps involved in starting a GBV Project. These are listed in a certain order in this guide because there is a logical progression to developing and implementing the GBV Project each facility chooses. For example, before staff could start asking clients about GBV they would first need to have set up a referral mechanism because asking clients about GBV without first having agencies to send victims to would be unethical and unprofessional. Some of these steps can be done simultaneously.

Steps in Project Development and Implementation

As mentioned in the last chapter, the project you choose will have all or some of the following steps briefly described below. Project A will have fewer steps, while Projects B and C will have more steps.

Figure 7. Project Development Guide

Project Type	Action
Project A : Steps 1-11	1. Meet with community stakeholders. 2. Assess staff capability 3. Assess financial resources 4. Assess referral services 5. Select type of GBV project 6. Create a work plan 7. Create a monitoring and evaluation plan 8. Set up a referral mechanism 9. Create GBV protocols and policies 10. Sensitise all staff 11. Develop or purchase educational material for clients

Project Type	Action
Project B : Steps 1-17	12. Develop screening forms 13. Modify patient routing 14. Train clinical staff 15. Promote continuity of care and follow-up 16. Provide staff support, supervision and continued training 17. Educate the community
Project C : Steps 1-18	18. Expand staffing and services

9.1 Description of Steps

9.1.1 Meet with Community Stakeholders

It is important to first meet with stakeholders in the community and have a broad discussion, which could include asking for their input, informing them of your plans, and getting their support for your project. Participants could include politicians, local leaders, NGOs, chief of the health district, health ministers, police, religious leaders and others. Part of the meeting could focus on finding out how these community leaders perceive the problem of GBV and how they see GBV affecting individuals, families, communities and the nation. Including them by soliciting their opinion about this problem is a critical step in terms of getting support and backing for your project.

It is not necessary to have prevalence data on GBV occurrence before meeting with stakeholders or before beginning your project. The immediate goal of each project is to help victims of GBV heal from the effect of the GBV. Each facility will be able to collect some data about the prevalence of GBV through the implementation of their projects.

9.1.2 Assess Staff Capability

Before beginning a GBV project, the managers at each facility need to assess the level of knowledge that staff at the facility already have about GBV. In addition, they need to find out what the staff see as barriers and benefits to beginning such a project. It would be important to assess what has been or is already being done, if anything, at the facility in terms of addressing GBV. For example, some staff may already be asking clients about GBV on their own initiative. (The form in Appendix 1 can help you with this assessment.)

9.1.3 Assess Financial Resources

Facilities need to look at their financial resources to see what monies are available or could be raised in order to implement a GBV project. There needs to be a matching of the monies

available with a detailed budget of what each Project (A, B or C) would cost. This can give the facility an idea of what they can do or at least start out doing.

Figure 8. Possible Project Expenses

Project A: funds needed for developing referral information, educational materials for clients, and for sensitisation of all staff.

Project B: funds needed for developing referral information and developing a referral book, educational materials for clients and staff, new forms, sensitisation of all staff, and for training and supervision of providers.

Project C: funds needed for developing educational material for clients and staff and new forms, sensitisation of all staff, training and supervision of providers, training of staff to provide treatment or for hiring new staff, and space for the on-site GBV treatment.

9.1.4 Assess Referral Services

Finding out what services are available in your community is crucial. This will tell you what types of resources are missing. If there are no resources, or critical ones are missing, then some services must be developed before beginning to actually ask clients about GBV. It would not be ethical to ask about GBV, have a client answer "yes" and not be able to offer her help. If a crucial service is not available in the community (e.g., psychological counselling) then the project will need to see that it is provided, perhaps on site. One way to do this might be to train staff members or former victims of GBV so that they can provide the needed psychological treatment or psycho-educational support on site.

9.1.5 Select Type of GBV Project

It is important that a GBV Project be chosen, from A-C, which can realistically be accomplished. This means choosing a Project based on certain considerations.

Considerations

- The capacity of your staff
- The local resources available for referral
- The financial status and prospects of your facility
- The physical infrastructure -- e.g., space for private conversations

Groups can also use a modular approach, starting with Project A, and later adding other components such as directly asking clients about GBV when they come to the clinic. When this happens the project is transformed into Project B. It is better for each group to begin with what they can realistically do and be successful at it and then at some point in the future add on other components.

Some GBV Projects may want to hire a co-ordinator (or choose a staff person who has an interest in the topic and the ability to take on that job) whose job it would be to oversee all the components of the Project. This co-ordinator would work with the staff on the actual implementation of the Project, collecting data, organising on-going training and support groups for the staff and trouble-shooting any problems or questions that arise.

9.1.6 Create a Work Plan

Now that you have assessed your resources and selected a project type, you should prepare a work plan to help you organise your efforts. A basic work plan specifies what has to be done, who will do it, and when. In this Project, you can organise your work plan using the steps that apply to your project type as outlined in Figure 7. (See Appendix 2 for a sample work plan.)

9.1.7 Create a Monitoring and Evaluation Plan

Monitoring is important, not just so that you can demonstrate to others what you have accomplished, but also so that you can judge how the project is progressing, which components are working well, and which may need adjusting. (See Appendix 3 for sample monitoring and evaluation plan.) It is crucial to plan monitoring and evaluation at the very start of the project. Otherwise, you may well find that you don't have the information that you need later on. One way to think about what information you will want later is to think about your annual or final report on the project. What will you want to say? What tables might you want to include? What questions will you want answers to? Now, how will you go about collecting the data you need?

To monitor the activities of your project you will need indicators. There are a number of types of indicators: input, process, output, outcome and impact. These are on a continuum and increase in terms of levels of difficulty.

Input indicators measure such things as supplies, equipment and materials that are purchased for the project.

Process indicators measure activities such as training and supervision.

Output indicators record the results of processes, such as number of people trained.

Outcome indicators are more general than outcome indicators, such as improved quality of care.

Impact indicators measure the ultimate result of the project, such as the reduction of the effects of the GBV on clients.

For a given activity, such as training, you would like to use a number of kinds of indicators. For example, number of training materials purchased (input); training programme developed (process); number of staff trained (output); improved staff knowledge and attitudes (outcome). It is not always either necessary or feasible to measure impact.

Having a clear work plan will help you develop your monitoring and evaluation plan. Under each step of project development there will be a number of activities. Look at each activity and think how you will monitor performance. Remember that in order for data to be recorded and collected staff have to be assigned these duties, trained to carry them out and supervised from time to time. For instance, if clients are asked about GBV and the answers are recorded who will collect this data each month?

(See Appendix 11 for a monthly data summary form.)

In addition to monitoring performance of particular activities, think about broader questions you may want to answer about your project, and how you can answer them. Some questions and means for answering them are presented below.

Projects A, B & C

- **Was the sensitisation process effective in increasing staff knowledge and changing attitudes?** Conduct pre-sensitisation and post-sensitisation tests.

- **Does the staff find the sensitisation process useful?** Do interviews with staff 2-3 months after sensitisation.

- **Do clients take the materials that are made available in waiting rooms, etc.?** Have a staff person keep track of materials.

- **Do clients find the materials useful? Conduct exit interviews with a random sample of clients, for example, every 5th or 10th client for one week**. (See Appendix 12 for sample exit interview questions.)

Projects B & C

- **Is the staff in fact asking clients about GBV?** Analyse records showing whether clients were asked about it.

- **Is GBV a common problem in your client population?** This can be answered by keeping records that show what proportion of women who are asked about it say that they have experienced GBV. Show proportions by type of violence.

- **Will at least some victims of GBV disclose this when asked?** Again, analyse clinic records.

- **How do women feel about being asked questions about GBV?** Conduct exit interviews with a random sample of clients (e.g., every 5^{th} or 10^{th} client for one week). (See Appendix 12 for sample exit interview questions.)

- **How many women were offered referrals for GBV, what kind of referrals, and how many accepted the referrals?** If you want to answer these questions, staff must record the information in the clients' charts and then the information has to be abstracted from the charts and summarised.

- **Does the staff find the support sessions useful?** Use confidential evaluation sheets every 3 months.

Project C

- **How do clients feel about the new services?** Use confidential questionnaires.

- **What kinds of GBV services would clients like to see added?** Conduct focus group discussions with clients.

- **Is the psychological treatment being provided on site effective in terms of reducing symptoms?** Questionnaires about symptoms can be given to clients at the start and end of treatment.

Once you have identified the questions that you will want to answer, and the information that you will need to do so, the next step is to prepare an overall monitoring and evaluation plan. This will show for each activity in your work

plan what indicators you are using, what the sources of data are, who is responsible for collecting the information, and how often it must be collected. (See Appendix 3 for sample monitoring and evaluation plan.)

Collecting data brings up the topic of confidentiality. It is important to safeguard clients' confidentiality when they answer questions about GBV. To do this you need to build in ways to protect clients' identities, for example, by only using chart numbers when abstracting data from clients' charts and keeping the charts in locked drawers. If clients' names are kept on computers, these files must be protected so that there is limited access to them.

9.1.8 Set Up Referral Mechanism

In order to implement Projects A, B and C, services for victims of GBV need to be available in areas such as psychological, psychosocial support, legal, housing, judicial plus other possible services. Some facilities may want to hire a consultant who could then meet with potential referral groups and evaluate their services. Or, if not a consultant, then a staff person from the facility should be given the task of identifying and assessing resources.

It is crucial that the people who staff the referral services have training and experience in working with victims of GBV so that women who are referred there can get the kind of help that they need. (See Appendix 4 for a sample guide on how to evaluate referral sources.)

Once the identification and assessment process of potential referral resources has been completed, the facility needs to decide how the staff will access the referral resources. For Project A, the material left in the waiting room and other places will include the contact information for the different resources so women could, on their own, call or visit them.

For Projects B and C (in addition to putting out material with referral sources in public and private places), a referral book needs to be created so that staff can make appropriate referrals and do so with ease. The referral book could be divided up by category of referral and under that category each referral resource would be listed on its own page, describing the services it offers. The contact person at the facility, fee they charge (if any), hours they are open, etc., should also be contained on that page.

Everyone at the clinic needs to be aware of where this book is kept and trained in how to use it. One staff person could be designated to regularly, twice a year for instance, update the book with new resources and edit out ones that no longer exist or have been found to provide poor quality of services.

9.1.9 Create Protocol and Policies

In order for GBV to be integrated into women's health programmes, there needs to be a written protocol stating how each Project works. The protocol should start at the point the client enters the facility. Some questions to cover in a facility-wide protocol are:

- **Will each client who attends the facility be handed material on GBV or will the materials be left in public and private spaces? Or both?**
- **Who will ask clients about GBV?**
- **What will happen next if a woman discloses that she is a survivor of GBV?**
- **How and where will this be documented in her chart?**
- **Who at the facility will offer victims of GBV referrals?**

The protocol will be a written document. A part of the staff training will be devoted to explaining the rationale for the protocol and how it will work so that everyone is clear. Each person at the facility will then know what their role is vis-à-vis the protocol and how to perform that role. Also contained in the protocol will be information about who the staff can go to if there are problems and questions in the implementation of the GBV Project.

In terms of policies, two critical ones are those covering confidentiality and privacy. These were discussed in earlier sections. (See Chapter 8.)

9.1.10 Sensitise All Staff

In order for a Project to succeed, staff must support it. It is important for the staff to understand both the reasons the GBV Project is being integrated into the existing programme and the implications of this for the facility as a whole. Whichever GBV Project is chosen, all staff members need to be sensitised. Even if, as in Project A, material is left in the waiting room for clients, if a client then starts to discuss with the receptionist what they she has read, that staff person needs to be able to talk with this client about her questions, concerns and experiences.

Figure 9. GBV Topics for Sensitising All Staff

- Rationale for integrating GBV into reproductive health
- The concept of gender
- Definitions of different types of GBV
- Statistics
- The laws against GBV in your country
- Myths about GBV
- The staff's own beliefs and attitudes about GBV
- The connection between RH and GBV
- Why GBV occurs in society
- The hidden nature of the problem
- The effects of GBV on the survivor, her family and society
- The dynamics of GBV
- Symptoms that GBV victims manifest
- Barriers to talking about GBV
- How this Project will work
- The staff's roles with victims of GBV

Just like most people, staff have preconceived beliefs about GBV. It is important for the staff to have an opportunity to look at their own biases and beliefs about this topic. Helping them to confront these and change them is crucial. Dividing people into small groups and having them participate in exercises that allow them to look at and question their biases can be very effective.

Getting people to do role plays about GBV -- where each person has the opportunity to play both the provider and the victim -- is a way for the staff to find out how it feels to be, for example, a battered woman talking to a nurse or doctor. Role playing a provider also gives the staff the opportunity to practice asking questions about GBV to clients in a safe environment. This part of the sensitisation is key to the success of the project. Administering pre- and post-training tests can tell you how effective the sensitisation has been in terms of both gains in knowledge and changing attitudes.

Sensitisation needs to be done for the whole staff before the GBV Project begins, and then done periodically to update staff and introduce this information to new staff.

9.1.11 Develop or Purchase Educational Material for Clients

Each project will need to develop or purchase the most appropriate GBV material for their client population. This material may need to be customised to some degree, especially if you are putting information about referral sources in the materials. (See Appendix 14 for the names of some places from which to order materials on GBV.)

The minimum amount of material to have at your facility would include having posters about GBV on the walls, short pamphlets or booklets located in the waiting room, bathroom and examining rooms, and pocket-sized cards. These cards could be put in the bathrooms and can, for example, say "You do not deserve to be hit, " or could describe different types of GBV and ask women if they are experiencing any of these. The cards could also be used to inform women about the laws about GBV in the country. Other possibilities are pocket-sized cards that educate women on how to make a safety plan if they are in a domestic violence situation. Another possibility is to include information about GBV in the health material that is already distributed at the facility.

Projects B and C also need to have cards and/or brochures with referral information placed in various areas in the facility. Even though in Projects B and C women will be asked about GBV, there are some women who will not be able to openly answer these questions but may be able to, on their own, take the material and use it at some point to get assistance. It is important to give them this option.

Educational material needs to be written in the appropriate language and at a reading level that most clients can understand. Looking at materials that other groups have created can give the staff ideas. Looking at this can help you decide what would work best at your facility and with your particular clients. Some of this material may be for sale (or be free) and purchasing this can give the Project the ability to quickly put out good-looking material rather than having to start from the beginning and develop their own.

9.1.12 Develop Screening Forms

In Projects B and C clients will be asked directly about GBV in their lives. It is important to ask the same questions about GBV with every client

who comes to the facility and to document the answers to these questions in their charts. (There is a screening protocol in the back of this programme guide in Appendix 5.) The briefest documentation form can be transformed into a portable stamp that can be stamped on a client's chart to document her answers to the questions about GBV. (See Appendix 6 for the sample documentation form.)

For Project B, if a client discloses, for example, that she is being beaten, the provider needs to find out more information including the level of danger she is in presently. And if she is in danger, the provider must work with her to make a safety plan. (See sample forms in Appendices 7 and 8.)

For Project C, if a client discloses that she was sexually abused as a child, the next step would be for the client to have an in-depth assessment (see Appendix 9). This can be administered by a psychologist/social worker or a staff member who has had specialised training in GBV. Completing this assessment form will help the client and the health professional understand how the past or present violence is affecting the client now, if she is in imminent danger, if and how the GBV is affecting her children, and what types of on-site services or off-site referrals she needs.

9.1.13 Modify Patient Routing

If your programme is adopting Projects B or C there needs to be a reworking and/or clarification of the route clients will now take as they move through the facility. This must be worked on before beginning the Project.

Questions to be answered include:

- **When will the client be asked about GBV and what will then happen next if the client answers "yes" to any of the questions about GBV?**

- **What happens if the client does not disclose GBV during the intake but rather discloses this to the medical provider who, for example, may notice bruises on her and then inquire about GBV? What then would be the next step for the client? Would she then return to the health worker or, if this is Project C, would she go to see the psychologist/social worker/trained staff member? Would she, after discussing the GBV, then return to see the medical provider?**

- **In Project C, what if the psychologist/social worker/ trained staff member was not in that day? What would be done for the client who disclosed GBV? Would she be given an appointment to see the psychologist/social worker/ trained staff member on another day?**

Thinking these questions through ahead of time will help each GBV Project work more smoothly for both the clients and the staff. Diagramming these different routes as a way of organising the possible routes and as a way to review it with staff is one concrete option. Presenting this at the clinical training would then inform staff of the new routing.

9.1.14 Train Clinical Staff

The clinical staff, including health workers, doctors and nurses, all must have in-depth training since they are the people who have the most direct

contact with clients and who will be addressing the topic of GBV with them. They need to feel comfortable and competent in order to do this well.

Since most past education and training of health care providers has not included the topic of GBV, this is something that they may not feel comfortable addressing with clients at first. The goals of the training are to help them get beyond their barriers, understand their role in the project and the important part they play in assisting women victims of GBV. Their roles in the GBV Project will incude: witness, listener, supporter, educator and validator. (See Chapter 8.)

Projects B and C need to locate consultants who can offer the clinical staff an in-depth training (see Figure 10). There are now consultants who have an expertise in this area and who can be contacted and interviewed to see if they are suitable. There is also material available for health care facilities and their staff to read about GBV. (Some of this material is listed in Appendix 14 of this programme guide and some can be found on the Web site addresses provided.)

Having a staff library so that providers can learn not only about the general topic of GBV but also about specific issues such as the connection between GBV and HIV/AIDS or childhood sexual abuse and its effect on pregnancy, would further assist staff in their work.

9.1.15 Promote Continuity of Care and Follow-up

Clients who have disclosed GBV need to have this documented in their charts. Having already been trained in the assessment and treatment of victims of GBV, the provider is aware that GBV may cause a client, for example, to feel very uncomfortable taking her clothes off and/or being touched by someone in an intimate way. He/she will factor in the GBV into whatever procedure is done or whatever family planning method is decided upon. For example, if a client's partner is beating her, the partner may also, as a way of controlling her, not want her to use any method of family planning. The client though, wanting to have control over her body (and whether she gets pregnant), then needs a form of family planning that she can use without her partner knowing about it. It is therefore important that providers factor in possible GBV into their clients' lives before recommending a family planning method.

When a staff person sees a client, who during her last visit disclosed GBV, s/he needs to make a non-judgmental, empathetic reference to this past disclosure. As part of the follow-up, the staff person will again ask the client about GBV in her life and update this information as to whether the GBV is still going on and how this is presently affecting the client's life. If appropriate, clients will also be offered a referral at that time. This is important, especially for women who have in the past have declined a referral. She may now be ready to accept the recommendation of a referral.

9.1.16 Provide Staff Support, Supervision and Continued Training

Having a GBV Project integrated into your programme is a way to reach

clients who are victims of GBV. It is not only important to open this topic up for clients but it must also extend to the staff. Statistically speaking, there are most likely members of the staff who are currently or have in the past been victims of violence. They need to know that they can get help through the GBV Project too, without experiencing shame or stigma. This is an important message for a number of reasons, including that this particular staff member may be in danger of being seriously injured. This disclosure can affect the quality of the Project. Staff who have been victims of GBV in the past and who have never talked about this may be reluctant to bring up this topic with clients. They may avoid asking clients questions about GBV because it makes them uncomfortable and anxious, bringing up memories of their own abuse experiences. Just as with clients, staff members who are victims of violence can begin to deal with the effects of the violence in their own lives if they are clearly given the message that this is something that can and does happen to any woman and that the people they work with are willing to offer them understanding, support and assistance. It would be beneficial to all and be a consistent message about opening up this topic if the GBV Project allowed all employees suffering the effects of GBV to get the help and support they need.

Ongoing training is an important component in the GBV Project. The staff periodically needs to have refresher trainings plus training on new aspects related to the GBV Project. Staff should periodically be assessed in order to find out from them what they see as important topics that should be included in the trainings. New staff, of course, needs training on this topic.

Figure 10. Topics for Training of Clinical Staff

- Understand the benefits to integrating GBV into the facility's programme
- Clarify each person's role at the facility in relation to the survivor
- Identify the physical and psychological effects and symptoms of GBV
- Recognise the dynamics of GBV
- Understand client barriers to disclosing GBV
- Recognise and overcoming staff barriers to addressing GBV
- Discuss providers' concerns about protecting themselves from retaliatory violence
- Learn to directly and indirectly assess a survivor of GBV
- Learn to ask clients about GBV
- Develop a comfort level so as to assist clients if they answer "yes"
- Develop skills to respond if there are suspicions of GBV but the client answers "no"
- Understand how to document GBV and maintain confidentiality
- Learn how to make a referral
- Discuss the effects this type of project may have on staff
- Gain familiarity with the new forms and referral book

Another important part of this or any Project is making sure to take care of the staff members who are themselves in the on-going position of taking care of clients. Listening to stories of

violence is difficult and can take a toll on them. This is especially true if the staff does not get enough support and further skills enhancement. They can then develop what is called secondary or vicarious traumatisation. In addition to being harmful to the staff, this would undermine the Project because staff, feeling overwhelmed, could then stop asking clients about GBV or else ask in ways that communicated to the clients that they did not really want to know the true answers to these questions.

To counteract this, it is necessary to have an on-going support and supervision component to the Project that gives staff the opportunity to discuss difficult feelings they have, get feedback on perplexing and upsetting cases, get support for doing this work and gain new skills. Staff support and supervision is as important as training.

It is also a way to fine-tune the Project by finding out what is working and what is not going well, what needs to be rethought or added, and what additional skills the staff needs in order to work with victims of GBV. Having a supervision meeting once a month led by a trained facilitator would allow staff to gain skills and feel supported in the GBV work they are doing. The more skills and tools the staff have, the more competent they feel and the better they can do this work.

9.1.17 Network With and Involve the Community

One way to raise awareness about a topic is to introduce ideas and ways of thinking about the topic that are novel. This is true with GBV. Firstly, some people may not even be aware that GBV is a topic that no longer is a private matter and that it in reality effects the whole community. Community workers can organise meetings that address this topic by focusing on original themes that would interest various people and community groups. Such themes include: the costs of GBV to the city and country, GBV laws in this particular country, the effects of GBV on children, and how to recognise symptoms of domestic violence and other forms of GBV in a victim. These are all topics to use to begin a discussion of GBV.

Informing citizens at these meetings about your facility's GBV Project and the services you offer women is a way to publicise these activities. Bringing material about GBV to these meetings allows participants to take these, read them and possibly pass along to others who may be victims of GBV. The participants can then act as informal referrers to the GBV Project.

Another way to effect change is to educate specific groups of people. Initiating groups for men in the community where they can talk about male socialisation and gender roles and the effect this has on their relationships with women is one example of this. These groups can be short-term and allow men, possibly for the first time, to look at their values and behaviour and work on changing abusive behaviour. When led by trained leaders these can be powerful groups. These types of groups have been successfully conducted in a number of countries and there is written material available that can be used as a guide to facilitate a men's

group. This is an excellent way to involve men in the issue of GBV (Corsi, 1999).

9.1.18 Expand Staffing and Services

If, as in Project C, there is to be on-site treatment, staff at the facility who have an interest and propensity for this work can be trained in the assessment and treatment of GBV. Or else, new staff can be hired to do the psychological counselling. These people would be trained social workers or psychologists with an expertise both in the treatment of GBV and group work, who could lead support groups for victims of GBV. There could then be groups for rape victims, battered women and adolescent and adult victims of childhood sexual abuse. These groups are both helpful to victims of GBV and an economical way to offer effective services.

Another option is to train formerly battered women or survivors of rape so that they can run support groups for victims of GBV. As part of the job, they could first meet with victims of GBV and assess clients by administering an in-depth assessment of the GBV and its effects. (See Appendix 9.) During this meeting she would also get a better sense of the victim's situation and evaluate what type of services she needed - legal, psychological, housing, support or psychosocial, on-site or off-site.

An additional service that Project C can offer is on-site legal assistance to victims of GBV. The lawyer could meet with victims of GBV and give them information about their legal rights, answer specific legal questions and assist them in finding ways to protect themselves from the perpetrator.

Chapter

10

A Practical Approach to Gender-Based Violence:

A Programme Guide for Health Care Providers and Managers

Appendices

Appendix 1. Facility Assessment Form

A. What Is Currently Being Done at Your Facility about GBV?

1. Has any of the staff had any general sensitisation on the topic of GBV?
2. If so, what type of training was it and who participated in it?
3. Is there any written material in the waiting room on GBV?
4. Has the staff been trained to identify, assess and assist victims of GBV?
5. Are clients presently asked about GBV at your facility?
6. If yes, is there a place in the client registration form or in the charts to document this? And is there a place to write notes regarding GBV?
7. Do you have a list of agencies at your facility to refer victims of GBV to?

B. Levels of Staff Interest and Concern

1. What is the interest level of the different staff in doing such a Project?

   (Rate on a scale of 1-5, 1 = lowest; 5 = highest level of interest)

Staff Category	Average Levels of Interest (1-5)	Comments
a. Health workers b. Doctors c. Nurses/Midwives d. Administrators e. MIS f. Education g. Social Workers h. Support Staff		

2. What does the staff see as the benefits to a GBV Project?
3. What does the staff see as the drawbacks of a GBV Project? (Use this information to address the concerns of staff about starting a GBV Project. Find a forum, such as a staff meeting, to discuss this.)

C. Potential Problem Areas

It is normal to experience difficulties. Examples of areas of concern are:

- **How to introduce this Project to the staff**
- **How to evaluate this Project**
- **How to train all the staff**
- **How to take a step-by-step approach and not jump over steps**
- **How to deal with staff's time concerns**

Appendix 2. Sample Project Work Plan

Date of sample work plan - January 1, 2002

Step	Activity	Person (s) Responsible	Deadline
Assess staff capability (Use form in Appendix 1.)	Interview individual staff members	Staff supervisor	January 19
	Hold staff meeting to discuss concerns, etc.	Clinic Director	January 26
	Plan how to deal with issues identified	Senior staff	February 9
Assess financial resources	Hold meeting to discuss resources	Clinic Director, Accountant	January 19
Assess referral services	Identify possible resources via telephone, meetings, internet, etc.	Provisional Project Coordinator	January 26
Etc.			
Etc.			
Etc.			

Appendix 3. Sample Monitoring and Evaluation Plan

Activity	Indicator	Data Source	Person Responsible	How Often
Staff sensitisation	Process-Sessions held	Project records	Project Coordinator	On-going
	Staff sensitisation	Pre and post	Project Coordinator	With each sensitisation
	Output - improved awareness, knowledge and attitudes			
Screen clients for GBV	Process - Number or percentage of clients screened	Client charts	Clinical staff	Daily
	Output - Number or percentage of women screened who say "yes"	Monthly data summaries (see Appendix 11)	Project Coordinator	Monthly
Etc.				
Etc.				
Etc.				

Appendix 4. Creating a Referral Network

<table>
<tr><td>Name of institution:

Director of Institution:</td><td>Type of institution:

Hours and Days Open:</td></tr>
<tr><td rowspan="3">Address:</td><td>Phone Numbers:</td></tr>
<tr><td>Fax Numbers:</td></tr>
<tr><td>E-mail Address:</td></tr>
<tr><td>What type of population do you serve?</td><td>Do you specifically see victims of GBV?
Yes/No</td></tr>
<tr><td colspan="2">What is the profile of the victim you serve? Does your group have any criteria that a potential client would have to meet?</td></tr>
<tr><td>Do you provide direct care or do you make referrals?</td><td>If you do provide direct care, what type is it? (Legal, medical, social, psychological, educational, etc.)</td></tr>
<tr><td>If you make referrals, where do you refer?</td><td>Do you charge a fee? Yes/No
If yes, do you have a fixed fee or can you make accommodations?</td></tr>
<tr><td>What is the profile of your staff who see victims of violence?</td><td>Are there other activities that your institution offers?</td></tr>
<tr><td>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?</td><td>Would you be interested in our two institutions making cross-referrals?
Yes/No</td></tr>
<tr><td colspan="2">Would you be interested in being a part of a network of groups that work in the area of GBV? Yes/No</td></tr>
</table>

Instructions

- Get names of potential referral resources from non-governmental organisations (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.

Appendix 5. Asking about Gender-Based Violence

A. Principles Behind Asking about GBV

It is important to ask questions about GBV in such a way that clients understand exactly what you are asking them. It is important **not** to use technical or negative terms that will confuse her or cause the client to feel blamed. It is best to use questions that describe behaviours and ask a client whether she has experienced these (see examples below). It is important for the staff to feel comfortable asking these questions. If they do not, the person asking will communicate their discomfort to the client and the client will then answer "no" to the questions, when they may in fact be victims of GBV.

It is crucial that every staff member in a Project who asks clients about GBV ask the same set of questions. This is important in order to collect data that will then show how many clients have experienced what types of GBV. The GBV coordinator or other personnel must decide which specific questions clients will be asked about GBV. Deciding which questions will be asked must be decided upon before the training of the clinical staff because they will be the people who will be asking clients these questions.

Before actually asking a client the questions about GBV, it would be important to first explain to the client why you are going to be asking her these questions and normalize the topic by using one of the following suggested openings:

"I ask all clients these questions."

"I know that there are many women who are victims of GBV and we believe at our facility that it is important for us to talk with clients about this."

"I know that there are things that have been considered private in society and that has included violence against women. At our place we don't believe that this is a private matter. We think it is important to talk about these things."

"Sometimes people are told that it's okay if they are hit or being abused by someone they care about. People say that this is an expression of love. But I know that this is something that should not happen. No one deserves to be hit or sexually abused in any way. I want to know if this has happened to you."

B. Asking questions about GBV

Questions need to be asked that can identify three types of GBV -- childhood sexual abuse, rape and domestic violence. There are sample questions in each of the categories listed below. Whatever questions are chosen, they should be written out on a form or kept close by in the room where women are assessed for GBV. This way, health workers will be able to use them as prompts and each health worker will ask the same set of questions.

Choose your Project Questions (Sample questions to ask clients about GBV)

Childhood Sexual Abuse

- Sometimes women are touched as children in ways that do not feel good? Did that happen to you?
- Did anyone ever try to touch you in a way that made you feel uncomfortable?
- As a child, did anyone touch you in a sexual way?

Rape

- Have you ever felt forced or pressured to have sex when you did not want to?
- Has someone you know or a stranger ever make you do something sexual that you did not want to do?
- Do you feel that you have control over your sexual relationships and that you will be listened to if you say "no" to having sex?

Domestic Violence

It is important to ask clients questions about different forms of domestic violence. (Rape as one aspect of domestic violence is included in the sample questions on rape.)

- Has a partner ever hit, kicked or slapped you or threatened to do so?
- Are you frightened of your partner?
- Has a partner ever criticised you, insulted you, yelled at you? Has your partner ever destroyed your things or objects in the household?
- Has a partner ever threatened your life, isolated you from family or friends, refused to give you money or not allowed you to leave the house?

Or more generalised questions can be asked:

- As an adult have you ever been injured or hurt by any kind of abuse or violence, for example, hit by a partner or forced to have sex?
- Is there anyone you are afraid of now?

C. Responding to the Client's Answers

If the client answers "yes" to any of the questions about GBV, you need to give the client support and validation. You can respond by saying:

"I'm sorry that this happened to you. I need to ask you more questions so that we can get you some help."

"No one deserves to be abused. You do not deserve to be abused. I know it is not easy for the person who is going through this."

"I'm glad that you were able to tell me. I think we can help you here. I need to ask you a few more questions about the GBV and that will give me more information so that together we can figure out the best options for you."

Get more information from the client if the client answers "yes"

You then need to ask her for more information such as who was (or is) the perpetrator, how long the abuse went on for, and if she is in danger now. (See Appendix 6 for the list of questions.) You would also want to get a sense of what types of referrals this client needs at this time. Give the client some idea of what referral options are available and discuss these options with her.

If the client answers "no" to the questions about GBV

Clients may answer "no" because they may never have experienced GBV. Even though she has said "no", asking again when a woman returns to the facility is important because circumstances change. For instance, a woman may get into a new relationship and it may be violent, or a woman after she becomes pregnant may start experiencing physical violence from her partner.

For a number of reasons, clients who are victims of GBV may say "no" to the questions about GBV the first time they are asked about this. Clients who have never talked about their experiences of GBV may not feel comfortable disclosing this immediately. They will need time to first feel safe or trust staff before answering this honestly. They also may feel frightened of disclosing this because of threats the perpetrator has made. This is why it is important to ask clients these questions each time they come. Some women have said that being asked repeatedly about GBV by their providers was what finally persuaded them to disclose the abuse. These women said "yes" because they felt that the provider had persevered by repeatedly asking, thereby letting them know they care and want to know.

Although it is important to ask clients each time they come to the facility if they are victims of GBV, it would not be helpful to try to force a client to disclose GBV before she was ready to do so. Actually, it may have a negative effect and consequently she might feel threatened by this and not return to the clinic. So if a client says "no" in answer to your questions about GBV but you suspect she is being abused, remember that she can only tell you when she is ready to do so. You can help her by respecting that and recognising that it takes time before someone can disclose a secret that she has kept for a long time.

If the client answers "no" but the provider thinks that the client may have been a victim of GBV.

The provider, if s/he suspects that the client is a victim of GBV, needs to document this in the documentation form. As stated above, some clients may be unable to initially disclose this information. That is why it is important to check off the "maybe" box in the documentation form (see Appendix 6). This way, staff at the facility could be alerted to this possibility. It is also critical to ask these clients questions about GBV when they return to the clinic.

D. Overview of screening, assessment and documentation

Project A	**Project B**	**Project C**
If a woman approaches a staff person about the educational material about GBV: • Take her into a private room • Respond to what she says in a caring, supportive manner • Ask her questions about her experience of GBV, if appropriate • Make an appropriate referral	**Asking a client about GBV and the client says "yes":** • Respond in a caring, supportive manner • Get more information about what happened • Find out if she is in danger now • If she is in danger go over the danger assessment form and make a safety plan with her • Make a referral • Document all of this in her chart	**Asking a client about GBV and the client says "yes":** • Respond in a caring, supportive manner • Get more information about what happened • Refer her for an in-depth assessment, which includes a danger assessment and a referral, on-site or off-site • Make a safety plan, if needed • Document all of this in her chart

Appendix 6. Sample Documentation Form

Have a rubber stamp made to put in each client's chart. It can look like the one below.

Type of GBV	No	Yes	Maybe
Childhood Sexual Abuse			
Rape/Sexual Assault			
Domestic Violence			

When the client answers the questions about GBV, the answers need to be put in her chart. If a stamp is used (as above) the health worker can check off the appropriate boxes in the stamp. (Domestic violence that is sexual goes in the "rape/sexual assault" box.) If the client answers "no" but the health worker suspects that the client has experienced or is experiencing GBV or if the client herself is unsure, the health worker needs to check-off the "maybe" column next to the specific type of GBV. (See Appendix 5 for more information about a client saying "no" and a provider checking off the "maybe" box.)

For Project B **(Questions to ask if the client answers "yes" to any of the GBV questions)**
When did this occur?
What is the perpetrator's relationship to the client?
What is the length of time the GBV went on?
How has the GBV affected the client?
Does the client report any re-victimization experiences?
Does the client feel in danger now? *If so, fill out the danger assessment form (see Appendix 7) and make a safety plan, if appropriate (see Appendix 8).*
Referral given? Where? Accepted by client?

The above form should be attached to the client's chart along with any other information about GBV.

Appendix 7. Danger Assessment

If a client discloses that she is currently in a violent relationship or she is thinking of leaving a violent relationship she needs to be assessed for danger. Asking these questions and finding out the answers will educate the client about her level of danger. Knowing the level of danger will help the provider and the client think through what her options are. To further help her, the provider may need to work on safety planning with the client. (See Appendix 8 for the safety planning form.)

1. Has the violence increased in the past year?
2. Does the perpetrator use drugs and alcohol?
3. Has the perpetrator made threats to kill you?
4. Are there weapons in the home?
5. Are you afraid to go home?

Appendix 8. Safety Planning

(Adapted from the New York State Office for the Prevention of Domestic Violence)

A. Increasing Safety in the Relationship

If I need to leave my home, I can go to _____ (list 3 places you can go).

I can tell _____ (list 2 people) about the violence and ask them to call the police if they hear loud noises coming from my home.

I can leave extra money, clothing, car keys and copies of documents with_____ (list one person)

If I have to leave, I will take _____with me.

To ensure safety and independence, I can keep change for telephone calls with me at all times, open my own bank account, rehearse an escape route from my home and review this safety plan.

B. For Increased Safety When the Relationship is Over

I can change the locks, put better lighting outside my home, and install a better door.

I can inform _____ (list at least 2 people) that my partner no longer lives with me and ask them to contact _____ (me, the police, others) if he is seen near my home.

I will tell the people who take care of my children the names of the people who have permission to pick up my children. Those people who have permission are_____ (list all the people this applies to).

I can tell _____ (list people) at work about my situation and ask them to screen my calls.

I can obtain a protective order from_____ and keep it with me at all times. I can also leave a copy of it with _____. (If applicable, list one person.)

If I feel down and ready to return to a potentially abusive situation I can call _____ (list at least one person) for support or attend groups to get support and strengthen my relationships with other people.

C. Important Telephone Numbers:

_____

_____

D. Items to Be Sure to Take With Me (make a list here)

_____

_____

Appendix 9. In-depth GBV Assessment Form (for Project C)

1. Client Name	2. Client ID#	3. Provider Name	4. Date
5. Type of GBV (Tick off all that apply)	a. Childhood Sexual Abuse	b. Rape	c. Domestic Abuse

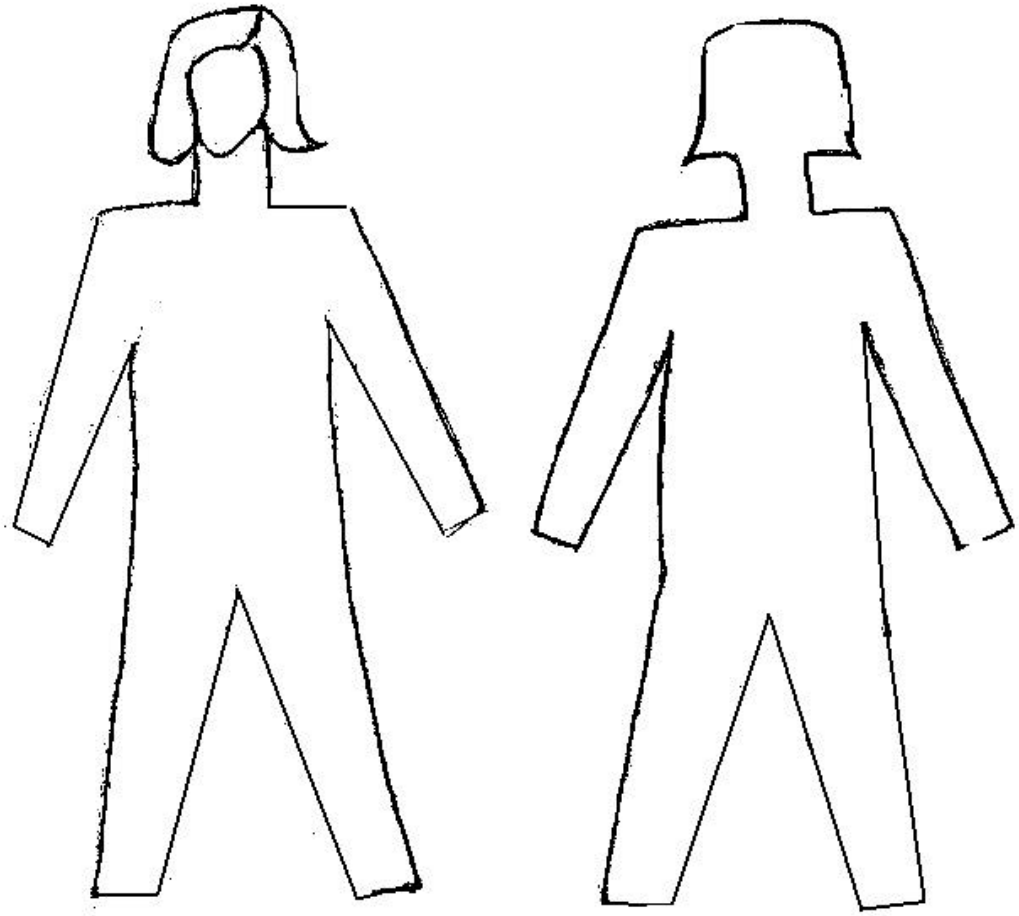
6. History of GBV	7. Present Day Effects (Place a tick mark in the appropriate column)			
a. When this occurred	**Symptoms**	**Yes**	**No**	**Comments of Staff Member**
	Depression			
b. Perpetrator's relationship to client	Drug/alcohol abuse			
	Anxiety/panic attacks			
c. Physical, sexual, verbal, emotional, psychological abuse	Sexual/intimacy problems			
(Check all that apply)	Eating/sleeping too much or too little			
d. Length of time abuse went on (note if still going on)	Self-harm			
	Shame/self-blame			
e. Told anyone about this before? Got help?	Numbness, intrusive memories			
	Suicidal thoughts/behaviours			
f. Any contact now with perpetrator? Yes/No	Post-Traumatic Stress Disorder			
If "yes", go to question 11.	Physical injuries and problems			
g. Was a safety plan discussed with the client? Yes/No	Other symptoms (specify)			

8. Effects on client's children	11. Danger Assessment
	a. Has the violence increased in the past year?
9. Re-victimisation experience(s)	b. Does the perpetrator use drugs and alcohol?
	c. Has the perpetrator made threats to kill you?
10. Other Comments	d. Are there weapons in the home?
	e. Are you afraid to go home?

12. Referral

Type of Service	Name of Referral	On-site	Off-site
Support group			
Counselling			
Legal			
Housing			
Social services			
Hotline number			
Other (specify)			

Appendix 10. Body Map



Appendix 11. Monthly Data Summary Table

Total Number of Clients, Clients Asked about GBV and Clients Reporting GBV, by Clinic and Type of Violence

(1) Clinic Name	(2) Total Clients	(3) Childhood Sexual Abuse	(4) Rape *	(5) Domestic Violence	(6 = 3+4+5) Total Abuse Cases	(7 = 6/2) Abuse Cases %
a.						
b.						
c.						
d.						
e.						
Total						

*The category "Rape" includes rapes committed as part of domestic violence.

Appendix 12. Sample Exit Interview

In order to get an assessment of quality of care from clients, you can do a study using exit interviews of randomly selected clients. For one week, ask every 5th or 10th client about her experience of the GBV Project. Below are some possible questions that these clients could be asked. It would be important to ask them these questions in a private place since they touch on a sensitive issue.

Interview Questions About Responses to the GBV Screening

1. Did you look at the GBV material in the clinic?

2. What did you think of them? Were they informative? Easy to read? Helpful? Do you feel you got new information about this topic by reading the material?

3. If you did not read the material, why not? Would there be anything that we could do that would make the material more desirable to read?

4. If you had a friend who told you she was being abused would you pass along this material to her? If yes, why? If no, why?

5. Do you have any other comments about the posters, cards, booklets or brochures we have on GBV?

6. Do you believe it is a good idea to put this type of material out in a health clinic for women?

Interview Questions About Being Asked about Responses to the GBV Screening

1. As part of the client intake, were you asked about GBV?

2. Did you think that when the staff person asked you these questions she really wanted to know your answers?

3. Do you think it is important for women to be asked such questions when they come to a health care facility?

4. If you were to answer "yes" to the GBV do you think that you could get the help you need here? If yes, why? If no, why?

5. If someone you knew was a victim of GBV would you send her here to get help? If yes, why? If no, why?

Appendix 13. Evaluation of this Programme Guide

1. **Overall, how would you rate this programme guide? Circle your response.**

Excellent Good Fair Poor

2. **What was most helpful about this programme guide?**

3. **What has least helpful about this programme guide?**

4. **Additional comments about the programme guide**

Appendix 14. Sources of Information on Gender-Based Violence

ANNOTATED BIBLIOGRAPHY

I. GENDER-BASED VIOLENCE

American Medical Association. (1995). Diagnostic and Treatment Guidelines on Mental Health Effects of Family Violence. [Brochure]. A portable-sized booklet that discusses the role of the physician in working with victims of gender violence. Focuses on assessment, treatment and referrals of these patients. Summarises the psychological effects of trauma on patients and describes how to take an abuse history and emphasises the importance of this. To order, visit AMA's Web site at http://www.ama-assn.org/violence

Heise, Lori, Ellsberg, Mary, & Gottemoeller, Megan. Ending Violence Against Women. Population Reports. Series L, No. 11. Baltimore, Johns Hopkins University School of Public Health, Population Information Program. (1999). This document focuses on the two most common types of violence against women: abuse of women within intimate relationships and coerced sex which can take place throughout a woman's life. It discusses the causes of gender-based violence, the impact of the violence on the individual, family and community and also what health care providers can do to assist victims of GBV. Has statistics and prevalence rates of GBV from many countries.

Heise, Lori, Moore, Kirsten & Toubia, Nahid. (1995). Sexual Coercion and Reproductive Health. New York: The Population Council. A report from a seminar sponsored by the Population Council on gender violence that brought together different groups and disciplines to develop a health research and action agenda on the effects of sexual violence on reproductive health.

Heise, Lori with Pitanguy, Jacqueline & Germain, Adrienne. (1994). Violence Against Women: The Hidden Health Burden. Washington, D.C.: The World Bank. A comprehensive documentation of the problem of gender violence. Looks at the health effects, its effects on development and steps that can be taken to eliminate gender violence. Includes DALYs, the disability-adjusted years lost to women that is attributable to domestic violence and rape.

Heise, Lori.(1994). Gender-Based Violence and Women's Reproductive Health. International Journal of Gynecology and Obstetrics,46: 221-229. Speaks to the many ways that gender violence affects reproductive health including unwanted pregnancy, HIV, STDs, teenage pregnancy, somatic problems and outlines ways that health care providers can intervene by asking about gender violence.

II. DOMESTIC VIOLENCE

American Medical Association. (1992). Diagnostic and Treatment Guidelines on Domestic Violence. Chicago. [Brochure]. A portable-sized programme guide for health care providers which includes basic information on the assessment, diagnosis, interventions, documentation and barriers to identification of domestic violence. To order, visit AMA's Web site at http://www.ama-assn.org/violence.

Olavarrieta, Claudia Diaz & Sotelo, Julio. (1996). Letter from Mexico City: Domestic Violence in Mexico. Journal of the American Medical Association, 275, (24): 1937-1941. A short article describing the history of domestic violence in Mexico, the judicial obstacles to reporting it and the availability of services for victims. Acknowledges the cultural acceptance of this public health problem as a one barrier to changing how Mexico responds to the problem of domestic violence.

Rodriguez, Michael, Guiroga, Seline Szkupinski & Bauer, Heide. (1996). Breaking the Silence: Battered Women's Perspectives on Medical Care. Archives of Family Medicine, 5, 153-158. Using focus groups the authors listened to battered women speak about what from the victim's perspective inhibited disclosure of domestic violence. The women also spoke about the factors that enhance disclosure, which included feeling that providers were aware, compassionate and respectful of their patients.

United Nations. (1993). Strategies for Confronting Domestic Violence: A Resource Program Guide. Center for Social Development and Humanitarian Affairs: Vienna. Written by a group of experts based on the report of the Secretary-General of the United Nations on domestic violence. Presents a range of options and strategies that are being used in different parts of the world to deal with the problem of domestic violence. Includes chapters on improving the criminal justice system, working with perpetrators and training practitioners.

III. RAPE

American Medical Association. (1995). Strategies for the Treatment and Prevention of Sexual Assault.{Brochure} Describes the needs of victims of sexual assault in an emergency setting and in a primary care setting. Asks physicians to be aware of and respond to both the physical effects of the trauma and to the psychological aftermath. A special focus on adolescents as a vulnerable population. To order, visit AMA's Web site at http://www.ama-assn.org/violence

IV. ADULT MANIFESTATION OF CHILDHOOD SEXUAL ABUSE

Stewart, Lindsey, Sebastiani, Angela, Delgado, Gisella & German Lopez. (1996). Consequences of Sexual Abuse of Adolescents. Reproductive Health Matters. 7: 129-134. This article uses interviews with girls in Peru and Columbia to show the extent and consequences of sexual abuse among female adolescents. They describe both the behavioural and psychological effects. They connect childhood sexual abuse to sexual risk-taking in adolescence, including poor or non-use of contraceptives. The authors believe that health care providers must be trained to deal with this problem and that facility policies and procedures must also be in place to help the patient and support the provider.

Contraceptive Technology Update. (1994). This is a special focus series of articles on the abuse of women. Using studies that have been previously done, they connect childhood sexual abuse to contraceptive non-compliance. This is important because often health care providers see the non-compliance but do not understand why patients are not using contraceptives. It also alerts providers to look for the possibility of revictimization in adolescence and adulthood for these women. The series includes a piece written from the point of view of an abused woman on what a provider can do to help an adolescent or adult woman who was sexually abused as a child. 15, (10): 113-139.

V. ASSESSMENT AND TREATMENT ISSUES

Herman, Judith. (1992). Trauma and Recovery. New York: Basic Books. A thoughtful book that connects domestic violence and childhood sexual abuse to the effects of combat. Speaks to the effects of trauma and the different stages and needs that victims have to go through to heal.

Stevens, Lynne. (1997). Sexual Abuse Victims: Assessing and Diagnosing the Trauma in Adolescent and Adult Women. Advance Magazine for Physicians Assistants. 5,(5),:47-49. Describes how adolescent and adult victims of childhood sexual abuse present in health care providers' offices. Defines the problem, lists possible symptoms victims have, describes why victims don't bring this up with providers and how to assess and diagnose the long-term effects of sexual abuse. (E-mail: lynnes@earthlink.net).

Stevens, Lynne. (1997). Breaking the Silence: Talking About Sexual Abuse With Female Patients. Advance Magazine for Physician Assistants, 5 (8). Asks health care providers to ask patients about a sexual abuse history. Describes the benefits to asking, who to ask, how to bring this topic up with patients, how to respond if patients say they were abused, how to give support to patients and how to make a referral. (E-mail: lynnes@earthlink.net).

Web sites to Use to Get Information and/or Material on GBV

1. Victim Services – in English and in Spanish: www.vicitmservices.org

2. Women Watch: www.un.org. Look in particular for (a) Final Report of Women Watch online working groups on all critical areas of concern of Beijing +5, including health, VAW, women and armed conflict. E/CN.6/2000/PC/CRP1. (b) All Beijing +5 documentation, in English, French, Spanish very often, especially Expert Group Meeting reports on the three areas mentioned above. (3) Links especially to NGO pages.

3. United Nations Commission on Human Rights (UNHCHR) – www.unhchr.ch for all reports of the Special Rapporteur on VAW, available in three languages above. Note specially, her reports on (a) Policies and practices that impact women's Reproductive Rights and contribute to, cause or constitute VAW. E/CN.4/1999/68/ADD.4 21 Jan.1999 (b) on Trafficking in women, women's migration and VAW Health aspects addressed. E/CN.4/2000/68, 29 FEB 2000 (c) VAW in family, domestic violence E/CN.4/1999/68 (d) VAW in armed conflict, custodial violence, refugee and internally displaced women – E/CN.4/1998/54.

4. United Nations Development Fund for Women (UNIFEM) home page www.undp.org/unifem for its pages on Human Rights and especially on UN General Assembly Trust Fund on eliminating VAW which gives information on activities and updates.

5. World Health Organization (WHO) home page www.who.int/ especially for (a) Prevalence and data on VAW at country level compiled from many sources (b) VAW bibliography (c) info on their on-going Multi-Country Study (d) forthcoming World Report on Violence, including gender-based violence.

6. UN Resources on Gender: www.undp.org/. Look especially at the Gender Good Practices Database http://www.undp.org/gender/practices/ which contains examples in area of VAW from many UN agencies including on health aspects (e.g., PAHO).

7. Population Council: www.popcouncil.org – especially for the report "Sexual Coercion and RH: A Focus on Research" (Executive Summary).

8. Men's Resource Center of Western Massachusetts www.mrc-wma.com. In addition to information on its own programmes, provides good links to other Web sites on "men" that deal with GBV among other issues.

9. IPAS: www.ipas.org – information on provision of reproductive health services for rape victims including safe abortion and after-care, among their other programmes.

10. Family Violence Prevention Fund: www.fvpf.org includes their Newsletter, screening information, and materials such as posters, stickers and cards on domestic violence for sale.

11. International Planned Parenthood Federation/Western Hemisphere Region: www.ippfwhr.org – has a newsletter, Basta! about its GBV projects in Latin America and the Caribbean.

12. White Ribbon Campaign: www.whiteribbon.ca/eindex.html – a group of "men working to end men's violence against women." Offers a newsletter, educational material for adolescent and adult men about violence against women, and counselling resources for abusers.

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This card is a prototype. Adapt it to your context

SAVE

S=SCREEN all clients for Gender-Based Violence (GBV).
GBV is a public health problem. All women are vulnerable to GBV. Health care providers are the group that women want to talk to about GBV. Many women will not volunteer this information but will disclose GBV if their provider asks them.

A=ASK direct questions about GBV in a non-judgmental manner in a private setting. Do not use formal, technical or medical language. Normalize why you are asking about GBV before asking questions about GBV.

EXAMPLES OF WAYS TO INTRODUCE THE TOPIC:
o "I know that we just met but I have to ask you these personal questions. We do this because there are many women who are victims of GBV and we believe it is important to talk about this here. What you tell me will be kept confidential"
o " I know that there are things that are considered private in society and that has included violence against women. I don't believe that this is just between two people. No one deserves to be abused. I want to ask you some questions about what is going on in your life…"

Find ways to ask that feel comfortable for both you and the client.

EXAMPLES OF QUESTIONS TO ASK ABOUT GBV:
o Has a partner ever hit, kicked or slapped you or threatened to do so?
o Have you ever felt forced or pressured to have sex when you did not want to?

HERE'S WHERE THE QUESTIONS YOUR FACILITY WILL USE WILL GO:

V=VALIDATE the client's response.
If a client answers "yes" to any of your questions offer her support. Do not minimize the client's response even if she does. Let her know you believe her and that no one deserves to be abused. Let her know help is available. Be sure to document the type of abuse and note the physical and psychological findings related to the GBV in the client's chart. If a client answers "no" but you suspect that she is a victim of GBV make a note about this in her chart and be sure to follow-up by asking again in the future.

E=EVALUATE, educate and refer.
Ask the client how you can help her. Offer her empathy, educational information and referrals. Let her know that you will not judge her if she does not follow-up with the referral now. If she is hesitant to take a referral now, let her know she can change her mind and receive one at some later time. Follow-up and mention the disclosure of GBV during her next visit.

Adapted from the NYS Coalition Against Sexual Assault SAVE card