Programming Module on

Working with the Health Sector to Address Violence against Women and Girls

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INTRODUCTION AND KEY CONCEPTS

- **Why is the Health Sector Critical in Addressing Violence against Women and Girls?**
  - **The health sector is a key entry point for survivors.**
  - **The health sector has a responsibility to quality of care.**
  - **The health sector has a critical role in preventing violence.**
  - **Health sector prevention and response programming can reduce the economic and development costs to societies of violence against women.**
  - **Health services for survivors are a basic human right.**

- **What are Key Elements of a Comprehensive Health Sector Approach to Violence against Women and Girls?**
  - **An evidence-base of good practices in health sector approaches to violence against women.**
  - **Key theoretical models for building a comprehensive approach.**
  - **The "systems" approach to health service delivery.**
  - **The "integrated" approach to health service delivery.**
  - **Adapting health sector approaches to different contexts and resource levels: from core services to comprehensive care.**

GUIDING PRINCIPLES

- **Overview of basic principles**
  - **Human rights-based approach**
  - **Survivor-centred approach**
  - **Quality of care approach**
  - **Medical ethics of care approach**
- **Standards for health service delivery**

INITIATING OR IMPROVING A NATIONAL HEALTH SECTOR STRATEGY

- **Conduct a situational analysis of the health sector.**
- **Create a multisectoral committee of stakeholders for coordinated action at the national and local levels.**
- **Ensure relevant laws are in place.**
- **Develop national and sub-national policies or action plans on a comprehensive health sector approach.**
- **Ensure protocols/guidelines are in place to support standardized implementation of national and sub-national policies.**
- **Create a national public health surveillance system.**
- **Ensure adequate funding for the health sector.**

DEVELOPING AND IMPLEMENTING HEALTH PROGRAMMES AT THE FACILITY LEVEL

- **Build institutional capacity of health facilities.**

- Identify the needs of the facility through an assessment.
- Develop policies, written protocols and strategies to support integration of services throughout facility.
- Conduct staff and sensitization training
- Build facility infrastructure
- Consider routine screening
- Ensure emergency and non-emergency services
    - 24-hour forensic examinations
    - Safety assessment and planning
    - Emotional care and support
    - Safe abortion
- Ensure medical records and an information system to document cases
- Establish a monitoring and evaluation framework for levels of service activity and quality of care
- Develop educational and informational materials and conduct community outreach about availability of support services
- Ensure coordination and referrals
- Develop community-based prevention programming
- Ensure funding

- **Integrate survivor support and assistance into reproductive health programmes.**
- **Link HIV/AIDS and violence against women and girls programming.**
    - Understand the linkages
    - Entry points for addressing HIV/AIDS and violence against women and girls
    - Conduct a situational analysis
    - Develop a framework for integrating health-related HIV/AIDS and violence against women and girls programming
    - Specific areas for integrated programming
    - Prevention programming targeting the dual pandemics

- **Develop specialized support services**
    - Sexual assault nurse examiner programmes
    - Intimate Partner Violence and/or Sexual Assault Centres (also referred to as One-Stop Centres)
    - Rape Crisis Centres

SPECIAL CONSIDERATIONS WHEN WORKING WITH SPECIFIC POPULATIONS

- Adolescents
- Women with disabilities
- Sex workers
- Migrants
- Trafficked women and girls

MONITORING AND EVALUATION

INTRODUCTION AND KEY CONCEPTS

1. Why is The Health Sector Critical in Addressing Violence against Women and Girls?

A. The health sector is a key entry point for survivors.

- The majority of women and girls who are survivors of violence may never report their victimization to anyone (UNIFEM, 2003a; WHO, 2009). However, those who experience and/or are at risk for violence are likely to seek out health services at some point in their lives, for routine care, sexual and reproductive health-related services, emergency treatment, etc. In fact, women who have experienced violence may be even more likely than non-victims to utilize medical services (Golding, 1988; Koss, Koss, & Woodruff, 1991; Kimmerling & Calhoun, 1994, cited in Weaver & Resnick, 2000; Campbell, 2002).
- Health care providers are therefore in a unique position to identify survivors and offer them appropriate treatment and referrals. In health care settings where providers are well trained, caring and sensitive, most women respond positively to being asked about their exposure to violence (Battaglia, Finley, & Liebschutz, 2003; McAfee, 1995; Littleton, Berenson & Breitkopf, 2007, cited in Stevens, 2007).
- Sexual and reproductive health services may be an especially important entry point for survivors of violence. The percentage of women and girls reporting violence can be higher among clients using sexual and reproductive health services than the percentages of women and girls reporting violence in population-based surveys (Luciano, 2007). The reasons for this may be diverse, but one common element among most sexual and reproductive health services – including ante-natal services, pregnancy testing, maternal and child health care, family planning, STI and HIV treatment– is that the women and girls who use these services have had unprotected sex. While many women and girls may have willingly participated in unprotected sex, a notable percentage may have had unprotected sex because they were in violent or coercive relationships. It may also be easier in sexual and reproductive health services to identify women and girls who have experienced abuse because service providers tend to follow clients over time.

The health sector has a responsibility to implement quality health services.

A. Violence against women and girls is a major cause of morbidity and mortality.

- Many women and girls do not typically seek out health care specifically related to their victimization, or do not acknowledge to health providers that they are seeking assistance because of victimization. Nevertheless, violence against women and girls is linked to many serious health problems, not only at the time the violence occurs but throughout life.

- Violence against women and girls is increasingly understood as a risk factor for a variety of diseases and conditions, and not just as a health problem in and of itself. Exposure to physical and sexual violence can result in a wide range of immediate and chronic health problems specifically related to the assault, and may also contribute to negative behaviours that affect long-term health and well being, such as smoking and alcohol and drug abuse (Brener, McMahon, Warren, & Douglas, 1999).

EXAMPLES OF FATAL OUTCOMES RELATED TO SEXUAL VIOLENCE AND INTIMATE PARTNER VIOLENCE
• Homicide • Suicide • Maternal mortality • Infant mortality • AIDS-related

EXAMPLES OF NON-FATAL OUTCOMES RELATED TO SEXUAL VIOLENCE AND INTIMATE PARTNER VIOLENCE				
Acute Physical Health	Chronic Physical Health	Reproductive Health	Mental Health	Social Health/Well-being
• Injury • Shock • Disease • Infection	• Disability • Somatic complaints • Chronic Infections • Chronic Pain • Gastrointestinal Complaints • Eating Disorders • Sleep Disorders • Alcohol/drug abuse • Headache • Fatigue • Fybromyalgia • Obesity or Anorexia	• Miscarriage • Unwanted pregnancy • Unsafe abortion • STIs including HIV • Menstrual disorders • Pregnancy complications • Gynaecological problems (e.g. pelvic inflammatory disease) • Cervical cancer • Sexual	• Post-traumatic stress • Depression • Anxiety, fear • Anger, aggression • Shame, insecurity, self-hate, self-blame • Suicidal thoughts • Low self-esteem	• Isolation • Stigma • Loss of role functions in society (e.g. caring for children, earning an income) • Sexual risk-taking

		disorders		

Sources: For health consequences of sexual violence and intimate partner violence identified above, see Campbell, 2002; Heise and Garcia-Moreno, 2002; Ellsberg, 2006; Garcia-Moreno and Stöckl, 2009; World Bank Gender-Based Violence, Health and the Role of the Health Sector website page.

- Violence against women and girls can also have an impact on maternal health and infant and child morbidity and mortality. Although violence is often not a part of health screening, when it has been included as a part of antenatal care, intimate partner violence during pregnancy is among the common conditions identified (Ellsberg, 2006). Violence and has been associated with adverse pregnancy outcomes, such as low birth weight, premature labour, pre-term delivery, miscarriage, and foetal loss (Campbell, Garcia-Moreno, and Sharps, 2004; Ellsberg et al., 2008; Garcia-Moreno, 2009).

- Girls who experience sexual abuse in childhood may be more likely to engage in sexual risk-taking later in life, compounding their long-term risk of sexually transmitted diseases and early pregnancy (WHO, 1997, cited in Ward et al., 2005).

- Girls who are forced or coerced into child marriage (before the age of 18) are at risk for a variety of negative health outcomes. Complications from pregnancy and childbearing the leading cause of death for 15-19 year-old girls worldwide (Black, 2001, cited in Ward et al., 2005). Girls who marry early may also be at greater risk of intimate partner violence, especially in relationships where their husband is significantly older (Ward et al., 2005).

- Female genital mutilation/cutting (FGM/C), considered to be a form of violence against women and girls, also has a wide range of maternal and child health consequences.

Obstetric Sequelae of FGC/M in Earlier Life	**Childbirth Sequelae of FGC/M in Pregnancy**
Antenatal Effects: • Pregnancy in presence of pinhole introitus (small opening in the vagina that remains after infibulation) • Fear of labour and delivery due to small size of introitus • Difficulty in performing antenatal vaginal examination	Antenatal Effects: • Haemorrhaging • Infection • Foetal injury

• Painful scar	
Effects During Labour and Delivery: • Urine retention during labour • Difficulty assessing progress of labour • Prolonged labour and/or obstruction • Foetal distress • Episiotomies and perineal tears • Postpartum haemorrhaging • Maternal death • Foetal death • Post-partum genital wound infection	Effects During Labour and Delivery: • Pre-term labour • Obstruction requiring caesarean section • Difficult labour • Maternal death • Foetal death

Source: World Health Organization. 2000. *A Systematic Review of the Health Complications of Female Genital Mutilation Including Sequelae in Childbirth*. Geneva: WHO. See also the World Health Organization Female Genital Mutilation website page.

- Violence against women and girls also has a **social health dimension**: it can contribute to diminished functioning in relationships, families and the workplace, impacting overall capacity of survivors to fulfill their potential and engage with and contribute to society (Golding, 1996).

Additional Resource:

- See an overview by the World Health Organization of the health effects of various types of violence against women.

B. Survivors who visit health clinics where providers are not trained to recognize and address violence against women and girls may be misdiagnosed or otherwise receive inappropriate care.

- If health care providers are not well-trained in the consequences of violence against women and girls, they may not be able to detect the indicators of abuse, preventing them from effectively treating the survivor and/or providing appropriate referrals for emotional, legal, housing and other services that can support survivors and end the abuse.

- Health care providers who themselves have experienced abuse and do not have sufficient professional training and support may avoid addressing the issue with survivors who present for assistance.

- Overlooking the health implications of violence is not just a missed opportunity. It is a violation of medical ethics. Providers may fail to provide holistic care, to recognize women in danger, or to provide necessary, even life-saving care, such as STI treatment and/or post-exposure prophylaxis for HIV.

- In addition, providers who are not trained in addressing violence against women and girls may respond to clients who report violence with victim-blaming attitudes that may inflict further emotional harm (Kim and Motsei, 2002) and discourage women from seeking treatment. At the very minimum, health care providers should seek to 'do no harm' when engaging with survivors so as not to revictimize those who have experienced violence.

- When health care providers are not trained in the guiding principles of working with survivors, such as when providers do not protect patient confidentiality, women and girls may be at risk of additional violence from partners and/or family members (World Bank, 2002).

C. The health sector has a critical role in preventing violence.

- The health sector can play a critical role in preventing violence by changing attitudes and behaviours that contribute to violence against women and girls, not among health care providers and other health staff, but also in the wider community.

- On a **national level**, the health sector can develop national laws and policies, ensure funding, and conduct public health campaigns to raise awareness that violence against women is unacceptable.

- At the **institutional level**, health providers can develop prevention programming targeting local communities.

- **Within health institutions**, providers and other health staff can participate in training to challenge harmful attitudes of health workers and ensure that staff interactions with survivors are supportive, non-blaming, and grounded in human rights-based and survivor-centred approaches. Health institutions can also reflect the unacceptability of violence against women and girls by providing informational media, such as pamphlets and posters, in hospital and clinic waiting areas.

- As extension and mobile workers, health providers can participate in radio programmes and community fora (e.g. special events, visiting schools and

workplaces). This can also build confidence in the health sector's response and encourage survivors to come forward, disclose the abuse they have experienced and receive care and referrals.

- Many other responsibilities of the health sector that may not be directly understood as violence prevention work can nevertheless contribute to overall efforts to address violence against women, some of which are highlighted below:

Box 4

Violence and injury prevention: the role of the health sector

Core tasks

- Develop a surveillance system to capture incidence and prevalence of injuries;
- Collect, analyse and disseminate data on the magnitude and health consequences of violence and injuries;
- Advocate for action to prevent and control violence and injuries;
- Contribute to policy development on violence and injury prevention;
- Make available the preventive services that are based in the health sector;
- Provide pre-hospital emergency care in coordination with the police and other emergency services;
- Provide emergency care for the injured in health facilities;
- Provide rehabilitation services for those who have been injured;
- Evaluate intervention activities related to violence and injury prevention using a science-based approach;
- Support and/or provide facilities for forensic assessment, in particular, in cases of sexual violence;
- Train pubic health and health-care providers in injury prevention and care.

Additional tasks

- Collect data on risk and protective factors;
- Design and implement information, education and communication activities to prevent violence and injuries;
- Lead policy development;
- Ensure leadership and coordination;
- Advocate for changes to existing legislation;
- Recommend new regulations;
- Perform research.

Excerpted from: World Health Organization, 2005a. "Developing National Policies to Prevent Violence and Injuries: a Guideline for Policy-Makers and Planners," p.11.

Additional Resources:

- For more information on prevention, see the general overview on primary prevention and dedicated module on primary prevention.
- ***Preventing intimate partner and sexual violence against women: taking action and generating evidence*** (World Health Organization/London School of Hygiene and Tropical Medicine, 2010).
- ***Violence Prevention Website*****.** Available in English**.**

- **Prevention Connection Website.** Available in English.
- **Prevention Institute Website.** Available in English.

D. Health sector prevention and response programming can reduce the economic and development costs of violence against women to societies.

1. Violence against women and girls is costly to societies.

- Improving efforts to address violence against women and girls is critical not only because women and girls have a right to live free from violence, but also because violence incurs considerable social and economic costs. It not only impoverishes individuals, it contributes to the impoverishment of communities and nations through:
    - Lost workdays, lower productivity and lower income;
    - Overall reduced or lost educational, employment, social or political participation and opportunities;
    - Expenditures (at the level of individual, family and public sector budgets) on medical, protection, judicial and social services.
- Violence against women and girls drains a country's existing resources and handicaps women's ability to contribute to social and economic progress. In some industrialized settings, the annual costs of intimate partner violence have been estimated in the billions of dollars. State expenses for one act of rape in the United States, when accounting for both tangible and intangible costs, may amount to US $100,000 (Post et al., 2002, cited in Ward et al., 2005).
- The health sector is directly affected by these costs, especially when taking into account the extra burden that caring for survivors of violence places on it.
    - In Uganda, the annual cost for hospital staff treating women for intimate partner violence-related injuries is US $1.2 million (ICRW, 2009).
    - In just one hospital in Kingston, Jamaica, it was estimated that treating victims of intimate partner violence cost almost half a million dollars as far back as 1991 (World Bank Gender-Based Violence, Health and the Role of the Health Sector website page).
    - In a first-ever study (2002) to estimate the disease burden of intimate partner violence, Australia found that for women under the age of 45, IPV was responsible for more preventable ill-health and premature death than high blood pressure, obesity or smoking (State Government of Victoria, Australia Victorian Health Promotion Foundation, 2004).
    - The costs of intimate partner violence in the United States were over $5.8 billion each year, $4.1 billion of which is for direct medical and mental health care services (CDC, 2003).

Additional Resources:

- **Costs of Sexual Violence Worksheet** (Minnesota Department of Health). This worksheet, can be used by programme implementers and advocates to raise awareness about the costs of violence against women in the cities. This information can be used to demonstrate that preventing gender-based violence is much more cost-effective than allowing it continue. Available in English.

- See Consequences and Costs in the Programming Essentials Module for additional statistics and for illustrative costing reports and tools.

2. Responding to and preventing violence against women and girls is a key strategy to help to achieve the health-related Millennium Development Goals.

- The Millennium Declaration (2000) adopted by 189 nations acknowledges that in order to achieve the Millennium Development Goals (MDGs), it is necessary to "combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women" (United Nations General Assembly. United Nations Millennium Declaration. Resolution *A/55/L.2).* The Secretary-General of the United Nations also launched an unprecedented campaign, *UNiTE to End Violence against Women* in 2008 running to 2015 in alignment with the deadline of the Millennium Development goals. Violence against women and girls negatively impacts the achievement of all of the MDGs, not only to the extent that gender equality is cross-cutting priority in each of the MDGs, but also in terms of the direct impact that violence against women and girls has in realising six of those goals. (See also the Violence against Women and the Millennium Development Goals in the Programming Essentials module.)

- The MDGs specifically target health issues such as reducing child mortality, improving maternal health, and combating HIV/AIDS, all of which cannot be accomplished without addressing the problem of violence against women and girls.

- In order to support the realization of the MDGs, the health sector must understand the links between achieving the MDGs and addressing violence against women.

Violence Against Women and Girls and the Health-related Millennium Development Goals

Goal 4: Reduce child mortality.
Violence against women and girls has direct links to child mortality. In addition to the estimated millions of girls who are 'missing' due directly to gender-discriminatory practices such as sex-selective abortion, female infanticide and differential feeding, evidence has indicated that children of women who suffer violence in intimate relationships are significantly more likely to die before the age of five. The practice of early marriage increases the risk of child mortality: If a girl is under the age of 18 when she gives birth, her baby's chance of dying in his/her first year of life is 60 percent higher than that of a baby born to a mother over the age of 18 (Black, 2001, cited in Ward et al., 2005).

Goal 5: Improve maternal health.
Intimate partner violence during pregnancy is among the common conditions identified in antenatal screening (Ellsberg, 2006), and has been associated with adverse pregnancy outcomes, such as low birth weight, premature labour, pre-term delivery, miscarriage, and foetal loss (Campbell, Garcia-Moreno, and Sharps 2004; Ellsberg et al., 2008; Garcia-Moreno, 2009). Early marriage and early childbearing also pose direct risks to maternal health: A leading cause of death for 15- to 19-year-old girls worldwide is complications from pregnancy and childbearing. Data indicates that for every girl who dies during pregnancy or childbirth, 30 more will suffer injuries, infections and disabilities (Black, 2001).

Goal 6: Combat HIV/AIDS, malaria and other diseases.
The 'feminisation' of HIV/AIDS, particularly in sub-Saharan Africa and particularly among adolescent girls and young adult women, may be directly linked to multiple forms of violence against women, ranging from sexual assault and exploitation to intimate-partner violence. Girls in abusive relationships, for example, are less likely to be able to negotiate condom use and are also less likely to access treatment for sexually transmitted diseases, including HIV.

Research conducted across Africa and India has found that women who have experienced abuse by their partner are more likely to be infected with HIV (Van der Straten A et al. 1995 and 1998; Maman S et al., 2002; Dunkle KL et al., 2004; Jewkes R et al., 2010). For girls who marry young, the risk is even greater: studies indicate that HIV rates are higher among married young women than among their unmarried female counterparts (Black, 2001; Otoo-Oyortey and Pobi, 2003).

See also **The Facts: Ending Violence Against Women and Millennium Development Goals** (compiled by UNIFEM, 2010). Available in English, French, and Spanish.

Excerpted from: Ward, 2007 and adapted from "Strengthening Women's Rights: Ending Violence against Women and Girls –Protecting Human Rights", Deutsche Gesellshaft fur Technische Zusammenarbeit (GTZ), (Eschborn, 2006), pp. 26-31.

E. Health services for survivors are a basic human right.

- A growing body of policy commitments and international and regional agreements hold governments accountable for addressing violence against women as a human right. It is critical that health care providers know and understand these commitments and agreements as the basis for applying a human rights-based approach to their work and meeting the obligations that human rights instruments outline.

- Health care providers must also understand the ways in which the cultures and communities in which they live do not uphold these rights, as well as the structural and cultural factors that contribute to violence against women and girls. Without this understanding, they cannot provide care that is compassionate, comprehensive, and effective.

- Because discriminatory beliefs regarding gender and sexuality are so pervasive in most cultures, the task of integrating attention to violence against women and girls into health services is long-term. Addressing gender inequality demands investment in cultural transformation among all those working in the health system.

II. What are key elements for a comprehensive health sector approach to violence against women and girls?

A. An evidence-base of good practices in health sector approaches to violence against women.

- While a great deal of knowledge has been accumulated about key aspects of health programming to address violence against women, the relative lack of evaluations of programming efforts worldwide means that the evidence upon which to build a comprehensive health approach is still insufficient.

- Even so, there have been several evaluations—most of them small-scale—that focus on various aspects of health interventions (including primary prevention and better responses) to address violence against women. These evaluations include:

    - IPPF/WHR Regional Initiative, Latin America
    - PAHO/PATH, Latin America
    - Stepping Stones, South Africa
    - Radar/IMAGE, South Africa
    - Minga Peru, Peru
    - Queen Mary's School of Medicine and Dentistry, United Kingdom

- Drawing from lessons learned through these and other programs, approaches to address violence against women and girls within the health sector should in general reflect and be situated within overarching strategies for ending violence against women and girls. Key elements of an overarching strategy are described in the Programming Essentials module, and include:

    - Investing in gender equality and women's empowerment, including changing gender norms and working with men and boys
    - Developing and/or reforming legislation
    - Ensuring holistic multisectoral policies and national plans of action
    - Securing resources and budgets
    - Promoting primary prevention (across different sectors)
    - Strengthening key sectors
    - Developing coordinated community responses
    - Engaging key groups
    - Capacity development
    - Conducting research, data collection and analysis
    - Monitoring and national accountability

- In addition to these overarching strategies, specific health-sector strategies include:

    - Utilizing a system-wide approach in health facilities, including attention to the policies, protocols, infrastructure, supplies, staff capacity to deliver quality medical and psychosocial support, staff training and other professional development opportunities, case documentation and data systems, the functioning of referral networks, safety and danger assessments, among other items that are relevant to specific contexts and programmes.
    - Advancing laws, policies and protocols to support comprehensive care to survivors and ensuring that health care providers understand the relevant laws, policies, and protocols
    - Investing in equipment and supplies necessary for comprehensive care
    - Ensuring quality response, for example through one-stop centres, integrated services within a facility or referrals to other health facilities and non-health services (e.g. police, social and legal support)
    - Establishing standardized data collection and management systems within and across health facilities
    - Institutionalizing health provider training
    - Increasing availability of forensic exams, for example through nurse examiners
    - Improving monitoring and evaluation for quality of care

- Providing community education about violence against women and availability of services
- Addressing the needs of specific populations, including adolescents, women and girls with disabilities, sex workers, indigenous populations or ethnic minorities, and HIV positive women, among others.

- It is also critical that the health sector understand specific responsibilities related to the type of violence being addressed.

- For example, the following framework proposes key aspects of a **comprehensive approach to post-sexual violence services**:

Framework for a comprehensive model of care, support and prevention of SGBV

1. Medical management of sexual violence at point of first contact with the survivors.
2. Psychological counselling of rape survivors.
3. Sensitive approaches to managing child survivors of sexual violence (of both sexes), and to encouraging and enabling presentation by male survivors.
4. Collection of forensic evidence (at health facility during medical management and/or at police station) and creation of a chain of evidence that can be used during a prosecution.
5. Strong links between police and health facility to enable incidents to be referred in either direction so that, if desired, a prosecution can be initiated. Ensure prosecutions initiated by the police are sustained through the judiciary.
6. New or strengthened community-based prevention strategies that are relevant and appropriate for the local context and that are directly linked to the nearest medical/police structures.
7. Physical (and psychological/emotional) violence between domestic or intimate partners addressed through:
   a. Messages communicated during the prevention strategies;
   b. Screening for signs and symptoms of such violence during routine health consultations.

Excerpted from Population Council, 2008b. *Sexual and Gender Based Violence in Africa: A Literature Review*, pg. 2.

- For **intimate partner violence**, key actors within the health sector might have the responsibilities described below (organized by the levels in the health system, from individual providers up to the Ministry of Health):

TABLE 1. Ways of addressing inimate partner violence, according to type of provider

Nurse/health worker	Clinic/care setting	Hospital	Ministry of Health
Being informed about the types, extent and underlying causes of violence	Developing policies on violence against women	Accepting referrals and acting as a reference point for clinic/case facilities implementing policies to address violence against women	Publicly condemning violence against women
Screening for abuse during reproductive health consultations	Ensuring private space is available when needed for consultations	Developing protocols on the management of rape, child sexual abuse and other forms of violence	Being informed about types of violence, underlying causes and consequences
Supporting women emotionally by validating their experiences, and by being nonjudgmental and willing to listen	Displaying posters/leaflets condemning violence against women	Ensuring staff are appropriately trained to handle rape, child sexual abuse and other forms of violence	Supporting the development of policies and protocols on different forms of violence against women
Providing appropriate clinical care (e.g., emergency contraception, pregnancy testing, and STI/HIV testing and treatment)	Supporting staff interested in helping women who have experienced violence, and promoting staff access to appropriate training	Developing statements on the unacceptability of violence	Incorporating specialized curricula on violence against women into health worker training
Documenting the medical consequences of violence	Supporting staff who have experienced partner violence	Supporting staff interested in helping women who have experienced violence, and promoting staff access to appropriate training	Monitoring and evaluating initiatives to address intimate partner violence
Maintaining confidentiality	Creating links with other local organizations working to address gender violence	Being active in multisectoral initiatives on intimate partner violence	Being active in multisectoral initiatives on intimate partner violence
Referring women to community services and resources, if they exist			

Excerpted from Watts and Mayhew, 2004. "Reproductive Health Services and Intimate Partner Violence: Shaping a Pragmatic Response In Sub-Saharan Africa." *International Family Planning Perspectives 30*, no. 4, p. 210.

Additional Resources:

- **Gender-Based Violence, Health and the Role of the Health Sector** (World Bank). Available in English.

- "**Addressing Gender-Based Violence: A Critical Review of Interventions**", *The World Bank Observer*. 2007; 22: 25-51 (Morrison, A., Ellsberg, M. and Bott, S., 2007). Available in English.

- "**Tackling Domestic Violence: Effective Approaches and Interventions**", Home Office Research Study, no. 290, Home Office, London (Hester, M., and Westmarland, N., 2005). Available in **English.**

B. Key theoretical models for building a comprehensive approach.

- There is no single model for addressing violence against women and girls within the health sector, which is related to the lack of an evidence-base for comprehensive health sector programming. . However, there are several overlapping and inter-related models that have been used globally and that are important for those working in the health sector to know and understand. The ecological model, the multisectoral approach, and an integrated model for services described below are all strategies to adopt when trying to respond to GBV. The multisectoral approach references the agency and sector level, while the ecological and integration models reference the health service-delivery level.

- These models can inform the development of health sector action plans, policies and protocols. They can also inform the practical approaches that are relevant to different country and health programming contexts.

1. The ecological model: from individual response to social change.

- The ecological model, described in detail in the module on Primary Prevention, provides a method for understanding some of the key factors that contribute to women's and girls' risk of violence. The model is organized in terms of four levels of risk: individual, relationship, community, and society. The model highlights the importance of understanding the complex interplay of biological, psychological, social, cultural, economic and political factors that increase women's and girl's likelihood for experiencing violence (and men's likelihood for perpetrating violence).

Table 1: Risk Factors for Violence based on the Ecological model

Societal	Community	Relationship	Individual
Broad factors that reduce inhibitions against violence	Neighborhood, schools and workplaces	With family, Intimate partners and friends	Personal factors that influence individual behavior
■ Poverty ■ Economic, social and gender inequalities ■ Poor Social Security ■ Masculinity linked to aggression & dominance ■ Weak legal and criminal justice system ■ Perpetrators not prosecuted ■ No legal rights for victims ■ Social and cultural norms support violence ■ Small fire arms ■ Conflict or post-conflict ■ Internal displacement & ■ Refugee camps	■ High Unemployment ■ High population density ■ Social isolation of females & family ■ Lack of information ■ Inadequate victim care ■ Schools & workplaces not addressing GBV ■ Weak community sanctions against GBV ■ Poor safety in public spaces ■ Challenging traditional gender roles ■ Blaming the victim ■ Violating of victim confidentiality	■ Family dysfunction ■ Inter generational Violence Poor parenting practices ■ Parental conflict involving violence ■ Association with friends who engage in violent or delinquent behavior ■ Low socio-economic status Socio-economic stress ■ Friction over women's empowerment ■ Family honor more important than female health and safety	■ Gender, age & education ■ A family history of violence ■ Witnessing GBV. ■ Victim of child abuse or neglect ■ Lack of sufficient livelihood & personal income ■ Unemployment ■ Mental health and behavioral problems ■ Alcohol & Substance abuse ■ Prostitution ■ Refugee Internally displaced ■ Disabilities ■ Small fire arms ownership

Sources: Buvinic, Morrison and Shifter 1999; Heise and Garcia Moreno 2002; Jewkes, Sen and Garcia Moreno 2002; Krug et al 2002; *http://www.dcp2.org/pubs/DCP/40/Table/40.3*

- Health care providers can use the ecological model not only to understand the risk factors that affect women and girls in the communities in which they live, but also to consider what interventions they should undertake in order to address and reduce risks at these different levels.

- The ecological model highlights the fact that if the health sector is going to effectively implement violence prevention and response programming, it will have to consider all of the factors that contribute to its perpetration, and develop strategies for identifying and caring for those at risk, as well as for reducing and/or eliminating risk through broad-based prevention programming. Using the ecological model can help health care providers shift from a individualistic, bio-medical orientation to service delivery, to a more holistic approach to health interventions that not only target individual health needs, but also address the need for social change.

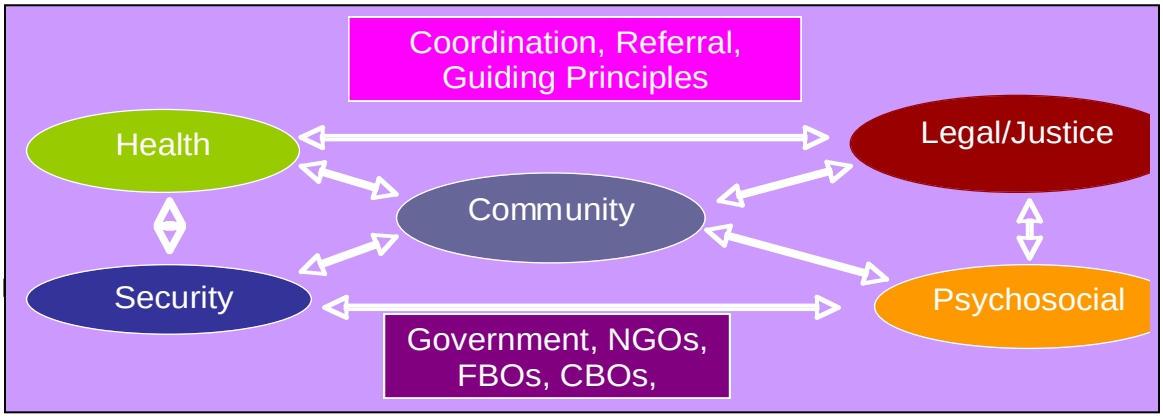
Level	Examples of Selected Risk Factors Related to Violence	Examples of What the Health Sector Can Do	Programming Examples
Individual	• Young age • Early age of marriage • Isolation • Substance abuse • Individual attitudes that justify and/or accept violence	• Screening young girls who are married for risk of violence • Substance abuse services • Clinic and community-based education efforts (theatre, videos, pamphlets, talks, etc.) • Gender-based violence prevention within HIV/AIDS and adolescent reproductive health programs	Program H Stepping Stones Puntos de Encuentro
Relationship	• Marital conflict and instability • Male infidelity and polygamy • Male dominance in the family and/or controlling behaviour by male partners	• Programs for men aimed at promoting gender equitable relationships and changing norms, attitudes and behaviours	Men as Partners Also see the module on Men and Boys
Community	• Community norms and beliefs that justify, excuse, or facilitate violence against women and girls • Weak institutional responses to violence against women and girls • Lack of support systems for women in the community	• Strengthen community support for survivor services • Strengthen coalitions and networks	SAGBVHI Minga Peru CHARCA SASA!

Society	• Lack of legal systems to address violence against women and girls • Society-wide social norms and cultural beliefs that justify, excuse, or facilitate violence against women	• Reforms of laws and policies regulating the medico-legal system (e.g. introduction of forensic nurses) • Reform of laws and policies regulating health care provider's obligations vis-à-vis victims of gender-based violence • Mandatory reporting laws/policies • National health policies and protocols • Laws/policies governing forensic medicine; provider obligations, abortion, EC and patient confidentiality	See Review laws and policies below, as well as the module on Developing Legislation on Violence Against Women and Girls

2. The multisectoral framework: engaging all stakeholders in prevention and response.

- Programming experiences from the field have revealed that no single sector or agency can adequately address violence against women and girls. The multisectoral model calls for holistic inter-organizational and inter-agency efforts that promote participation of those affected by or at risk of violence, interdisciplinary and inter-organizational cooperation, collaboration and coordination across key sectors including (but not limited to) health, psychosocial, legal/justice and security (Ward, 2005). Sectors include all the institutions, agencies, individuals and resources that are targeted towards a specific goal (e.g., the health sector includes the Ministry of Health, hospitals, health care centres, health care providers, health care administrators, health care training institutions, health supplies, etc.).

- The multisectoral model draws from models of a 'coordinated community response' to domestic violence originally introduced in industrialized settings and now being used throughout the world. In general, the multisectoral model is the equivalent of applying a coordinated community response at the national level.



- The multisectoral model explicitly highlights responsibilities unique to each sector. Members of the health sector must not only understand their role in promoting a multisectoral framework, they must also have a basic understanding of the some of the key roles and responsibilities of other relevant sectors. The following is a brief summary of some of those roles and responsibilities.

- The **health sector** should train providers across a wide variety of health services to recognize and address violence against women and girls; ensure same sex interviewers for individuals who have been exposed to violence; respond to the immediate health and psychological needs of the woman or girl who has been exposed, including safety planning; institute protocols for treatment, referral and documentation that guarantee confidentiality; provide violence -related services free of cost; and be prepared to provide forensic evidence and testimony in court when authorized by the individual.

- The **psychosocial sector** should be able to provide immediate support (e.g. through support groups); information on what the woman's rights are and where she can seek recourse if she desires; ongoing psychological assistance, which requires the training and on-going supervision of social workers and community services workers; and facilitate referrals for other services as necessary. Education and income-generation supports are also considered under the umbrella of psychosocial programming within this multisectoral model. Education systems should ensure curricula on "safe touch," healthy relationships, and basic human rights; institute codes of conduct for all teachers as well as training on identifying risk signs among children; and provide school-based services for children who have been exposed to violence. Income-generating projects should not only promote women's economic self-sufficiency, but also monitor for domestic violence risks and integrate human rights education into project activities.

- The **legal/justice sector** should be able to provide free or low-cost legal counselling, representation and other court support to women and girls who have been exposed to violence; review and revise laws that reinforce violence against women and girls; enforce laws that protect women and girls and punish perpetrators; monitor court cases and judicial processes; provide orders of protection and other legal safety mechanisms for survivors; and monitor perpetrators' compliance with court-ordered rehabilitation (e.g., batterer programmes).

- Within the **security sector** police, military and other security personnel should be educated about violence against women and girls and be trained on how to appropriately intervene in cases of violence against women and

girls. Police should have private rooms to ensure confidentiality and safety of survivors reporting victimization; ensure same sex interviewers; institute protocols for referrals to other sectors; collect standardized and disaggregated data on incidents; and create specialized units to address violence against women and girls.

- Some of the **crosscutting functions** of each of the sectors include engagement and education of the community, safe and confidential data collection, and monitoring and evaluation. Another critical component is inter- and intra-sectoral coordination, including the creation and monitoring of reporting and referral networks, information sharing, and participation in regular meetings with representatives from the various sectors.

- A key principle underlying the multisectoral approach is that the **rights and needs of survivors are pre-eminent**, in terms of access to respectful and supportive services, guarantees of confidentiality and safety and the ability to determine the course of action for addressing the incident.

- Another essential element of the multisectoral approach is close cooperation with **local women's groups**. Women and girls must be included from the beginning of programme design and maintain an active role throughout programme monitoring, evaluation and on-going programme development. (See guiding principles for more information.)

3. The "systems" approach to health service delivery.

- Whereas the ecological model underscores the importance of a society-wide approach to understanding and addressing **risk factors** linked with violence against women and girls, and the multisectoral framework highlights the **responsibilities within and across key sectors** for prevention of and response to violence, the "systems" approach speaks directly to the responsibilities across relevant health service-delivery organizations to develop effective, efficient and ethical services.

- This approach **focuses on developing resources and skills across an entire organization**, not just training individual providers (Heise, 1999 cited in Bott et al., 2004; USAID, 2006). Key elements of a systems approach might include:

The following table is adapted from *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries* (Bott et al., 2004).

Key elements	Why this element is important
Strengthen the institutional commitment to address gender-based violence	The overall commitment of an institution can have a powerful influence on the professional culture of healthcare organizations. Ideally, senior managers should recognize GBV as a public health problem and a human rights violation and support the effort to improve the health service response to violence. The work environment should promote respect for all staff members, including women and subordinates, and demonstrate a commitment to nonviolence with a policy prohibiting sexual harassment in the workplace.
Collaborate with other organizations actively addressing GBV	Addressing GBV requires multidisciplinary action. Because a single organization may not be able to carry out or fund all required steps, institutions need to collaborate to assess the existing situation and decide what piece of the puzzle each one can take on. The inability to undertake all necessary steps should be a motivating factor to collaborate rather than a justification for not addressing the issue.
Strengthen privacy and confidentiality for all women who come for health services through infrastructure improvements and clinic policies	Privacy and confidentiality are essential for women's safety in any healthcare setting. Breaching confidentiality about pregnancy, HIV status, and other issues may unwittingly put women and girls at risk of future violence. Moreover, women need privacy and confidentiality to disclose GBV without fearing retaliation. Programs need to ensure that consultation rooms cannot be overheard from outside; that clinic procedures do not require women to share personal information in public areas, such as the reception area; and that policies outline when and where providers may discuss personal information about clients.
Improve health workers' and law enforcement's understanding of local and national laws and policies regarding violence against women and the health sector	Both managers and service providers need to be familiar with laws about GBV, including what constitutes a crime, how to preserve forensic evidence, how to report violence, whether and how women can obtain protection orders, what women need to do if they wish to separate from a violent spouse, and what healthcare providers are legally required to do when they detect a case of childhood sexual abuse. This knowledge allows health workers to provide accurate information to survivors and to ensure the collection of forensic evidence (when applicable). This knowledge may also alleviate providers' concerns about getting involved in legal proceedings.
Improve providers' knowledge, attitudes, and skills through sensitization and training	All women's healthcare providers need to be prepared to respond to disclosures of GBV with compassion and skill. Even when providers do not ask about violence, women may disclose such experiences voluntarily. Providers who respond poorly can inflict great emotional harm or fail to provide essential medical care. Moreover, ignoring the possibility that women live with violence may make it impossible for providers to counsel women effectively about contraception, HIV prevention, or to treat health conditions such as recurrent STIs. Each institution must decide how much training it can afford to provide. At a minimum, staff should understand the epidemiology of GBV and the needs of survivors. Organizations should also offer emotional support to providers working in the area of violence.
Strengthen referral networks and facilitate survivors access to other services	Because it is difficult for a single organization to address all of survivors' needs, health programs should investigate local social and legal services, compile this information for health providers, and build referral networks to facilitate survivors' access. Additionally, organizations can consider implementing in-house services, including low-cost interventions such as support groups for women and girls, which have been identified as an important intervention by survivors. Networks and alliances also allow the health sector to play a role in the broader policy debate by raising awareness of violence against women as a public health problem.

Key elements	Why this element is important
Develop or improve written institutional policies and protocols for caring for women who have experienced violence	Health programs should develop written protocols for staff that outline how to ask about violence, care for women and girls who disclose violence, and refer women and girls for specialized services (e.g., see Warshaw and Ganley, 1998; Bott et al., 2004). Clear, written policies can reduce the risk of harm to patients posed by negative attitudes from staff, especially if they are developed with the participation of frontline providers and management. Although many prototypes already exist, such policies work best if they are adapted to the particular context of each institution.
Ensure the provision of emergency services and supplies	Women who experience violence may need emergency services and supplies, including first aid, STI prophylaxis (in some settings HIV prophylaxis), forensic exams, emergency contraception (where access is supported by the government), and so forth. Health programs need to have the necessary supplies and to train providers to use them.
Ensure/improve educational materials available to clients on topics related to GBV	Displaying and distributing posters, pamphlets, and/or cards about GBV can be an important way to indicate the organization's commitment to combating violence, as well as to raise awareness of the problem, educate clients, and inform women about their legal rights and where they can turn for help.
Strengthen medical records and information systems to enable staff to document and monitor cases of GBV	Information systems play an important role in the response to GBV. Documenting information about violence in medical records may be an important way to ensure that women's medical records are complete, and in some cases may provide evidence for future legal proceedings. To protect women's safety and well being, records need to be securely stored. Information systems are also important for monitoring a health organizations' work in the area of GBV. Healthcare organizations can gather service statistics on the number of women identified as victims of violence to help determine the demand for services.
Ensure adequate monitoring and evaluation related to GBV	Monitoring and evaluating quality of care is another essential way to ensure that health services are responding to violence appropriately. At the level of management, administrators should receive ongoing feedback from providers to identify problems and ways to improve the services. The input of women who have experienced violence can be crucial for successfully refining the design of health services. Programs should also make an effort to document unanticipated consequences.

Excerpted from USAID, 2006. *Addressing Gender-Based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers*. Washington, DC, pp. 26-27. **and adapted from** Bott, S., Guedes, A., Claramunt, C., and Guezmes, A., 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries.* New York: International Planned Parenthood Federation, Western Hemisphere Region. Available in English and Spanish.

Case Study: The International Planned Parenthood Federation/ Western Hemisphere Region (IPPF/WHR) Regional Initiative to Address Gender-Based Violence

Following the International Conference on Population and Development in Cairo, 1994 (ICPD), The International Planned Parenthood Federation/ Western Hemisphere Region took steps to help member associations incorporate a new vision of sexual and reproductive health and to improve the quality of service delivery programmes by integrating a gender perspective. Within this context, the International Planned Parenthood Federation/Western Hemisphere Region carried out trainings and evaluations focused on gender to raise consciousness among association staff. During this process, clients and providers repeatedly mentioned physical and sexual violence as an issue that merited attention. This led to the **Regional Initiative to Address Gender-Based Violence** which was carried in four member associations in Latin America: Profamilia (the Dominican Republic), INPPARES (Peru), and PLAFAM (Venezuela), with some participation from BEMFAM (Brazil). Exemplifying a "systems approach", the initiative involved the following four components:

1) Improving the capacity of sexual and reproductive health service delivery programmes to care for women who experience violence;
2) Raising awareness of violence against women as a public health problem and a violation of human rights;
3) Advocating for better laws and application of the laws related to gender-based violence and;
4) Increasing knowledge about effective health service interventions in the area of gender-based violence.

The first objective, strengthening the health service response, involved a broad package of reforms throughout the organizations. This was done in a variety of ways. In some affiliates, services already existed (such as emotional support units), but were strengthened through training and the implementation of institutional policies. In other cases, affiliates had to hire staff capable of providing the needed assistance. In some locations, International Planned Parenthood Federation member associations were able to establish partnerships with existing non-governmental organizations to which they could refer women for specialized services, such as in the Dominican Republic, where women were referred to two non-governmental organizations (depending on their city of residence) that provided legal counselling. To ensure a thorough evaluation of the initiative, the participating facilities developed baseline, midterm, and follow-up studies using standardized indicators and instruments as well as systems for gathering service statistics on screening levels, detection rates, referrals, and specialized services. Each association documented case studies on pilot services, and regional office staff monitored the work of the associations through site visits and informal interviews with providers, managers and clients. The initiative was funded by the European Commission and the Bill and Melinda Gates Foundation. Additional support was provided by the Ford Foundation and the MacArthur Foundation. (Excerpted from: Guedes, 2004)

See additional information and access the evaluation findings in English.

See the tools produced under the initiative:

Tools for Service Providers Working with Victims of Gender-Based Violence: This series of tools assists health providers with detection of gender-based violence, data collection, and monitoring and evaluation. Available at:

Improving the Health Sector Response to Gender-Based Violence: Produced in collaboration with the Pan American Health Organization (PAHO) and the "UNITE to End Violence against Women" campaign, this manual provides tools and guidelines for health care managers in order to improve the health care response to violence against women in developing country settings. It includes practical tools to determine provider attitudes to gender-based violence, legal definitions and responsibilities, and quality of care. This manual is based on the experiences of the International Planned Parenthood Federation/Western Hemisphere Region initiative to integrate services for victims of gender-based violence into sexual and reproductive health programmes.

¡Basta! Women Say No to Violence: This video is intended as a general sensitization tool on the issue of gender-based violence, providing key definitions and addressing some of the most common myths about gender-based violence.

¡Basta! The Health Sector Addresses Gender-Based Violence: This training video for health care providers and others who may be in a position to help women living in situations of violence, frames the issue of violence against women as a human rights violation and a public health problem.

Using a Systems-model Approach to Domestic Violence Prevention Services in a Health Care Setting in the United States

Kaiser Permanente Northern California's Family Violence Prevention Program in the United States sought to improve the identification, prevention, and treatment of domestic violence by treating it as a serious health condition and using a "systems model" approach. The components of the programme using this approach included the creation of a supportive environment that encourages patients to disclose domestic violence to their providers, routine inquiry of patients, and referrals to mental health providers and community advocates for survivors of domestic violence.

The programme led to a fivefold increase in the number of patients identified as being victims of domestic violence. Of these patients, a high percentage received follow up services with high levels of patient satisfaction reported across the 25,000 members surveyed.

The Kaiser Permanente "systems model" approach and tools have been adapted and upscaled for use across numerous clinical settings including: expansion to all eight Kaiser Permanente regions and other health services across the United States; in community clinics across Bangalore, India; and to inform domestic violence services in Dunedin, New Zealand.

Read the full case study and download the additional resources.

Source: Brigid McCaw, MD, MPH, MS (Brigid.McCaw@kp.org) Medical Director, Family Violence Prevention Program, Kaiser Permanente

4. The "integrated" approach to health service delivery.

- Integration is closely linked to the "systems" approach, insofar as its focus is on health delivery organizations, but integration refers more specifically to targeting various types of existing health providers (e.g. emergency rooms, clinics, sexual and reproductive health services, etc.) and determining how violence-related services can be incorporated to ensure that **survivors presenting for care (whether or not related to an incident of violence) receive the necessary assistance related to their exposure to violence as quickly as possible.**
- Three basic models of integration include:

Level of	Approach	Example

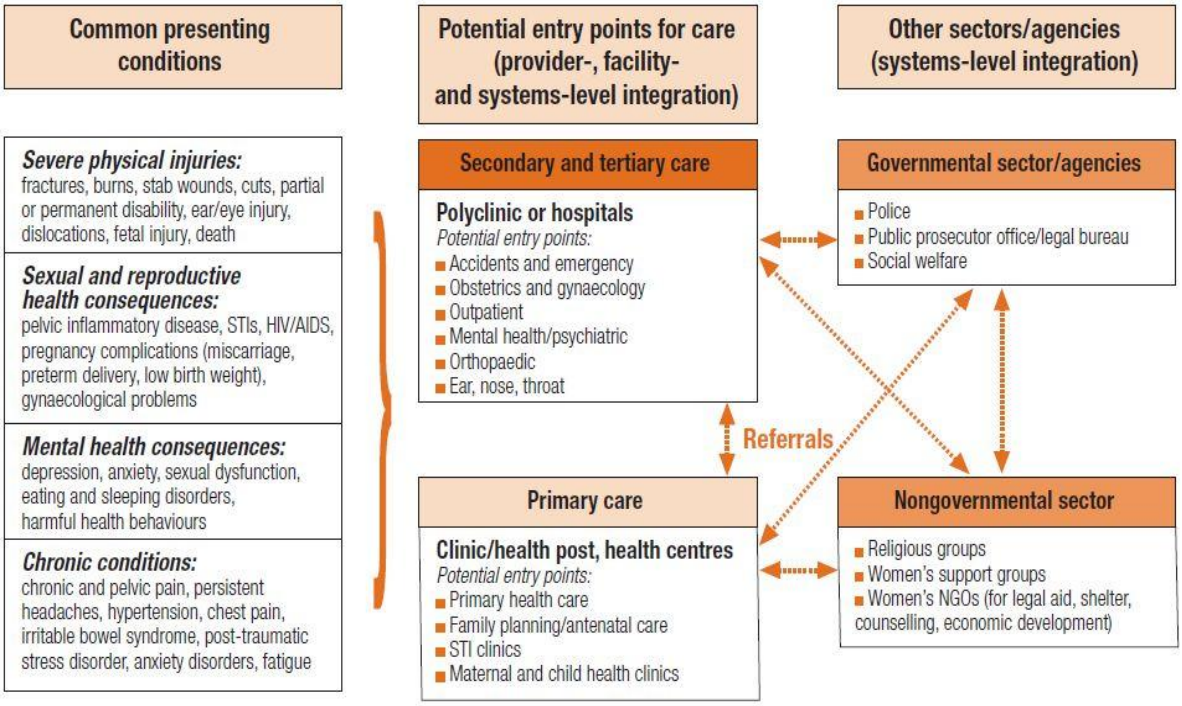
Integration		
Provider-level integration	The same provider offers a range of services during the same consultation.	A nurse in accident and emergency is trained and resourced to screen for domestic violence, treat her client's injury, provide counseling and refer her to external sources of legal advice.
Facility-level integration	A range of services is available at one facility but not necessarily from the same provider.	A nurse in accident and emergency may be able to treat a woman's injury, but may not be able to counsel a woman who discloses domestic violence, and may need instead to refer the woman to the hospital medical social worker for counseling.
Systems-level integration	There is facility-level integration as well as a coherent referral system between facilities in order to ensure the client is able to access a broad range of services in their community.	A family-planning client who discloses violence can be referred to a different facility (possibly at a different level) for counseling and treatment. This type of integration is multi-site.

Adapted from Colombini, C., Mayhew, S., and Watts, C., 2008**.** "Health-sector Responses to Intimate Partner Violence in Low- and Middle-income Settings: A Review of Current Models, Challenges and Opportunities." *Bulletin of the World Health Organization* 86 (8), pgs. 635-642.

- Within the health sector, most violence-related services involve a combination of provider- and facility-level integration; full systems-level integration is rare, in spite of the fact that systems-level integration likely offers the promise of the most comprehensive care within a community. Based on a review of integration efforts in various low and middle-income countries around the world, several key lessons learned about integration include:
    - Development and implementation of policies, protocols, and other tools and procedures is important to help institutionalize services as part of care delivery.
    - Staff training must be sustained over the long term and support and supervision must be available to providers.
    - Integration plans must be careful to address facility infrastructure (including private counseling rooms, availability of appropriate equipment, etc.) as well as documentation systems (see Colombini, Mayhew and Watts, 2008).

- When considering how to determine what services should be integrated into a specific service delivery organization, it is important to understand the needs of those who are presenting for treatment. The following diagram illustrates some of the common presenting conditions of women experiencing IPV (including sexual violence), the potential entry points at different levels of the system, and the referral networks needed.

Fig. 1. **Potential entry points for delivery of health care to abused women and systems of referral for effective integration**



Excerpted from: Colombini, C., Mayhew, S., and Watts, C., 2008**.** "Health-sector Responses to Intimate Partner Violence in Low- and Middle-income Settings: A Review of Current Models, Challenges and Opportunities." *Bulletin of the World Health Organization* 86 (8), pg. 639.

- A sample of issues related to integration in emergency and other services are briefly outlined below:
    - **Emergency Rooms:** Broadly, emergency rooms most often identify violence when survivors present with severe physical injuries and/or when rape victims are seeking emergency treatment. Evidence suggests that most women and girls experiencing rape will go to a hospital before going to the police, and may be reluctant to go to the police for safety (fear of retaliation) and economic reasons (fear of loss of financial support resulting from imprisonment of her partner). **For post-sexual violence visits in particular, there is a crucial 72-hour period in which HIV Post-exposure Prophylaxis (PEP) is possible, and 120 hours for**

emergency contraception (and up to five days if an IUD is used—which it rarely is in cases requiring emergency contraception), strongly arguing for 24-hour availability of services, use of facility-level integration, and "one-stop services."

- **Primary care (MCH), HIV and other Sexual and Reproductive Health Services:** In primary care and sexual and reproductive health entry points, the health consequences of violence may be a presenting condition, but women typically will not disclose their experience of violence unless asked. Therefore, policies and protocols for inquiry become a crucial component when planning for integration, including decisions on whether to implement universal screening or screening only in selected services such as HIV Voluntary Counseling and Testing (VCT), family planning, and the emergency room. (For more information about implementing screening, see Consider Routine Screening.)

C. Common challenges in implementing a comprehensive approach.

- There are many challenges within the health sector to employing the ecological, multisectoral, systems-based and integrated models for addressing violence against women and girls. These challenges must be anticipated when developing and implementing policies and programming:

  - **Insufficient evidence base.** Although there are numerous anti-violence against women and girl's initiatives taking place in various parts of the world, many of them are quite small and few have been rigorously evaluated and/or documented. When evaluations have been implemented, their scope, depth, methodological approach and overall quality tend to be uneven. The majority of rigorous health sector evaluations have been undertaken in North America and Western Europe, making it challenging to extrapolate the findings to other regions and contexts (Feder et al., 2009; Ramsay, Rivas and Feder, 2005). These evaluations also tend to focus on one specific aspect of health care, such as screening or provider training, rather than on systems-based approaches or national level interventions. Developing a health surveillance system and conducting monitoring and evaluation are critical to improving programming efforts (United Nations, 2006a).

  - **Lack of coordination.** Programmes too often operate independently of one another, failing to build on mutual resources to plan and implement comprehensive services (Colombini, Mayhew and Watts, 2008). Developing multisectoral national coordination networks and ensuring coordination and referral is critical to efficient and effective programming (United Nations, 2006a).

- **Poor legal/policy framework.** National laws and policies regulating domestic violence, sexual violence, harmful traditional practices such as FGM/C and child marriage, inheritance rights, marriage and divorce vary widely throughout the world and can even be inconsistent or conflicting within various domestic frameworks. Even still in settings where comprehensive laws and policies addressing violence against women and girls exist and are aligned, there are challenges in ensuring their implementation, due to lack of technical and financial resources, coordination, and prioritization of violence issues (USAID and UNICEF, 2006). Developing legislation on violence against women and girls, including in the context of HIV and AIDS, is the basis for prevention and response programming. Within the health sector, it is important to review relevant laws and, when necessary, conduct advocacy to upgrade laws.

- **Lack of financial and technical resources.** Ministries of Health operating at national, district and local levels face numerous demands with often limited financial and human resources. As a result, violence against women and girls is rarely prioritized and budgeted for, despite the substantial costs of violence against women and girls to the individual, family, society and to public health. Ensuring funding is key to building effective programming.

- **Lack of minimum standards for services.** Minimum Standards represent the lowest common denominator that all states and services should aim to achieve. Standards provide benchmarks- for states and service providers – with respect to both the extent and mix of services which should be available, who should provide them, and the principles and practice base from which they should operate. For example, according to a review of forty-seven European countries, standards have yet to be formalised in most (Council of Europe, 2008a). The Council of Europe (2008a) has recommended minimum standards for various violence programming, including 24-hour hotlines, sexual assault centres in hospitals and rape crisis centres.

- **Individual service providers' attitudes and lack of knowledge about violence.** Service providers may promote unhelpful or even hurtful attitudes and practices due to insufficient training, high turnover of trained staff, lack of inclusion of violence-response training in national medical curricula, etc. (Kim and Motsei, 2002; Colombini, Mayhew and Watts, 2008). Staff may also have been exposed to violence themselves, which may limit their capacity to effectively engage with clients. Staff sensitization, specialized training, and on-going supervision and staff support are key to ensuring supportive responses to survivors.

- **Managerial and health systems' challenges**. These might include a lack of clear institutional policies on violence, entrenched medical

hierarchies, lack of coordination among various actors and departments involved in planning integrated services, and lack of commitment by administrators (Colombini, Mayhew, and Watts, 2008). Conducting facility assessments and developing policies and protocols to address gaps in services are key to overcoming health systems' challenges (Troncoso et al., 2006).

- **Lack of prevention activities.** Due to the bio-medical orientation of the health sector, there is often a failure among health institutions and agencies to undertake broad-based prevention activities that target attitude and behaviour change at the community level. However, prevention programming should be considered an integral part of health facilities' work on violence against women and girls.

D. Adapting and prioritizing health sector approaches to different contexts and resource levels: from core services to comprehensive care.

- In addition to the overarching challenges presented above, developing a comprehensive model for health sector response is difficult in many settings where there is a shortage of health providers, facilities, equipment, and supplies, especially at the primary care level. Even in these settings, and without overloading community health volunteers and health workers who are addressing multiple issues, some basic interventions are still possible to enable the health sector to support women and girls affected by violence.

- When developing policies and interventions to address violence against women and girls, the health sector should realistically consider resources and other challenges (such as those identified above), and develop a standard for minimum response that makes every effort to meet those challenges with the resources available. As resources improve, countries should aim to provide an increasingly comprehensive package of care.

- In addition to the services that are provider within a particular facility, all facilities should know and link with other referral sources in their communities, and be able to provide referrals as necessary to survivors.

- The following has been proposed as a model for considering what to prioritize according to resource availability in different settings around the world when responding to sexual violence. However, it should be noted that the model described below should not *encourage* middle- and low-income countries to provide less than comprehensive services—the goal in all settings is to work towards the delivery of comprehensive care to survivors.

Services for Sexual Assault Survivors

	Health Services Provided	Features of Service or Facility Management	Training
Core Services for Sexual Assault (for all settings)	1. Post-sexual assault pregnancy prevention and accessible, safe termination of pregnancy services [*where legal*] 2. Treatment of sexually transmitted infections 3. Treatment of genital or other injuries 4. A report of the genital examination, where required, for legal purposes 5. Basic information on treatments to victims/ survivors	1. All facilities have clinical management guidelines and the country's sexual assault policy 2. All facilities have a fully enclosed room for providing care to victim/survivors in privacy 3. Service providers have an understanding of the need to provide care in a manner that is confidential, sympathetic and non-judgmental and provides victim/survivors with information about their treatment, law on rape and how to access police and legal services. 4. Services are provided at no cost to the victim/survivor	**1.** All institutions training doctors and nurses include a module on understanding of gender-based violence, including sexual violence, the clinical management guidelines and policy as part of their basic curriculum
Mid-level Services for low to middle income countries (in addition to the core):	1. Prophylaxis against HIV infection where relevant for the country/[local] risk level 2. A thorough examination of the victim/survivor, with documentation of findings and collection of specimens for DNA testing according to a standard policy and evidence kit **3.** Written or pictorial information to victims/survivors on treatment, rape and the law and accessing counselling and support	1. Health service providers providing care for victim/survivors identified for most of the country 2. Health facilities have policies that ensure care is provided sensitively, including having private waiting areas 3. Health services are co-ordinated, managed and staff trained and supervised by an identified senior clinician 4. Inter-sectoral collaboration is established at a facility level 5. Forensic laboratories are available to support analysis of specimens collected	1. Identified health service providers are given in-service training to update their clinical management and understanding of the needs of victim/survivors

Comprehensive Services for middle and high income countries (in addition to the core and mid-level):	1. Comprehensive health services as outlined in the WHO's *Guidelines for medico-legal care for victims of sexual violence* (2003).	1. All services are provided by designated health service providers who are highly motivated, trained and continuously updated through on-going training 2. All services are provided in facilities which are equipped to be conducive to sexual assault examinations 3. People reporting sexual assault are transported to these facilities by the health service or the police (if they have been involved) 4. All people are offered sexual assault care without having to report cases to the police 5. Good inter-sectoral links with the preparation of victims for court testimony and advocates who are available to partner and support victim/survivors after sexual assault	

Source: Jewkes, R., 2006. Paper for Policy Guidance: Strengthening the Health sector Response to Sexual Violence (Unpublished).

III. What are the guiding principles for the health sector in addressing violence against women and girls?

A. Overview of basic principles.

- The core ethical guiding principles of **safety, respect, confidentiality and non-discrimination** apply to all violence-related health interventions and must be considered in all decisions providers make, from the policy level to the delivery of services for individual survivors.

- These guiding principles are embodied in four essential and interlinked approaches described below: the human rights-based approach and the survivor-centred approach have emerged from the human and women's rights communities, and the quality of care and medical ethics approaches are from the health community. Each is important to understand in offering care to survivors.

1. Human rights-based approach

- A **human rights-based approach** seeks to analyze root causes of problems and address discriminatory practices that contribute to violence against women and to the ability of survivors to access assistance. It:

    - Is based on international human rights law standards (outlined in the Timeline of Policy Commitments and International Agreements in Programming Essentials. See also the General Assembly Resolutions, Security Council Resolutions, Work of the Human Rights Council and ECOSOC.
    - Integrates these norms, standards and principles into plans, policies, services and processes related to violence against women.
    - Is multisectoral and comprehensive.
    - Involves many stakeholders (government and civil society).
    - Cannot be addressed in isolation of prevailing political, legal, social and cultural norms and values.
    - Must be aimed at empowering survivors and their communities.

- A human rights-based approach requires providers to meet the needs of women and girls affected by violence according to legal and moral obligations and accountability. All those within the health sector—from government officials at the Ministry of Health to community-based health workers--are "duty bearers" bound by their obligations to encourage, empower and assist "rights holders" (i.e. women and girls) to claim their rights. A human rights-based approach to violence against women requires that all those who develop and deliver health services:

    - Assess the capacity of rights holders to claim their rights and identify the immediate, underlying, and structural causes for non-realization of rights. For example, identify the barriers to women and girls access to health services for violence and address those barriers through improved legislation on health sector response to violence against women and girls, integrated and comprehensive health programming, and community outreach to women and girls.
    - Assess the capacities and limitations of the duty bearers (health care personnel, police, prosecutors) to fulfil their obligations according to national and international standards, laws and agreements.
    - Develop strategies to build capacities and overcome limitations of duty bearers, such as through staff training and supervision.
    - Monitor and evaluate both outcomes and processes guided by human rights standards and principles, and ensure national accountability.
    - Ensure programming is informed by the recommendations of international human rights bodies and mechanisms.

2. Survivor-centred approach

- A survivor-centred approach means that all those who are engaged in violence against women programming prioritize the rights, needs, and wishes of the survivor.

- Essentially, a survivor-centred approach applies the human rights-based approach to designing and developing programming that ensures that survivors' rights and needs are first and foremost. The survivor has a right to:

    - be treated with dignity and respect instead of being exposed to victim-blaming attitudes.
    - choose the course of action in dealing with the violence instead of feeling powerless.
    - privacy and confidentiality instead of exposure.
    - non-discrimination instead of discrimination based on gender, age, race/ ethnicity, ability, sexual orientation, HIV status or any other characteristic.
    - receive comprehensive information to help her make her own decision instead of being told what to do.

- The survivor-centred approach is based on a set of principles and skills designed to guide professionals-- regardless of their role—in their engagement with women and girls who have experienced sexual or other forms of violence. The survivor-centred approach aims to create a supportive environment in which the survivor's rights are respected and in which she is treated with dignity and respect. The approach helps to promote the survivor's recovery and her ability to identify and express needs and wishes, as well as to reinforce her capacity to make decisions about possible interventions (UNICEF, 2010). Providers must have the resources and tools they need to ensure that such an approach is implemented.

3. Quality of care approach

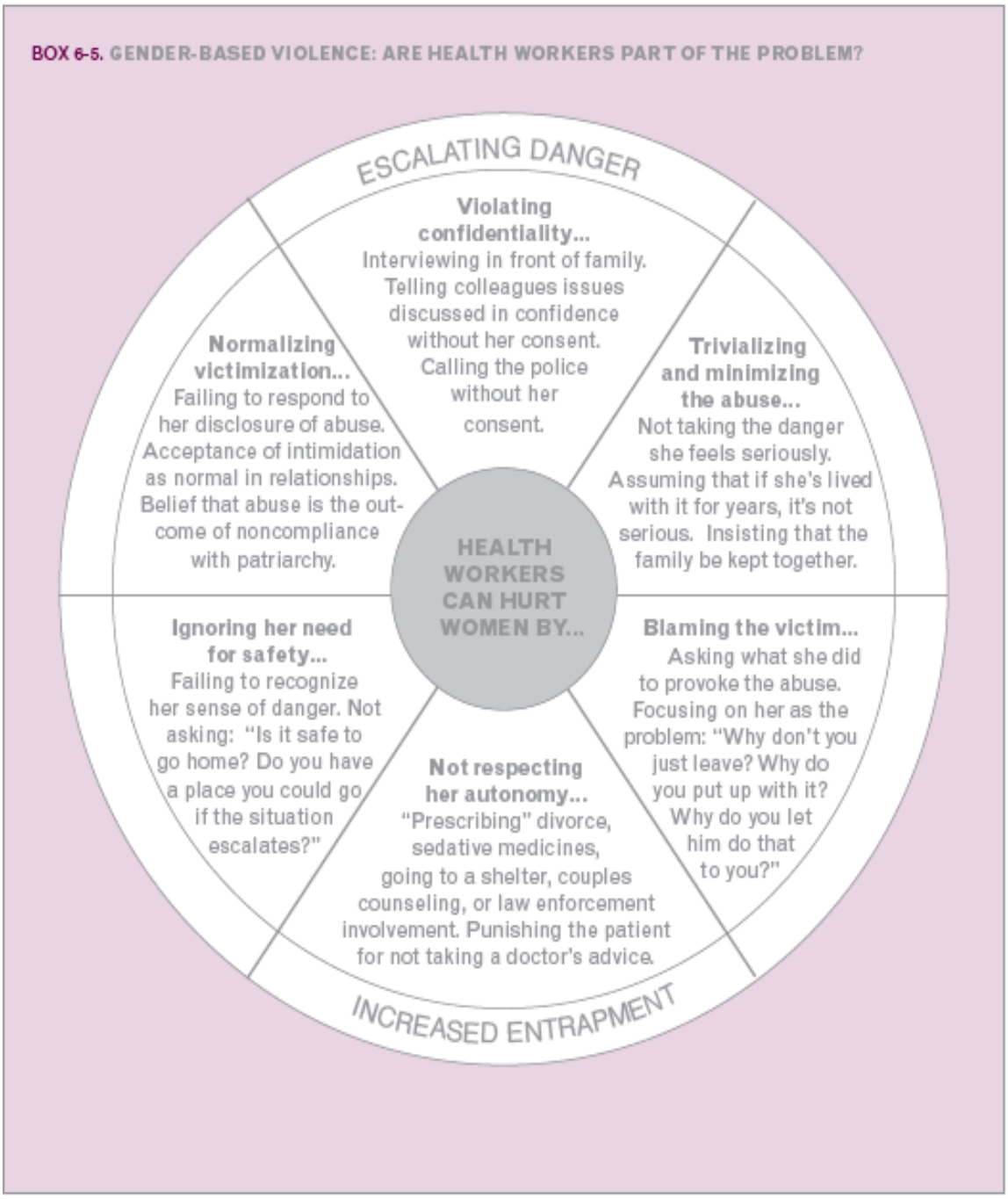
- Service quality can be defined in terms of the different dimensions outlined below, each of which is dependent on the other in order to realize overall quality of care. The priority is always to promote the health and well-being of survivors.

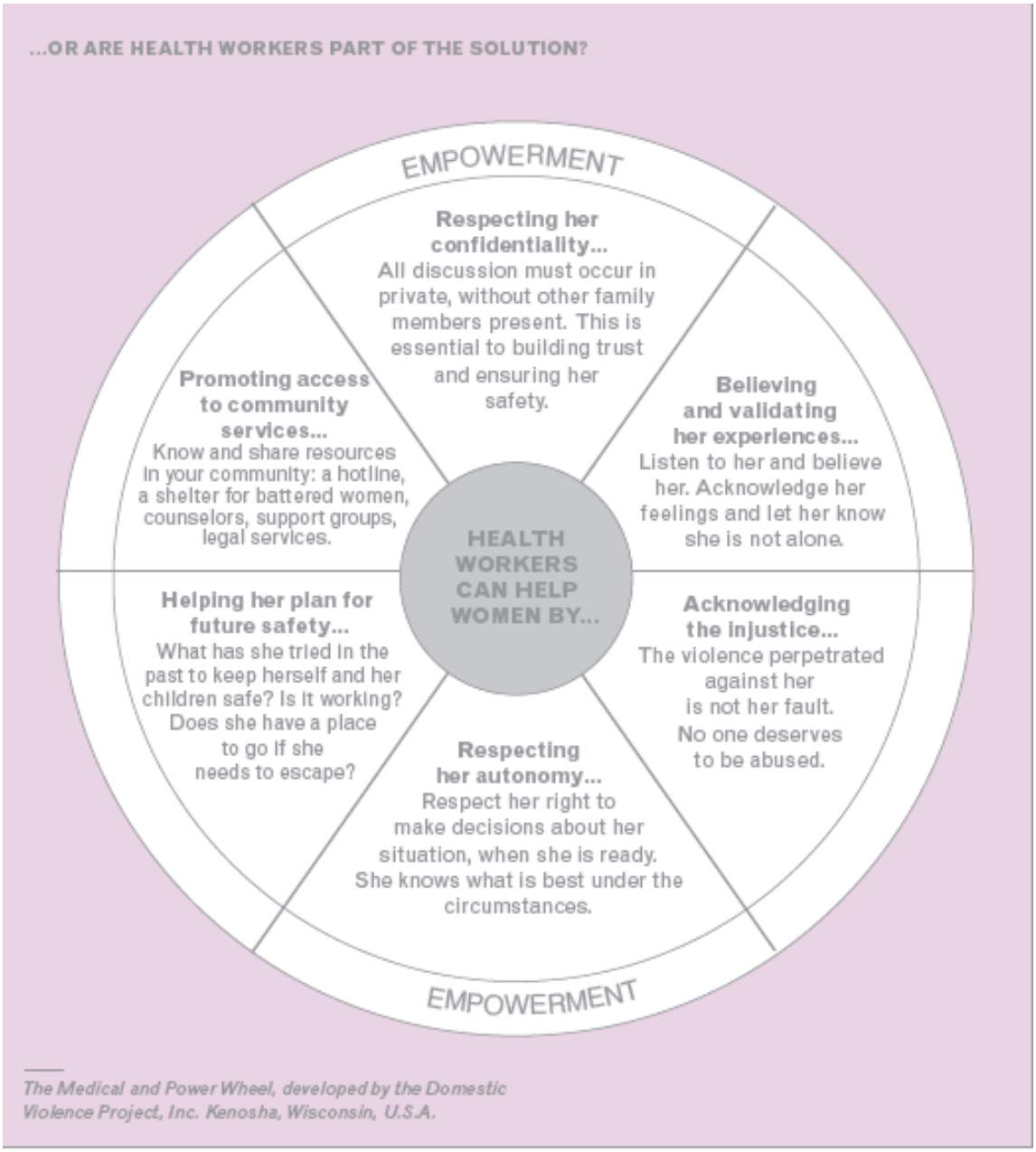
Equity	Equity along several dimensions needs to be considered in service planning. Geographical equity can be achieved by ensuring that plans are developed to improve sexual assault health services progressively throughout the country. Services need to be equitably available to different groups in society, and in particular marginalized groups, who are often at particular risk of sexual assault, such as those engaged in sex work or drug users, need to be able to have their health needs met without fear of experiencing penalties. Equity also demands that services are provided to those in institutions as well as the general population.

Effective-ness	Effective health services meet the health and welfare needs of survivors of recent and past sexual violence. Effective services need to be well managed and provide care of a high clinical standard.
Efficiency	Efficient services are those that meet the needs of survivors promptly and effectively. The greatest threat to health service efficiency in most countries is low quality of clinical care resulting in a failure to treat sexually transmitted diseases, prevent pregnancy, meet mental health needs and provide information that can be used persuasively in court. Monitoring and evaluation of health services are key tools in ensuring and building quality of care and ensuring efficiency. Legal and health outcomes can be monitored and the organisation and activities scrutinised in order to ensure that these are optimised. Victim/survivors have a critical role in service evaluation, as described further in the Monitoring and Evaluation section.
Access	In every country where it has been examined, research has shown that the majority of people who are sexually assaulted do not currently come forward to the police. Public perceptions of health services available to sexual assault victims/survivors are crucial in promoting access to health care. It is very important that health services enable health needs to be met without mandatory police reporting and involvement in cases. Involving courts or the police should be the woman's decision, based on full information on the implications of taking such steps. Geography is important in access, and services need to be planned so that they can be reached by all within an acceptable travelling time, and at an acceptable transport (or other) cost. If it is possible there should not be user fees for these services as they will pose a barrier to seeking health care and gaining access to justice. Services also need to be available 24 hours a day, seven days a week, and survivors should be able to access same-sex health-care providers.
Appro-priateness and Accepta-bility	Appropriate services are based on the recognition that survivors need special consideration paid to them, and that health services need to ensure that, as far as possible, health care seeking does not further stress survivors, but rather is seen as a step in regaining control over their lives. Protocols for providing care should be developed such that the number of examinations and interviews victim/survivors have to undergo is kept to a minimum, preferably one at the health facility. High quality health care needs to be coordinated such as to link the provision of immediate medical care, forensic examinations, crisis and short term counselling, follow up medical care and advocacy. This is best achieved in a dedicated service with clear lines of management.
Choice	Choice is a very important element in high quality sexual assault health services and lies at the heart of respect for differences between people in their preferences, needs and wants. Where it is possible, survivors should

	be able to choose which health facility they get their care from. High quality care should be sensitively provided and individualised. Thus victim/survivors should be taken through each stage of their health care and examination separately and have choices about the services they receive, with informed consent sought at each stage.

Excerpted/Adapted from Jewkes, R., 2006. Paper for Policy Guidance: Strengthening the Health sector Response to Sexual Violence (Unpublished), **based on** Maxwell R.J., 1992. Dimensions of quality revisited: from thought to action. Quality in Health Care, pp. 171-177.





The Medical and Power Wheel, developed by the Domestic Violence Project, Inc. Kenosha, Wisconsin, U.S.A.

4. Medical ethics of care approach

- Codes of medical ethics are built on internationally accepted principles. It is a fundamental duty of all health workers that they use their skills in an ethical manner and observe the laws of the community. Health service provision and the related policy framework must be based on the same ethical principles. Countries need to be mindful of these principles when considering their legal frameworks for services and modes of operation.

Autonomy	Autonomy involves right of victim/survivors to make decisions on their own behalf or, in the case of children, the right of the individual acting in their interests (parent or guardian). Respecting the principle of autonomy, requires that health care professionals make themselves aware of the needs and wishes of patients with respect to both their treatment and their interactions with police, the legal system or other referrals. Within the health services all steps taken should be based on informed consent i.e. the provision of information about the procedure to be performed and medication to be given and any side-effects.
Beneficence	Beneficence is the duty or obligation to act in the best interests of the victim/survivor. The principle of beneficence requires that staff act with sensitivity and compassion. Fundamentally, staff actions need to convey that they believe the victim/survivor and that he or she is not to blame for what occurred.
Non-malfeasance	Non-malfeasance is the duty or obligation to avoid doing harm to a survivor.
Justice or fairness	Justice/fairness is doing and giving what is rightfully due to the survivor according to international and national health and human rights standards and laws. In health services for sexual violence survivors, the lower social status of women has often been reflected in a culture of victim-blaming, accusatory modes of questioning and lesser priority given to providing post-sexual assault. These practices are not ethical. It is essential that health care professionals are supportive and non-judgmental when providing care to victim/survivors.

Excerpted/Adapted from Jewkes, R., 2006. Paper for Policy Guidance: Strengthening the Health sector Response to Sexual Violence (Unpublished).

Additional Resource:

- See the International Code of Medical Ethics and the World Medical Association site.

B. Standards for health service delivery

- In order to put all of these principles into action, it is critical that policy makers, health care administrators, and health care workers understand how these principles overlap, as well as how they actually relate to the provision of services for survivors. Some examples are provided below.

BASIC PRINCIPLE	SERVICE SPECIFIC STANDARDS
Right to privacy	• Ensure privacy during any conversation between the survivor and provider or receptionist so that no one in the waiting room or in adjoining areas can overhear. In low resource settings where no such space exists, creative measures such as walking to another part of the facility with the client or to an outdoor patio might have to be taken. • Systems and staff training to ensure privacy for adolescent clients so that—when deemed necessary--family members are not apprised of the reason for their visit.
Right to confidentiality	• Do not share any information regarding a survivor without the survivor's informed consent. All staff should be trained in maintaining confidentiality and services should have a policy related to this. Strict measures should be in place so that staff only discusses cases with other providers when strictly necessary, and in a manner that cannot be overheard. • Institute secure measures for confidentiality of patient files.
Right to choose/ Autonomy	• Seek informed consent for the examination and any tests. The principle of autonomy requires that survivors should be able to get health care without interacting with any other service before, or as a condition of, gaining health care. They should not have their name passed to any other agency, including a non-governmental organisation, social workers or researchers, unless they agree to such a referral. Autonomy is obviously reduced in settings where there is mandatory reporting and in situations where the victim/survivor is a child and needs protection from agencies, often from family members (excerpted from Jewkes, 2006). Informing the woman of legal mandates in order to help her engage in safety planning is also important.
Non-discrimination/ Equity	• Ensure the same level of quality of care for all persons seeking assistance. • Ensure that health programmes are age-specific and tailored to different sub-groups with wide access across a variety of settings, including considerations of geographic, cultural and linguistic diversity. • Ensure that a range of support options are available that take into account the particular needs of women facing multiple discrimination (United Nations, 2006a).
Dignity/ Appropriateness	• Ensure availability of female examiners where requested, and promote bodily integrity in examinations. • Remind survivors that violence is not their fault and abuse should not be tolerated (Carreta, 2008). • Ensure access to family planning, contraception, and where legal, safe abortion (WHO, 2008). • Ensure confidentiality and comfort with private waiting areas, a private

	toilet and washing facilities, and a private examination room. (Jewkes, 2006).
Accessibility	• Ensure services for survivors and prevention initiatives are free of cost (Schechtman, 2008; Claramunt and Cortes, 2003). • Ensure location of services is accessible and/or provide transportation. • Ensure linkages with the community, especially through community-based and non-governmental organizations. Identify appropriate means for reaching out the most marginalized members of the community about availability of services. (Jewkes, 2006). • Ensure survivors have access to same-sex health care providers.
Safety	• Ensure safety of the survivor as the paramount concern (Garcia-Moreno, 2002 b), as well as safety for the staff, and cultivate a working environment that does not minimize or deny potential safety risks (Council of Europe, 2008a). Conduct safety assessments and safety planning.
Non-malfeasance	• Prioritize the well being of survivors and the delivery of services over data collection or any other secondary objectives.
Effectiveness/ Efficiency	• Ensure that service providers are skilled, gender-sensitive, have ongoing training and conduct their work in accordance with clear guidelines, protocols and ethics codes (United Nations, 2006a). • Ensure health policies and programmes are based on evidence. • Monitor and evaluate service provision, seeking participation of service users. • Ensure coordination among multisectoral actors. Sexual assault evidence collection kits, evidence chains and standard forms must be agreed by all sectors (Jewkes, 2006).

IV. Initiating or improving a national health sector strategy

A. Conduct a situational analysis of the health sector.

- As a first critical step a situation analysis and mapping should be conducted to determine the health sector's existing role vis-à-vis violence against women and girls. This type of assessment is crucial to planning, standardizing quality of care among different types of service providers and in coordinating efforts. Periodic assessments will also help monitor the success of efforts and point to gaps and challenges that should be addressed (Bott et al., 2004).

- A comprehensive situational analysis should take place at a variety of levels. At the national and sub-national level, the focus might be on implementation of laws, policies and protocols as well as coordination structures, funding and other resources. At the facility level, the focus might be on institutional policies and protocols as well as the range and quality of services. At the provider level, a situational analysis might investigate knowledge, behaviour and provider practices. At the community level, a situational analysis will

investigate the nature and type of violence, help-seeking behaviour, health needs, and perceived accessibility and quality of services.

- The situational analysis can be seen as an intervention itself, as it initiates public discussion of violence against women and girls, raises awareness, and opens dialogue among key actors and within the community. However, it is critical that all research on violence against women is *action-oriented,* such that the goal of the research is to improve the well being of survivors.

- When planning a situational analysis, it is critical to operate under ethical guidelines and abide by the World Health Organization's **ethical and safety standards for collecting information on violence against women and girls** (see resources below).

WHO TO ASSESS	WHAT TO ASSESS	HOW TO ASSESS
• Key stakeholders and actors responsible for developing policies and protocols; • Key stakeholders and actors involved in coordination; • Key stakeholders and actors involved in providing services; • Members of the community; • Leaders of the community; • Women's organizations.	**At the national and sub-national levels:** • Whether there are laws and policies in place to promote protection for women and girls and support the delivery of ethical and safe health services. • Whether health plans, protocols or other guiding frameworks are in place and whether they are funded. • The level of implementation of policies, plans and protocols, including gaps and bottlenecks, infrastructure, human resource capacity, access barriers by different sub-groups of the population, resource flows among other institutional and administrative factors. • Whether an institutional coordination mechanisms exists at national and/or sub-national level, how it is functioning, which stakeholders are involved and who is not that should be. • Whether prevention services are being undertaken, to what extent, by whom (government, women's groups, non-governmental organizations or others), for which target audience(s) and the effectiveness of those interventions. **At the level of service delivery (facility and provider):** • Which health services exist for survivors of domestic violence, sexual violence and other forms of violence against women and girls that are prevalent in the country or region. • Which entities are providing them (government, women's groups, non-governmental organizations, others). • Where services are concentrated and where there are gaps.	• Review existing assessments • Conduct key informant interviews with relevant stakeholders • Conduct focus groups • Undertake site observation

	• How they are being financed and what the costs are for survivors. • The level of quality and user experiences. • Who is accessing them and who is not. • What services are provided at different types of health facilities (including hospitals, the emergency rooms of hospitals, one stop centres, reproductive health clinics; during prenatal care; within HIV/AIDS voluntary testing and counselling or prevention, treatment and care programmes). • Whether the facilities provide safety (e.g. security guard, police presence) and confidentiality (e.g. substituting the survivor's name with a patient number or alias). **At the community level:** • Key forms of violence. • Help-seeking behaviour and availability of referral services. • Obstacles to help-seeking. • Vulnerabilities and needs of marginalized groups.	

Adapted from Ward, J., 2010, *Guidelines on Coordinating GBV Interventions in Humanitarian Settings*. New York: GBV AOR Working Group. and Bott, S., Guedes, A., Guezmes, A. and Claramunt, C., 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries.* New York: IPPF/WHR. Available in English and Spanish.

Case Study: The "Critical Path" in Central and South America (Pan American Health Organization)

The Pan American Health Organization's work on violence against women started with the "Critical Path" Study which documented and provided the first in-depth understanding of what happened to women once they broke their silence an actively sought help: from state services, church and schools in their community, and even neighbours and family members. The "Critical Path" study was carried out in 16 communities of the 10 countries that were included in the two Pan American Health Organization projects to address violence against women and girls. These countries were: Belize, Bolivia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama and Peru. The study communities reflected the diversity of rural and urban settings in Latin America, as well as that of its ethnic groups. The Pan American Health Organization and its Ministry of Health counterparts selected the study communities based on size, the availability of basic services and the existence of non-governmental organizations and/or women's organizations. From each community, participants included 15-27 women aged 15 years or older, who were presently experiencing violence and who had contacted a service provider within the previous 24 months. A minimum of 17 providers from among the various types of service centres were interviewed in each community. Data analysis was based on the interpretation of structured questionnaire. Interviews were recorded and transcribed for detailed analysis. The researchers worked closely with community teams to develop their skills and knowledge for collecting, analyzing, and utilizing the results. The Critical Path uses an interactive, qualitative methodology with a standard protocol that is translated and adapted for various ethnic groups. Information is collected through in-depth interviews with women and semi-structured interviews with service providers in health, law enforcement, legal/judicial, education, religious, and non-governmental organization sectors, as well as through focus groups with community members. For an explanation of the research protocol used in the Critical Path, as well as research tools including **key informant interviews** with sector representatives, individual **survivor interview guide** and **focus group guidelines**, see the publication in English and Spanish.

Following from the Critical Path research a subsequent protocol was developed for the purposes of rapid assessment. Conducting a simplified "Critical Path" Survey can be a useful method when it is necessary to generate basic information but there is not enough time, resources, or staff to carry about a more comprehensive study like the one described above. Using a simplified "Critical Path" Survey involves interviewing survivors of violence and those who might provide services such as the health, legal, police and non-governmental organizations in order to assess how the experience is for the survivor and be able to improve quality and enable survivors to overcome bottlenecks identified at different pints of the health and referrals continuum. For a description of the "rapid assessment protocol" and examples of the adapted tools, see the manual in English and Spanish.

Source: excerpted from Velzeboer, M., Ellsberg, M., Arcas, C., and Garcia-Moreno, C., 2003. *Violence against Women: The Health Sector Responds*. Washington, DC: PAHO, pp. 9-11.

Additional Resources for Research:

- ***Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women*** (WHO, 2001). Available in English, French and Spanish.

- ***Ethical and Safety Recommendations for Interviewing Trafficked Women*** (WHO, 2003). Available in Armenian, Bosnian, Croatian, English. Japanese, Romanian, Russian, Serbian and Spanish.

- ***Researching Violence against Women: A Practical Guide for Researchers and Activists***; Chapter 2: Ethical Considerations for Researching Violence Against Women (Path 2005), Available in English.

- ***WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*** (WHO, 2007). Available in English and French.

Illustrative Tools for Situational Analyses:

- ***How to Conduct a Situation Analysis of Health Services for Survivors of Sexual Assault: A Guide*** (Sexual Violence Research Initiative, 2006). Available in English.

- **Needs Assessment Checklist for Clinical Management of Survivors of Sexual Violence** (Pan American Health Organization, 2010). Available in English and French.

- ***A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers*** (Billings/UNFPA, 2001). The guide provides detailed guidance on planning and implementing GBV assessment and treatment into reproductive health services in low resource settings. Available in English, French and Spanish.

- "**Conducting a Rapid Diagnosis of the Situation**" in *Improving Health Sector Response to Gender-based violence: A Resource Manual for*

Health Care Professionals in Developing Countries (International Planned Parenthood Federation/Western Hemisphere Region, 2004). See pp.18-21. Available in English and Spanish.

- ***Situación De Los Servicios Médico- Legales Y De Salud Para Víctimas De Violencia Sexual En Centroamérica*** (Claramunt M. and Cortes M./PAHO, 2003). See annex 3, "Contenido de informes nacionales, pp 61-67; Cuadro, #8, "Existencia de profesionales por tipo de institucion Honduras," p. 23; Cuadro #14, "Numero de instancias por pais," p. 31; "Cuadro #17, "numero de instancias por 100,000 habitantes en Belice," p. 32. Available in English.

- ***Twubakane Gender-Based Violence/Preventing Mother to Child Transmission Readiness Assessment*** (IntraHealth International, 2008). Available in English and French.

- ***Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls*** (Engenderhealth and International Community of Women Living with HIV/AIDS, 2006). This reproductive health tool can also be adapted to focus on violence against women; see pp. 201-208 and 213-214. Available in English, Spanish, Portuguese, and Russian; 239 pages.

- ***Ver y Atender! Guia Practica para Cononcer como Funcionan los Servicios de Salud para Mujeres Victimas y Sobrevivientes de Violencia Sexual*** (Troncoso, E., D. Billings, O. Ortiz and C. S. Suárez/ IPAS and UNFPA, 2006). Available in Spanish.

- **Organizational Assessment for Agencies Serving Victims of Sexual Violence** (The National Resource Sharing Project and the National Sexual Violence Resource Center, 2010). This tool was developed to assist organizations that serve victims of sexual violence in identifying strengths and strategies to improve their practice. The assessment is available in English.

- See additional facility assessment resources in Identify the needs of a facility through an assessment.

B. Create a multisectoral committee of stakeholders for coordinated action at the national and local levels.

- Multisectoral coordination groups should be convened at the national, sub-national and local levels to facilitate harmonization of action on violence against women and girls. At a minimum, participants should include government officials from relevant sectors, health care providers, service providers from other key sectors, and representatives of women's groups and other civil society organizations working on VAW. The people involved should be senior enough to be able to make coordination-related decisions on behalf of their agencies.

- Too often, information-sharing is perceived by coordination partners to be the primary purpose of coordination. While information-sharing is one important aspect of coordination, it is not the only one. Coordination is about putting in place multisectoral, inter-agency plans of action to address violence against women and girls, i.e., moving from theory to practice. The goal of coordination is to provide accessible, prompt, confidential and appropriate services to survivors according to a basic set of guiding principles and to put in place mechanisms to prevent violence.

- Those working within the health sector will want to use the coordination mechanism to support health-specific activities related to policy and programme development. Some of the specific activities of coordination related to the health sector might include:

    - Facilitating assessments of health sector prevention and response
    - Developing and monitoring information systems for health-related data on violence against women and girls
    - Facilitating funding for health programming and administration
    - Conducting advocacy for improved programming
    - Supporting development and implementation of policies, protocols and other tools related to health sector response to violence against women and girls
    - Coordinating networks and coalitions within the health sector and across other sectors for referrals and support
    - Monitoring service delivery in terms of both availability and quality

- In order to promote coordination at all levels, coordination leaders must be identified and their responsibilities delineated. Clear roles and procedures should be developed for each sector and shared across agencies and sectors. To ensure sustainability and encourage government accountability and action, it is preferable in most settings for government to facilitate and oversee coordination. Often, coordination mechanisms are led by the ministry or institution responsible for overseeing the country's violence against women

programme. Ideally leadership of any coordination mechanism would be defined by a terms of reference and activities of the coordination group guided by an action plan.

- There should also be structures and protocols for linking national coordination mechanisms with sub-national and local mechanisms, as these coordination bodies often have different but mutually reinforcing responsibilities: the national coordination mechanisms may work on the "bigger picture"—including national-level advocacy, data collection and management, national policies and protocols, etc.) and the sub-national and local coordination mechanisms may work more on operational guidance and oversight of service delivery. Methods should be established to regularly share information among various levels of coordination groups through established channels of communication.

Example: The Partnerships against Domestic Violence Programme of Australia

This model initiative is a collaborative effort between the Australian Government and the States and Territories, as well as the business sector, non-governmental organizations and the community. Key projects include: community education campaigns; national competency standards for workers dealing with domestic violence; prevention workshops for young people; a clearing house for information and best practices; and perpetrators' programmes. A range of events nationwide has allowed local, regional and national dissemination of knowledge about new finding in domestic violence research, policy and programmes. Current work includes addressing the impact of domestic violence on children; strengthening perpetrators' programmes; and community education for a range of audiences, including indigenous and culturally and linguistically diverse communities (Excerpted from Commonwealth Secretariat, 2003. *Integrating Approaches to Eliminating Gender-based Violence*, pg. 25).

See a description of the Partnership Project as well as other national initiatives to address domestic violence in Australia.

Case Study: Project for the Comprehensive Care of Sexual Violence Survivors/Proyecto de Atención Integral a Víctimas Sobrevivientes de Violencia Sexual (Ipas and Marie Stopes, Bolivia)

In Bolivia, a fairly solid legal framework and the broad provision of services (medical, legal and psychosocial) by NGOs, private institutions and government provided a strong foundation for improving coordinated services for survivors of sexual assault. Several organizations, including UNFPA supported a mapping

and situation analysis to better understand the strengths and weaknesses of the existing service delivery models. The findings pointed to areas of need and identified entry points for developing an integrated and comprehensive response model. In this context, Ipas Bolivia and Marie Stopes embarked on a project from 2005 to 2008 to implement a model based on an integrated and comprehensive approach, with the aims to reduce sexual violence and its consequences, and to empower survivors to exercise their rights and demand access to quality health and legal services.

The model's principles included:

- A victim services network for shared understanding of an intersectoral approach between key sectors, namely justice, social support, health, education and NGO.

- An interdisciplinary team that could deliver integrated services.

- Strengthened social and institutional networks for prevention.

- Quality care standards across all stakeholders.

Through the project's advocacy a National Committee to Combat Sexual Violence was established, comprising more than 30 government institutions, NGOs and civil society tasked with improving national policies on the issue. The coordination mechanism was led by the Department of Justice and Rights, the Ministry of Health, the Ministry of Gender, the police, Ipas and Plan International. The Committee's work yielded an agreed "Declaration on Integrated Attention to Sexual Violence", solidifying state commitment to this approach at both national and sub-national levels.

To operationalize the commitment, "work tables" were established were key stakeholders would come together to discuss, reflect and design coordinated strategies to ensure the delivery of comprehensive services.

This process was complemented by a large-scale social media campaign, "sexual violence affects all" delivered in Spanish, Quechue and Aymara and tailored to different audiences and contexts. Journalists and the media were also an important target group for training and sensitization.

For additional information, see the full case study on Bolivia in Spanish.

For additional information on good practices and lessons learned in providing comprehensive care to survivors of sexual violence, see the case study on Bolivia, Brazil, Costa Rica and Mexico in Spanish.

Case Study: National Task Force for the Comprehensive Care of Family Violence in Peru

In Peru, national ministries, civil society, and international agencies convened to develop a national model for prevention of and attention to family and gender-based violence. Through the formation of the Mesa Nacional Multisectorial para la Atencion Integral de la Violencia Familiar (National Task Force for the Comprehensive Care of Family Violence) they have achieved a coordinated, sustainable approach to these issues. Additionally, the coordination of the members' contributions and expertise has resulted in greater quality and efficiency of the programmes and policies that address gender-based violence. Accordingly, the Mesa has facilitated training programmes for health and other sector providers and has established a national database of information, research, and surveillance results. The model of the Mesa nacional has been replicated in 18 departments (states) and in many of their respective communities. During this process, the various sectors have been able to overcome many long-standing obstacles and work together to support and care for those affected by violence. The decentralized Mesas have raised their communities' awareness about the existence of violence and have provided incentives to overcome this problem. Their efforts have been strengthened by regular sharing of lessons learned and best practices among communities and departments. Beginning in 1997, a number of communities started self-help groups of women affected by violence. Through the coordinated efforts of their Mesas, member institutions facilitated the training of these groups' coordinators from Lima, Cuzco, and Plura, which resulted in the formation of more than 40 women's men's and mixed groups that involved approximately 5000 participants per year, the majority of whom are women. Throughout this process the Pan American Health Organization has played a leadership role in consensus-building, the formation of Mesa working groups, and the creation of community self-help groups.

More information is available about the Mesas and multisectoral efforts to address domestic violence in Spanish.

See also Peru's national action plan on violence against women (2009-2015). Available in Spanish.

Source: excerpted from Velzeboer, M., Ellsberg, M., Arcas, C., and Garcia-Moreno, C., 2003. *Violence against Women: The Health Sector Responds*. Washington, DC: PAHO, pg.34.

Illustrative Tools:

- ***Bridging Gaps—From Good Intention to Good Cooperation*** (Women Against Violence Europe, 2006). This manual is a resource for service providers across sectors addressing violence against women. The manual offers guidance and recommendations on multi-agency cooperation in the protection of domestic violence survivors. The manual is organized into 15 chapters covering: background information on violence against women; multi-sector service provision and multi-agency cooperation; general and sector-specific standards for practice; violence prevention and safety planning; survivor involvement in programmes; actions and models for multi-agency cooperation. Available in English; 116 pages.

- ***Guidelines on Coordinating GBV Interventions in Humanitarian Settings*** (Ward, J./GBV Area of Responsibility, 2010). Available in English.

Additional Resources:

- ***Council of Europe General Recommendation, 2002. Rec 5, para. 27*** and the Benefits of Coordination. Available in English, French and German.

- ***Community of Practice in Building Referral Systems for Women Victims of Violence*** (Jennings, M./UNRWA, 2010). Available in English.

C. Ensure relevant laws are in place.

- In order for the health sector to develop and implement comprehensive services, relevant laws must be in place. Some of these laws will focus broadly on the problem of violence against women. There are others that will be more specific to health services for survivors. Those wishing to improve health sector programming should assess and, if necessary, work to reform laws in key areas related to quality of care and the rights of survivors. (Bott, Morrison, and Ellsberg, 2005a)

- The process for developing legislation on violence against women and girls is described in detail in the module on legislation. Issues specifically pertaining to the health sector are excerpted from that module and are elaborated below.

1. Review laws related to the health sector and violence against women and girls.

- In general, regardless of the type of violence, health-related legislation should include a statement of the rights of survivors that promotes survivor safety and assistance and preserves confidentiality, and also seeks to prevent re-victimization. Legislation should name an agency or agencies responsible for victim services and should clearly describe the responsibilities of the agency or agencies. The legislation should clearly identify the services provided for different types of violence and the obligation of health providers to offer comprehensive services. The legislation should also mandate coordination, implementation, and funding mechanisms to ensure those services are established, monitored and evaluated.

- Key components for **domestic violence**:

    - Legislation should mandate access to health care for immediate injuries and long-term care including sexual and reproductive health services, emergency contraception, HIV prophylaxis and safe abortion (where legal) in cases of rape.

Example: The Maria da Penha Law no 11.340 (2006) of **Brazil** contains the following provision: *The assistance to the woman in a situation of domestic and family violence will include access to benefits resulting from scientific and technological development, including emergency contraception services, prophylaxis of Sexually Transmitted Diseases (STDs) and of the Acquired Immune-Deficiency Syndrome (AIDS) and other necessary and appropriate medical procedures in the cases of sexual violence.* Chapter 2, Article 9, Paragraph 3.

    - Legislation should mandate **protocols and trainings** for health care providers, who may be the first responders to domestic violence. Careful documentation of a survivor's injuries will assist a survivor in obtaining redress through the legal system.

Example: The Anti-Violence Against Women and their Children Act (2004) of the **Philippines** requires health care providers, therapists, and counsellors who know or suspect that abuse has occurred to record the victim's observations and the circumstances of the visit, properly document all physical, emotional, and psychological injuries, provide a free medical certificate concerning the exam, and to retain the medical records for the victim. They must also provide the victim with immediate and adequate notice of their rights and remedies under Philippine law, and the services which are available to them. Section 31.

    - The law should **prohibit the disclosure of information** about specific cases of domestic violence to government agencies without the fully informed consent of a complainant/survivor, who has had the opportunity to receive advice from an advocate or lawyer, unless the

information is devoid of identifying markers (i.e. the information is presented in such a way that the victim's identity cannot be discerned).

Example: The The Anti-Violence Against Women and their Children Act (2004) of the **Philippines** states: *Confidentiality. – All records pertaining to cases of violence against women and their children including those in the barangay shall be confidential and all public officers and employees and public or private clinics to hospitals shall respect the right to privacy of the victim. Whoever publishes or causes to be published, in any format, the name, address, telephone number, school, business address, employer, or other identifying information of a victim or an immediate family member, without the latter's consent, shall be liable to the contempt power of the court.* Section 44.

- Legislation should include provisions that require **agency collaboration and communication** in addressing domestic violence. NGO advocates who directly serve domestic violence victims should have leadership roles in such collaborative efforts.

Examples of nations with provisions which mandate cooperation by state agencies:

- An objectives of **Albania**'s Law On Measures for Prevention of Violence In Family Relations (2006) is: *a. To set up a coordinated network of responsible authorities for protection, support and rehabilitation of victims, mitigation of consequences and prevention of domestic violence*. Article 2.

- The Anti-Violence Against Women and their Children Act (2004) of the **Philippines** includes the following provisions on community collaboration:
SEC. 39. Inter-Agency Council on Violence Against Women and Their Children (IAC-VAWC). In pursuance of the above mentioned policy, there is hereby established an Inter-Agency Council on Violence Against Women and their children, hereinafter known as the Council, which shall be composed of the following agencies: Department of Social Welfare and Development (DSWD); National Commission on the Role of Filipino Women (NCRFW); Civil Service Commission (CSC); Council for the Welfare of Children (CWC); Department of Justice (DOJ); Department of the Interior and Local Government (DILG); Philippine National Police (PNP); Department of Health (DOH); Department of Education (DepEd); Department of Labour and Employment (DOLE); and National Bureau of Investigation (NBI).

These agencies are tasked to formulate programs and projects to eliminate VAW based on their mandates as well as develop capability programs for their employees to become more sensitive to the needs of their clients. The Council will also serve as the monitoring body as regards to VAW initiatives…

SEC. 42. Training of Persons Involved in Responding to Violence Against Women and their Children Cases. – All agencies involved in responding to violence against women and their children cases shall be required to undergo education and training to acquaint them with: the nature, extend and causes of violence against women and their children; the legal rights of, and remedies available to, victims of violence against women and their children; the services and facilities available to victims or survivors; the legal duties imposed on police officers to make arrest and to offer protection and assistance; and techniques for handling incidents of violence against women and their children that minimize the likelihood of injury to the officer and promote the safety of the victim or survivor….

- **Spain**'s Integrated Protection Measures against Gender Violence Law (2004) states that —*The female victims of gender violence are entitled to receive care, crisis, support and refuge, and integrated recovery services…Such services will act in coordination with each other and in collaboration with the Police, Violence against Women Judges, the health services, and the institutions responsible for providing victims with legal counsel, in the corresponding geographical zone.* Art. 19 Spain's law also provides for funding and evaluation of these coordination procedures.

- Key components for **sexual violence**:
    - Legislation should provide that survivors have the **right not to be discriminated against**, at any step of the process, because of race, gender, sexual orientation or any other characteristic. See: UN Handbook, 3.1.3.
    - Legislation should provide for a **comprehensive range of health services** which address the physical and mental consequences of the sexual assault. These services should include: one rape crisis centre for every 200,000 population; programmes for survivors of sexual assault; survivor witness programmes; elderly survivor programmes; sexual assault survivor hotlines; and incest abuse programmes. See: UN Handbook 3.6.1 and 3.6.2. The legislation should include a plan to provide survivors with this information. See: Minnesota, USA Statute §611A.02; the Rape Victim Assistance and Protection Act (1998) of Philippines. Legislation should provide that access to these services need not occur within a particular time frame and that access is not conditional in any respect. See: World Health Organization, —*Guidelines for Medico-Legal Care for Victims of Sexual Violence* (2003). Available in English.

Example: The Prevention and Elimination of Violence Against Women and Gender Violence (2008) law of **San Marino** requires the state to provide specialized social services for victims of sexual violence that are easily accessible to victims and which employ specifically trained staff. Ch.1 Art.4

Lesson learned: In many countries there is legal requirement that sexual assault be reported to the police. This is called **mandatory reporting** and is most common where there has been sexual assault of children. In some countries there is an expectation that incidents will be reported to the police before health care is accessed, indeed it has been inculcated as a practice in the health sector that victim/survivors give a statement to the police before they receive health care. Whilst health workers clearly have to follow the law of their country, it is not desirable that health sector policy privileges justice needs over health needs. Health services should be accessible before cases are reported to the police, and health and justice policies should clarify this (Jewkes, 2006). Mandatory reporting has also been found to discourage women from seeking needed health care and discouraged health providers from asking questions related to violence, for fear that they will get involved in court cases (Velzeboer, 2003)

- Legislation **should** ensure that the **costs of forensic examination** to gather and preserve evidence for criminal sexual conduct shall be paid for by a local government body in which the sexual assault occurred. See: Sexual Offences Act (2003) of Lesotho, Part VI, 21 (1).

- The collection of forensic evidence should be decentralized. DNA capacity, conducting exams and writing reports should be expanded to a greater number and levels of providers, such as nurses and midwives as well as physicians (Kilonzo, 2008a). Experience has shown that forensic nurse examiners have reduced waiting and assessment times for medical forensic exams; increased the number of sexual assault kits completed; generated more accurate and complete sexual assault kits; improved the chain of evidence or custody; aided law enforcement officials in collecting information and laying/filing charges; and enhanced the likelihood of prosecution and conviction (Excerpted from: Du Mont, J. and White, D., 2007. *The Uses and Impact of Medico-legal Evidence in Sexual Assault Cases: A Global Review*. Geneva, Switzerland: WHO, pg. 37). These measures need to be followed up by implementation by other relevant actors (e.g. prosecutors) to ensure the evidence is processed and used.

Lessons learned: Many countries **restrict the collection of forensic evidence** to specially certified doctors, such as district surgeons or forensic physicians.

The low numbers and availability of certified doctors poses a challenge to women who want to access these services. Women are often required to wait long periods and to navigate complicated paths to get the care they need. In some settings, forensic exams are often used (unreliably) to establish whether and when a girl or woman lost her virginity--evidence that may be used against her in court (Human Rights Watch, 1999; Brown, 2001). A number of countries are working on expanding and providing better services, including through professionalization and training of additional health care personnel.

- Legislation should provide for **cost-free and unconditional tests** for sexually transmitted diseases, emergency contraception, pregnancy tests, abortion services, and post-exposure prophylaxis (PEP). Post-exposure prophylaxis (PEP) is —short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. From: World Health Organization. *See:* Stefiszyn, —A Brief Overview of Recent Developments in Sexual Offences Legislation in Southern Africa, expert paper prepared for the Expert Group Meeting on good practices in legislation on violence against women, May 2008.

Example: The Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32) of **South Africa** provides that when a survivor reports a sexual assault to the police or a medical practitioner, the survivor must be informed about sexually transmitted infections and of the importance of obtaining post-exposure prophylaxis (PEP) within 72 hours of the assault. Ch. 5, 28 (3).

Example: In a 2010 decision, the Supreme Court of **Mexico** upheld the Norma Oficial Mexicana (NOM-046-SSA2-2005) Violencia familiar, sexual y contra las mujeres requiring that all states distribute emergency contraception and provide access to safe abortion for rape victims.

- Legislation should provide for a **coordinated community response** for survivors of sexual assault. See: Coordinated Crisis Intervention, StopVAW, the Advocates for Human Rights.

- Legislation should provide for coordinated sexual assault response teams or programmes to give survivors a broad range of necessary care and services (legal, medical, and social services) and to increase the likelihood that the assault can be successfully prosecuted. Such programmes or teams should include a forensic examiner, a sexual assault advocate, a prosecutor, and a law enforcement officer. All responding actors should follow specific protocols that outline their responsibilities in treating and providing services to survivors of sexual assault.

- Legislation should mandate **dedicated funding** to ensure the appointment of sexual assault service providers, their registration as service providers, and to provide for their specialized training. *See:* Good practices in legislation on —harmful practices against women (2010) 3.4.2 and 3.4.3.

- Legislation should include all necessary provisions for **full implementation** of the laws on sexual assault, including development of protocols, regulations, and standardized forms necessary to enforce the law. Legislation should require that these protocols, regulations and forms be developed within a limited number of months after the law is in force, and legislation should provide a fixed time that may pass between the adoption of a law on sexual assault and the date that it comes into force. See: UN Handbook, 3.2.6 and 3.2.7.

- Legislation should provide for a specific institution to **monitor the implementation** of the laws on sexual assault, and for the regular collection of data on sexual assaults. See: UN Handbook, 3.3.1 and 3.3.2.

Example: Sexual Offences Act (No.3) (2006) of **Kenya** (2006) includes the following provision: *—The Minister shall (a) prepare a national policy framework to guide the implementation, and administration of this Act in order to secure acceptable and uniform treatment of all sexual related offences including treatment and care of victims of sexual offences; (b) review the policy framework at least once every five years; and (c) when required, amend the policy framework.* Section 46

Additional Resources:

See Tools for Developing Legislation on Domestic Violence and Tools for Drafting Legislation on Sexual Assault in the module on Developing Legislation on Violence Against Women and Girls. The module also contains information on legislation related to sexual harassment, sex trafficking, harmful practices, forced and child marriage, female genital mutilation/cutting, honour crimes, maltreatment of widows and dowry-related violence.

2. Conduct advocacy to upgrade laws.

- Often, advocacy is misunderstood as synonymous with behaviour change communication (BCC)/ information, education, communication (IEC) and/or community mobilization. Although these activities are targeted toward promoting change and involve developing messages tailored to a specific audience, advocacy stands apart from these approaches because the ultimate goal of advocacy is policy change. The advocacy process is complete when a decision-maker takes a prescribed policy action. While

raising awareness of the general public may be an important step in this process, it is not the ultimate goal.

- A collective voice is often much stronger than a solitary voice, and speaking out collectively avoids backlash being directed at a lone individual or organization, especially when an issue is controversial or difficult. For that reason, advocacy efforts are often best undertaken by a coordinated group of key stakeholders who are, for example, organized as a coalition. Health actors should work within a coordination mechanism to develop and implement advocacy efforts.

- The following presents a brief overview of an advocacy process (excerpted from Ward, 2010 and adapted from CEDPA, 2000).

Data collection is an ongoing activity throughout the advocacy process and may include researching the position of a policy audience regarding the advocacy issue.

Monitoring and evaluation take place throughout the advocacy process. Before undertaking the advocacy campaign, it is important for the advocates to determine how they will monitor their implementation plan. In addition, group members should decide how they will evaluate or measure results. Can they realistically expect to bring about a change in policy, programmes or funding as a result of their efforts? How will the group know the situation has changed?

Case Study: The South African Gender-Based Violence and Health Initiative (SAGBVHI)

Health sector coalitions can play an important role in **advocating for public policy and institutional reform**. For example, the South African Gender-Based Violence and Health Initiative (SAGBVHI) consists of 15 partner organizations and individuals in South Africa. They conduct research, build research capacity, disseminate research findings, and use research to advocate for policy reforms. SAGBVHI works closely with the Gender and Women's Health Directorates of the National Department of Health. The impact such networks produce are difficult to measure, but informal assessments suggest that SAGBVHI has achieved important results. For example, they convinced two medical schools to increase their emphasis on gender-based violence within their curriculum, helped to develop a one-week module on rape for medical students, and contributed to new national policies on gender-based violence and health. Their work exemplifies how researchers can collaborate with government to translate research findings into policy (Medical Research Council, 2003; Guedes, 2004).

Excerpted from: Bott, S., Morrison, A., Ellsberg, M., 2005a. Preventing and Responding to Gender-based Violence in Middle and Low-income Countries: A Global Review and Analysis. *World Bank Policy Research Working Paper* 3618, p. 28.

For more detailed information on advocacy related to legislative reform, see Advocating for New Laws or the Reform of Existing Laws in the module on Legislation.

Additional Resources:

- **Women Leadership Program Initiative for Equity Tanzania** (Women Leadership Program Initiative for Equity Tanzania, 2003). This resource provides practitioners and trainers a comprehensive overview of a leadership training to address GBV. The training develops community change agent skills, with topics including gender concepts, the linkage between GBV/VAW and human rights, communication for advocacy against GBV and developing action plans for networking. The workshop objectives, agenda, outcomes and facilitation methodology are provided alongside the workshop evaluation as a reference to the training. Available in English; 52 pages.

- **Gender, Reproductive Health, and Advocacy** (Centre for Development and Population Activities, 2000). Training Manual Series. (Sessions 9-14). Available in English.

3. Ensure that laws are implemented.

- In the absence of enforcement, even the best laws do not prevent violence or protect survivors. Globally, rape is among the least convicted of all crimes. On average, only ten percent of reported violence will result in a conviction, and in many settings, that number is likely to be even lower (Amnesty International, 2004, cited in USAID and UNICEF, 2006; Johnson et al. 2008; Vetten et al. 2008; and Lovett and Kelly 2009).

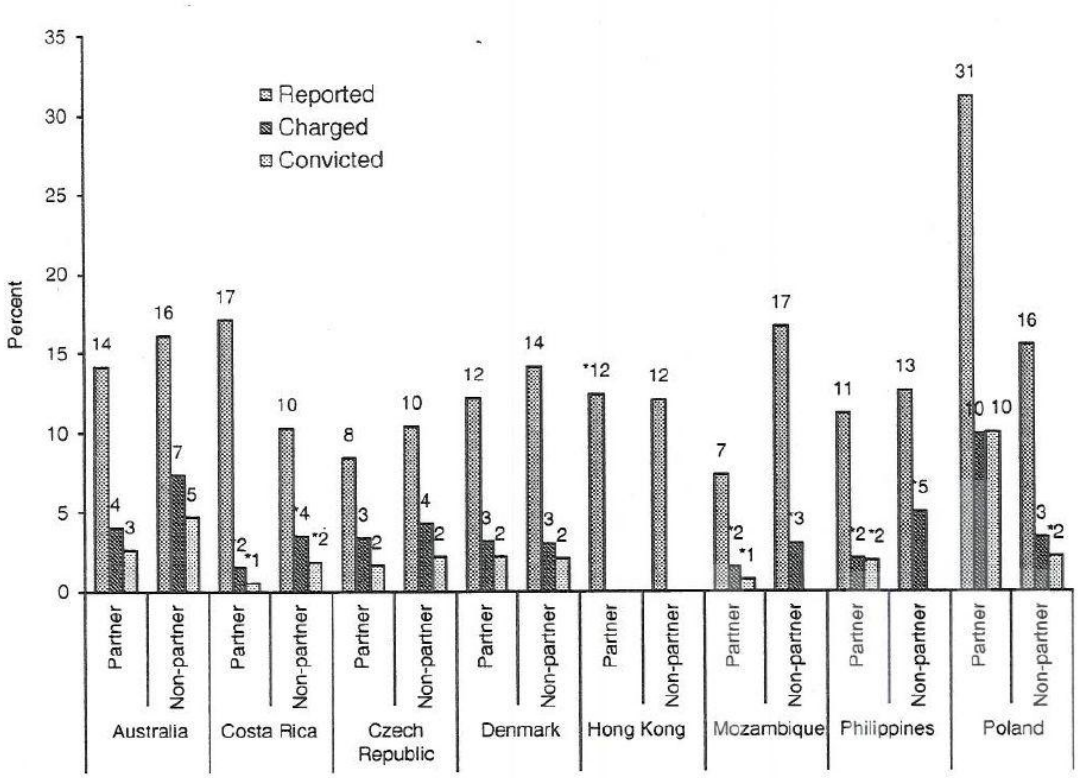


Fig. 6.11 Attrition for violence perpetrated by partners and non-partners: percentage of cases reported to the police, percentage with charges laid and percentage with convictions calculated as a percentage of all victimised women

*Relative standard error is between 25 and 50.

Sample counts for some categories were less than 5 in Hong Kong, Mozambique, and the Philippines.

Source: Johnson et al. 2008. *Violence against Women: An International Perspective.* Springer: New York.

- Particularly in some developing countries, marital rape is not defined as a crime. Even where there are laws against intimate partner violence, they often go unrecognized, carry light sentences—of which just the minimum is often applied—or are compromised by customary law, which often dictates that husbands may use a certain degree of violence against their wives to

discipline them (Center for Reproductive Law and Policy, 2001, cited in USAID and UNICEF, 2006).

- Budgetary constraints, low political commitment, and/or limited popular support of women's rights and a lack of training for lawyers and judges in the application of relevant laws, policies, and protocols also undermine the implementation of protective legislation. Furthermore, many women have little access to information about their rights and how to negotiate the legal system when their rights are violated (USAID and UNICEF, 2006).

- The health sector therefore has a responsibility to ensure that laws related to the rights of survivors to services and the obligations of health care providers are properly implemented. Facilitating implementation involves training health care providers about their obligations related to relevant laws, ensuring that communities are aware of their rights and the availability and range of services, and monitoring delivery of services and quality of care. For more information about Implementing Laws see the module on Developing Legislation on Violence Against Women and Girls.

D. Develop national and sub-national policies or action plans on a comprehensive health sector approach to violence against women.

- National policies (or action plans) are necessary as a basis and guiding framework for delivering services. They can provide important information about how relevant laws should be implemented.

- At the most essential level, national policies should recognize violence against women as a public health issue and outline principles for caring for survivors based in a human rights and gender perspective. They should take into account the needs of special populations, including girls, and consider issues of diversity related to language, ethnicity, and cultures (Ellsberg and Arcas, 2001).

- National policies should also outline a plan for implementation, which may include how to increase services and resources incrementally, and how these services and resources will be funded (Claramunt and Cortes, 2003).

- In some instances, **the health sector services and programmes that address violence against women and girls can be integrated into a larger national policy on violence against women** that places the health sector within a multisectoral framework that highlights cooperation, division of labour, and referral networks among all the key sectors engaged in violence prevention and response. The components of national policies that affect the health sector might include a range of support services for victims/survivors;

educational outreach for prevention and to acquaint women with their rights and the resources available to them; and capacity building for staff and officials. National multisectoral policies also include judicial and security sector services aimed at prosecution, punishment and rehabilitation of perpetrators. Generally, if there is a national multisectoral policy on violence against women, the health sector will need to elaborate sector-specific action plans, protocols, and or guidelines that address key forms of violence against women and health care for survivors.

- **National policies may also focus on how to integrate violence against women into different types of health services, especially those most frequented by women (e.g. reproductive health services).** It is important to consider complementary health frameworks, since many women who experience violence will rarely seek help from a stand-alone service. They are more likely to seek other health services from hospitals, health clinics, and other primary and secondary health facilities, and those that provide health care for their children; therefore it is important to ensure that violence against women and girls is accounted for in various health frameworks (Colombini, Mayhew and Watts, 2008).

- **National policies should provide a model for other policies that are developed at sub-national levels (regional, district, etc.).** Sub-national policies are useful in contextualizing the national policy. They may also be developed in place of a national policy where one does not exist.

- National policies can be created from scratch or adapted from those in other countries (see the examples provided below and also see the Secretary-General's Database on VAW for policies and protocols from different countries as well as WHO's *Developing National Policies to Prevent Violence and Injuries: a Guideline for Policy-Makers and Planners*). In all cases, existing country-level data and findings from the situation analysis should be used to inform the policy and the committee of stakeholders should be actively engaged in all review, drafting, reform and monitoring processes.

- All policies and/or action plans should include a list of indicators to measure progress in implementation. Action plans can utilize the comprehensive list of key health indicators in Violence against Women and Girls: A Compendium of Monitoring and Evaluations Indicators.

FOCUS	EXAMPLES of National Health Policies Addressing Violence against Women
National Domestic Violence Policy	In 2010, the **United Kingdom** Government released Improving Services for Women and Child Victims of Violence: the Department of Health Action Plan, articulating the Health Department's role in evidence and information, raising awareness, training its workforce, and improving the quality of services.

	In 2008, the **Australian** Government appointed an 11 member National Council to provide advice on the development of an evidence-based National Plan to Reduce Violence against Women and their Children. In 2009, the council produced *Time for Action: the National Council's Plan for Australia to Reduce Violence against Women and their Children 2009-2021* (the Plan of Action). The National Plan intends to bring together the efforts of all service systems for the common goals of preventing violence, delivering justice for victims and improving services. In 2007, the Government of **Turkey** launched a three year Combating Domestic Violence Against Women National Action Plan (2007-2010). This plan focused on integrating violence against women into different types of health services through the extensive involvement of the Ministry of Health throughout the plan's implementation phase.
National Sexual Violence Policy	The *Cross-government Action Plan on Sexual Violence and Abuse* of the **United Kingdom**, articulates the government's commitment to improve access to criminal justice, increase access to a wide range of services and prevent sexual violence and abuse. It includes the roles and responsibilities of all the participating agencies, including the police, Crow Prosecution Service, Courts, National Offender Management Service, Local Authorities, Voluntary and Community Sector Organizations, Sexual Assault Referral Centres, Primary Care Trusts/Local Health Boards and External Forensic Service Providers and Practitioners.
Other National Policies with Violence Components	The **Bolivian** *Sectoral Development Plan 2010-2020: Towards Universal Health* includes budgeted priorities for addressing intimate partner and sexual violence. The 2007 *Integrated Plan to Confront the Feminization of AIDS and other STDs* in **Brazil** prioritizes the reduction of sexual and domestic violence against women as one of its five objectives. The Government of **Ethiopia** addresses sexual and domestic violence as well and female genital mutilation and early marriage within its nine-year National Reproductive Health Strategy (2006-2015). For example, one of the strategy's targets is to ensure that all new law enforcement recruits are trained in the protection of women's rights, especially those pertaining to gender-based violence, including female genital mutilation/cutting and early marriage. The National AIDS Council of **Papua New Guinea's** National Gender Policy and Plan on HIV and AIDS addresses gender-based violence as an important factor in the spread of HIV. The plan outlines objectives and strategies to address violence against women. The Government of **Rwanda** includes the management of sexual violence as one of the major areas within its National Reproductive Health Policy (Schechtman, 2008). The other priority areas include: safe motherhood and child health, family planning, prevention and treatment of STIs including HIV, adolescent reproductive

	health and social changes to increase women's decision-making power. The Government of **Timor-Leste** comprehensively addresses gender-based and sexual violence throughout its eleven-year National Reproductive Health Strategy (2004-2015). Strategic priorities include: ensuring that the prevention and management of gender-based violence are part of integrated reproductive health care; and developing behaviour change communication on matters of sexual violence, coerced sex, equitable decision making and gender issues within families on sexual matters. The Government of **South Africa** includes sexual violence and domestic violence in its National Policy Guidelines for Victim Empowerment. These National Policy Guidelines provide a framework for sound inter-departmental and intersectoral collaboration and for the integration of effective institutional arrangements for a multi-pronged approach in managing victim empowerment. Of particular importance is the cross-cutting nature of the programme. In addition, the National Policy Guidelines serve as a guide for sector-specific victim empowerment policies, capacity development and a greater emphasis on the implementation of victim empowerment programmes by all relevant partners. The HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011 also addresses gender-based violence as a factor that increases risk for HIV.
Sub-national Policies	The Department of Health in the Western Cape Province of **South Africa** has developed their own sub-national policy to address sexual violence: *Survivors of Rape And Sexual Assault: Policy And Standardised Management Guidelines*. In **Canada** the province of Ontario has developed their own sub-national policy to address **domestic violence**: *A Domestic Violence Action Plan for Ontario*.

E. Ensure protocols/guidelines are in place to support standardized implementation of national and sub-national policies.

- In general, protocols and guidelines establish what services should be provided, by whom, how, and the mechanism for monitoring them (Velzeboer, 2003). They standardize quality of care and provide clear procedures for staff to more confidently and effectively address violence against women and girls in accordance with their obligations. Protocols are an important step in institutionalizing violence programmes and raising awareness among personnel (Velzeboer, 2003).

- As for any specialty in medicine, protocols are needed to standardize survivor care based on evidence. Having norms and protocols in place also provides tools for monitoring quality of care (Ellsberg and Arcas, 2001).

- Protocols and guidelines are generally created as reference tools for service providers to assist them in providing specific types of care to survivors. They can be developed at the national, sub-national, and institutional levels.

- It may be helpful to have a "Standards Committee", which could be established by the national health ministry or health department, that is responsible for setting standards, developing standardized protocols and guidelines, and monitoring the extent and quality of training and protocol and guidelines implementation (Jewkes, 2006).

- **Sexual assault** responses require additional standards with respect to bodily integrity and dignity, including in medical and forensic procedures, as well as specific mental health needs (Council of Europe, 2008a). See examples in the table below.

- Protocols must also address the needs of different demographic populations of survivors. For example, statistics show in many countries a considerable percentage of rapes occur to children under the age of 14 (Kim et al., 2007a; Chang, 2004; Peterson, 2005). Adolescent girls may need different programmes than adult women or women who attend antenatal care. Paediatric programmes often only address child abuse. Disabled women and girls and older women may also need to know they can access specialized services (Beaulaurier, 2007). (See section on special considerations when working with specific populations for more information.)

- Drafting health sector policies on violence is only the first step in a longer process. The policies must be disseminated as widely as possible, through training to health workers, as well as through community education to the society at large. Raising awareness of the health policies is an important way of promoting accountability of the health sector (Ellsberg and Arcas, 2001). One useful method for professional dissemination is to create a process for accreditation, licensure and **certification on violence against women and girls for health professionals**.

FOCUS	EXAMPLES of NATIONAL GUIDELINES
Medical Management of Rape	Global: *Guidelines for Medico-Legal Care for Victims of Sexual Violence* (WHO, 2004). Brazil: *Prevencao e Tratamento Dos Agravos Resultantes da Violencia Sexual Contra Mulheres E Adolescentes: Normas Técnicas* (Ministry of Health, 2005). Chile: *Normas y Guia Clinica para la Atencion en Servicios de Urgencia de Personas Victimas de Violencia Sexual* (Ministry of Health, 2004). Colombia: *Protocolo para el abordaje integral de la violencia sexual desde el Sector*

	Salud (Convenio Secretaría Distrital de Salud, 2008) Costa Rica: Protocolo de Atencion a Victimas de Violencia Sexual y/o Domestica en el Departamento de Ciencias Forenses and Protocolo para la Atención de la Violencia Sexual y/o Doméstica en el Departamento de Departamento de Medicina Legal (Ministerio Público de la República de Costa Rica, 2008) Kenya: *National Guidelines: Medical Management of Rape/Sexual Violence* (Ministry of Health and Liverpool VCT, 2004). United States: *A National Protocol for Sexual Assault Medical Forensic Examinations* (US Department of Justice, 2004).
Responding to Domestic Violence	Albania: *The Albania Health Protocol on Domestic Violence* (USAID, 2006). Costa Rica: *Protocolo de Atencion a Victimas Mayores o Menores de Edad de Delitos Relacionados con la Violencia Doméstica Cometidos por Personas Mayores de Edad* (Ministerio Público de la República de Costa Rica, 2008) Guatemala: *Protocolo de Atención a víctimas de Violencia Intrafamiliar* (Ministerio de Salud Pública y Asistencia Social de Guatemala Programa Nacional de Salud Mental, 2008) United Kingdom: *Responding to Domestic Violence: A Handbook for Health Professionals* (Department of Health, 2005). Available in English. United States: *The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings* (Family Violence Prevention Fund, 2002, updated 2004).
Abortion	Global: "Safe Abortion: Technical and Policy Guidance for Health Systems" (WHO, 2003). Global: La Atención del Aborto Centrada en la Mujer: Manual del Capacitador (Ipas, 2006)
Post-exposure Prophylaxis	Global: *Post-exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO Guidelines on Post-exposure Prophylaxis (PEP) to Prevent HIV Infection* (WHO and ILO, 2007). Available in English and French. South Africa: *South Africa Treatment Guidelines for the use of AZT (Zidovudine) for the Prevention of HIV Transmission to Children who have been Sexually Abused*
Screening	Global: *Improving Screening of Women for Violence: Basic Guidelines for Healthcare Providers* (Stevens, 2005) Dominican Republic: *Detección y Atención de la Violencia Basada en Género:*

	Protocolo (Profamilia, 2006) South Africa: *Screening for Domestic Violence: A Policy and Management Framework for the Health Sector* (Martin and Jacobs, 2003) During Pregnancy (Global): *What Works: A Policy and Program Guide to the Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions* (Policy Project, 2003). See pages 160-161.
Children and Adolescents	Australia: *Guidelines on the Management of Sexual Health Issues in Children and Young People* (Department of Health and Families, Northern Territory Government, 2010) Costa Rica: *Protocolo de Atención legal a Víctimas de Delitos Sexuales y Violencia Doméstica Cometidos por Personas Menores de Edad* (Ministerio Público de la República de Costa Rica, 2008) South Africa: *The Integrated Case Management Guidelines: Child Abuse (for under 14)* (Cape Metropolitan Council, Cape Town City Council, 2003) United States: *Child Sexual Abuse: Intervention and Treatment Issues* (Faller, 1993).

F. Create a national public health surveillance system on violence against women and girls.

- A public health surveillance system is necessary to understand the consequences of violence against women and girls; to determine the costs associated with violence; and to monitor the scope, coverage and quality of care survivors are receiving (Ellsberg and Arcas, 2001).

- A public health surveillance system may also contribute to understanding the prevalence and incidence of violence against women and girls, though it is very important to remember that surveillance systems based on service-delivery data only provide information on women and girls who report or seek help for violence. Many women who experience violence will not report to a health facility or disclose that they have experienced abuse. Service delivery data is therefore more useful in monitoring demand for services, capacities of service providers to respond, and the number and scope of services provided. Prevalence is better measured through population-based surveys, as described in Conducting Research, Data Collection and Analysis in the Programming Essentials module.

- Ideally, surveillance will be based on a national system to collect, track and report data on violence against women by the public health system that is

aligned at the sub-national and local levels. The best way to collect data is electronically and stored in a centralized location.

WHAT IS PUBLIC HEALTH SURVEILLANCE?

- Public health surveillance is "the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in the planning, implementation, and evaluation of public health practice." Typically, public health surveillance includes data collection and analysis, as well as dissemination of data to those who are responsible for undertaking prevention and response programming. Surveillance data is not only useful in terms of identifying health service needs of a given population, but also for understanding research and training needs. Public health officials usually have responsibility for overseeing any kind of public health surveillance system.

- Planning a surveillance system begins with a clear understanding of the purpose of surveillance—e.g. the problem that is being studied—after which begins a process of deciding how best to obtain, analyze and disseminate information about the problem. Public health data can be drawn from a variety of different sources, such as hospital discharge records, medical management information, police records, etc. However, it is important to remember that while these data systems can be used for surveillance, they are not surveillance systems in and of themselves. Surveillance is a larger process that requires analysis, interpretation, and use of the data.

- It is important to remember that surveillance systems are ongoing, require and the input and participation of many individuals and organizations, and must provide information that is timely enough to be acted upon.

- The general steps for developing a surveillance system include:

1. Establish objectives
2. Develop case definitions
3. Determine data sources data-collection mechanism (type of system)
4. Determine data-collection instruments
5. Field-test methods
6. Develop and test analytic approach
7. Develop dissemination mechanism
8. Assure use of analysis and interpretation

Source: excerpted from **Teutsch S**, **Thacker S**: Planning a public health surveillance system**.** Epidemiological Bulletin 1995**,** 16(1), pgs.1-6)

- In order to contribute to a surveillance system, all providers should be using standardized medical records and information systems on violence against

women and girls in order to generate comparable data—meaning that each agency or institution should have intake and other client forms that utilize nationally-determined case definitions and that document similar case information (Kilonzo, 2008a). Each agency or institution should also have a method for centralizing and reporting data that is not linked to names or other identifying information to ensure survivor safety and confidentiality (Ellsberg and Arcas, 2001). Data collection forms and methods should not be unduly complicated, and health care providers should be trained in data collection.

- Data collected at the clinic and hospital level should be forwarded to the municipal level, then to the district level, and then to the national level (Ellsberg and Arcas, 2001). While it is critical that a designated office or institution at the national level is tasked with overseeing the surveillance system, data should not only be analyzed at the national level; it should also be analyzed at the clinic, hospital, municipal, and district levels to improve services, prepare budgets and as a basis for planning.

Example: In Belize, Guatemala, and Panama, a **single registration system** has been developed that is intended to be used by professionals from all sectors that come into contact with violence victims, such as the Ministries of Health, law enforcement, the court system, and non-governmental organizations. The system also applies to reports by forensic doctors. In Belize, the Ministry of Health is responsible for consolidating, processing, and analyzing the information from these sectors and then afterwards reporting it to the other pertinent ministries. In Panama, the information is sent to the Legal Medicine Institute for analysis.

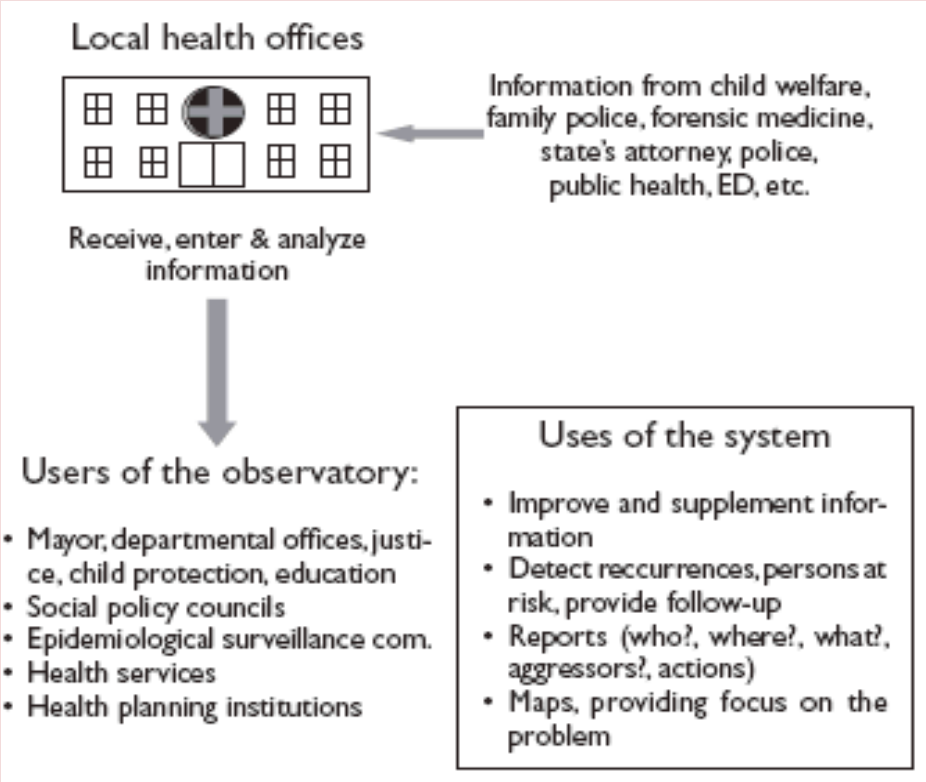
Lessons learned from this approach are that information and surveillance systems are an essential part of the integrated approach to gender-based violence and should not function independently from the development of services. For the reporting system to work, and before it is implemented, it is important to develop norms and protocols for the detection and care of the affected women and to train providers in their appropriate use. Untrained personnel can actually cause harm to women by asking about violence in insensitive or victim-blaming ways.

Furthermore, **information systems are only valid if the data are used to improve services**. Not only is it a waste of resources, but also it is unethical to collect information or carry out active screening for violence with the sole purpose of information-gathering, if no services are offered in return

Source: Excerpted from Velzeboer, M., Ellsberg, M., Arcas, C., and Garcia-Moreno, C., 2003. *Violence against Women: The Health Sector Responds*. Washington, DC: PAHO, pgs. 55-57.

Example: The province of Valle, Colombia created a domestic surveillance system with the support of the Secretary of Health of Valle. This was done using resources from the basic health plan allocated for strengthening the **municipal**

reporting system and response to domestic violence. By creating an active surveillance system, a municipality with 185,000 inhabitants increased the documented cases of violence against women and girls from 192 in 2002 to 1,059 in 2004 – a fivefold increase in reported cases over a three-year period. Reliability and validity of data also improved. Strategies included: implementation of a standard digitalized reporting and analysis system along with advocacy with community decision makers; strengthening inter-institutional attention networks; consulting for constructing internal flow charts; sensitizing and training network teams in charge of providing health care in cases of domestic violence and supporting improved public policy prevention initiatives. The system was useful for improving survivor services. The project was phased in, with sites added in over a three-year period. The system created geographic references and plotted where reported cases of violence against women and girls occurred; developed a prevention strategy for early detection of violence against women and girls; constructed charts for decision making for each institution; and constructed a common protocol and flow chart for referral of survivors within a network of inter-institutional prevention and treatment. Standardized information gathering in a common software programme became an epidemiological surveillance system including all cases within a defined population, with active collection, consolidation and verification procedures.



Source: Adapted/Excerpted from: Espinosa, R., Gutiérrez, M.I., Mena-Muñoz, J.H., Córdoba, P., 2008. "Domestic Violence Surveillance System: A Model", pp. S13-S16.

Illustrative Resources:

- ***Domestic Violence Surveillance System: A Model*** (Espinosa, R., Gutierrez, M., Mena-Munoz, J. and Cordoba, P. 2008)**.** *Salud Publica de Mexico* 50 (Issue Supplement 1): S12-S18. Available in English.

- ***Data Collection System for Domestic Violence*** (The United Nations Economic Commission for Latin America and the Caribbean, 2002). Available in English.

- ***Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements*** (Centres for Disease Control and Prevention, 2002). Available in English.

- ***Administrative Data Collection on Domestic Violence in Council of Europe Member States*** (Council of Europe. 2008*).* Available in English.

- ***Gender-based Violence Information Management System Project Tools***. The GBVIMS is a multi-faceted initiative being undertaken in humanitarian settings to enable humanitarian actors to safely collect, store, and analyze reported GBV incident data. The GBVIMS includes: a workbook that outlines the critical steps agencies and inter-agency GBV coordination bodies must take in order to implement the system; an Excel database (the "Incident Recorder") for data compilation and trends analysis; and a global team of GBV and database experts from UNFPA, UNHCR and the International Rescue Committee for on-site and remote technical support. For more information about the tools, see the information brief and the website.

- For general tools on collecting data on violence against women and girls, see Conducting Research, Data Collection and Analysis in Programming Essentials.

G. Ensure adequate funding for the health sector to address violence against women and girls.

- Services for survivors of violence should be funded by the government and provided at no cost to the survivor. National and local governments should fund civil society organisations working on addressing VAW/G and VAC. (Schechtman, 2008)

- Government funding should not be ad hoc; it should be sufficient, predictable and long-term. It should provide support and services to victims and survivors for both short and long term consequences.

- Successful allocations in the sectoral or national budget are linked to the political commitment to the problem. (ICRW, 2003)

- Tracking how government and non-governmental actors allocate and spend resources ("resource flows") through to the final expenditure, can help assess the impact of funding of VAW/G. Resource flows can also: determine how much of the originally allocated resources reach each level, detect problems, and identify places where funds are not reaching beneficiaries or are being used for purposes other than what was intended. (U4 Anti-Corruption Resource Centre, N.d.; Dehn, Reinikka and Svensson, 2003; Schechtman, 2008.)

- Some financing mechanisms can assist with raising revenue to meet the costs of health care services, such as: tax revenue, social health insurance, user fees, private (for-profit) health insurance, and community funds (UNFPA and UNIFEM, 2006).

- Some innovative methods have been developed in order to improve financing for services to survivors. In the United States, two states have established funding through fines paid by convicted sex offenders (Jewkes, 2006).

- Gender Responsive Budgeting (GRB) initiatives promoted by UNIFEM and other United Nations partners can provide information needed to create enabling policy frameworks, build capacity and strengthen monitoring mechanisms to support accountability to women. GRB is "government planning, programming and budgeting that contributes to the advancement of gender equality and the fulfillment of women's rights. It entails identifying and reflecting needed interventions to address gender gaps in sector and local government policies, plans and budgets. GRB also aims to analyze the gender-differentiated impact of revenue-raising policies and the allocation of domestic resources and Official Development Assistance." The UN Women sponsored portal on Gender Budgeting provides governments, non-governmental organizations, parliaments and academics with resources for understanding and applying GRB.

Example: In both functional and program classifications, one sometimes finds that the categories are not disaggregated in a way that allows identification of the amounts allocated for the thing you are interested in. In particular, the topic of interest is sometimes grouped with other services. Paraguay's Senate Commission on Equality, Gender and Social Development encountered this problem when they attempted to find out how much was allocated for sexual and reproductive health by the Ministry of Public Health and Social Welfare. By raising the problem, they succeeded in persuading the Ministry to introduce a separate line item for allocations for purchasing contraceptives. The Commission found that donors were covering 100% of the amount spent on contraceptives. The Municipality of Asuncion was inspired by what was being achieved at national level and asked for UNFPA assistance in doing GRB [Gender Responsive Budgeting] work at municipal level. This initiative resulted in the dropping of user fees for pre- and post-natal care at municipal polyclinics for pregnant adolescents less than 20 years of age. The municipality also increased by 300% the amount allocated for the costs of family planning methods.

Source: excerpted from UNFPA and UNIFEM. 2006. *Gender Responsive Budgeting and Women's Reproductive Rights: A Resource Pack*. Box 18, p.53. Available in English, French and Spanish.

- Measuring the economic costs of VAW/G can provide an evidence-base to assist with annual budgeting at the national and sub-national levels:

  i) Exact financial figures can help decipher between what is needed and what is available;

  ii) Committed and dedicated decision-makers can strengthen their arguments with hard facts about the economic consequences of VAW/G and demonstrate what could be achieved with more money;

  iii) Assessing the costs and resources can help set priorities. (Potts, 1999)

- The first known efforts to estimate the economic costs VAW/G started in the late 80s with studies estimating the cost of domestic violence against women. Since then, studies and methodologies have become more sophisticated and ambitious and have been done in many countries (Gancheva and Davidson, 2006). Yet costing estimates vary substantially since they depend on "the data and methodology used, the inclusion or exclusion of different categories, and the monetary value allocated to human life and suffering." See the World Bank website for additional information.

- Four of the most common methods used for costing are:

    - **Accounting methodology**: consists of calculating the costs of specific categories or costs (see table below). The total cost of VAW/G to society would then be the sum of all categories of costs (Bott, Morrison and Ellsberg, 2005a). Typical of this approach is the calculation and distinguishing of direct and indirect costs (see diagram below).

    - **Modeling technique**: with this method, costs and outcomes from different sources are brought together. Typically this means that the lifetime of a particular patient or of an entire population is replicated, including the "health states they will move into and out of over time because of the intervention or its absence." (Kuntz and Weinstein 2001, cited in Norman, Spencer and Feder, n.d.)

    - **Cost-effectiveness analysis**: studies that look at measuring the cost of implementing preventive interventions versus the cost of dealing with the outcomes of violence.

    - **Approximations**: this method consists of using the findings of costing studies conducted in other provinces or countries.

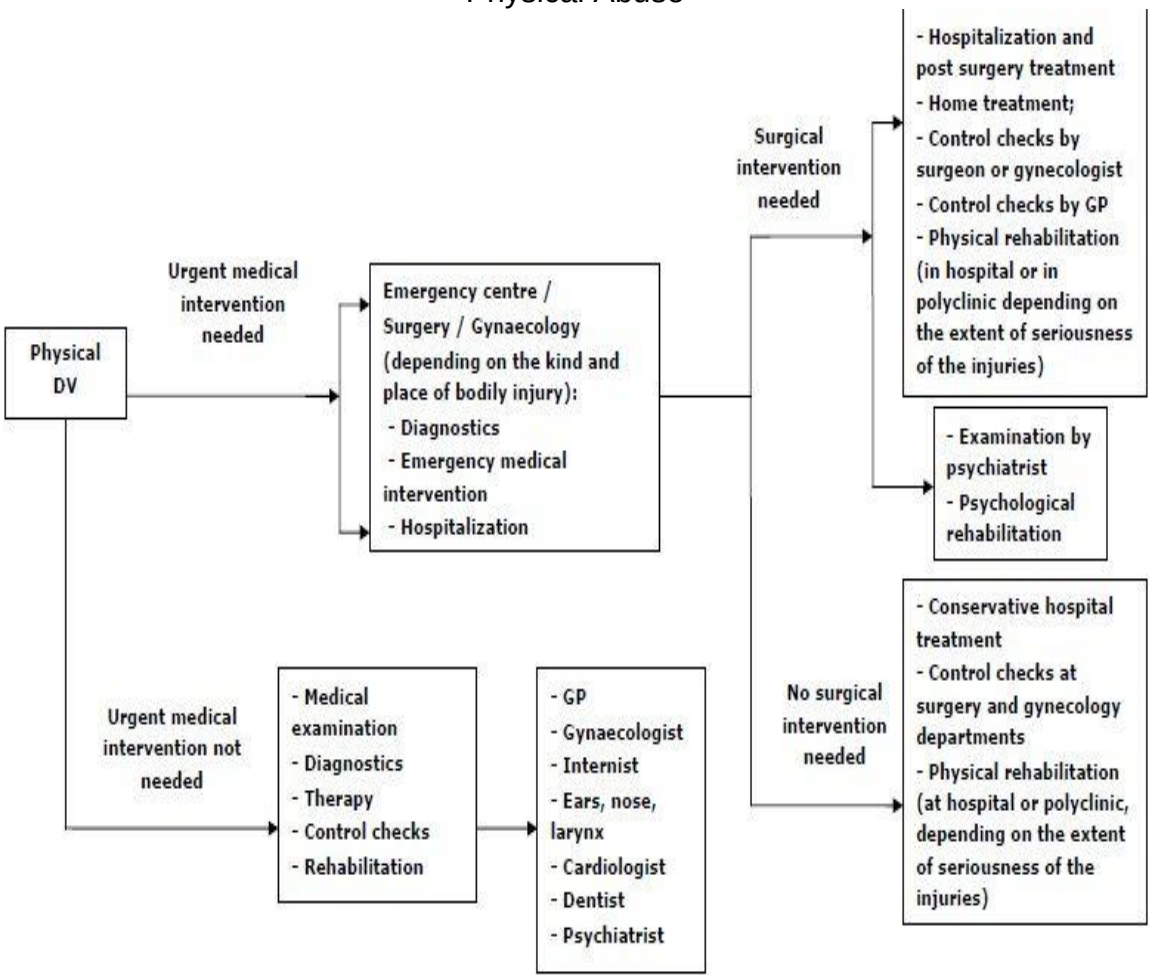
Cost category	Description	Type of cost	Components
Direct costs	Direct costs arise directly from acts of violence and require actual payments by individuals or institutions.	Medical	Hospital inpatient Hospital outpatient Transport/ambulance Physician Drugs/laboratory tests Counselling
		Non medical	Policing and imprisonment Legal services Foster care Private security

Indirect costs	Indirect costs are harder to quantify and typically do not factor into budgets. They refer to lost resources and opportunities resulting from violence.	Tangible	Lost productivity (earnings and time) Lost investments in social capital Life insurance Indirect protection Macroeconomic
		Intangible	Health-related quality of life (pain and suffering, psychological) Other quality of life (reduced job opportunities, access to schools and public services, participation in community life)

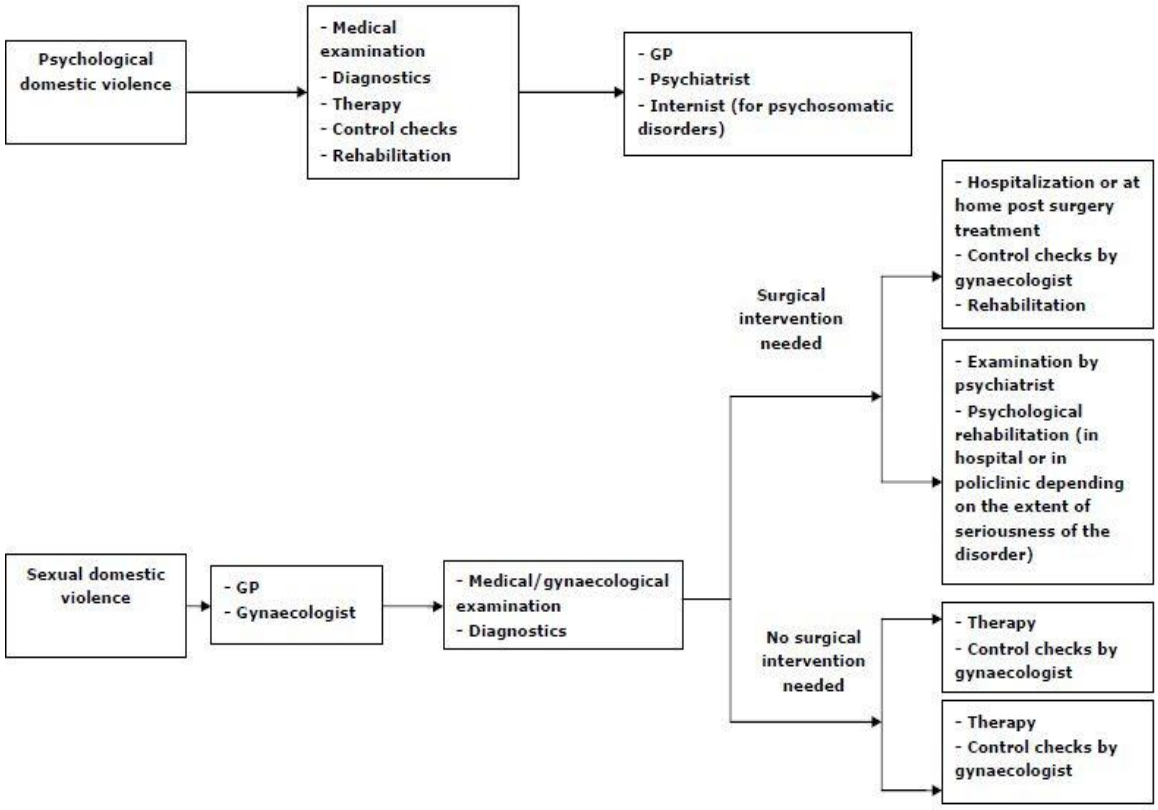
Source: excerpted/adapted from: WHO and CDC. 2008. M*anual for estimating the economic costs of injuries due to interpersonal and self-directed violence*, Table 1, pg. 62 and ICRW, 2003, "How to make the law work? Budgetary Implication of Domestic Violence Policies in Latin America", pg.12. Available in English.

In Macedonia, the institutional health care response to violence against women was mapped to determine what costs need to be accounted for (Gancheva, Y. and Davidson, D.I. (Eds.), 2006. *The costs of domestic violence against women in FYR Macedonia. A costing exercise for 2006).*

Physical Abuse



Psychological and Sexual Violence



Example: In her 1998 paper *The Economic Costs of Violence against Women*, economist Ermi Amor Figueroa Yap attempted to identify and quantify, in the Republic of the Philippines's first exploratory study, the economic cost of VAW. Yap used seven variables, classified into three main groups: costs to the government, the individual victim, and the community. These are: (1) the budget/expenditures of the government on activities related to the treatment; (2) prevention and monitoring of VAW cases; (3) direct expenditures of the individual victim/survivor for medical services, transportation and subsistence allowances; (4) expenditures of the individual for pursuing legal action against the aggressor such s docket and lawyers' fees; (5) opportunity cost to the individual (income loss) due to absence from work; (6) productivity loss to the market due to absence from work and; (7) opportunity cost to the community such as loss of productivity, reduction of income, higher monitoring costs; and social costs such as breakdown of family and communal relationships, and social unrest.

Yap estimated that the economic cost of domestic violence to the Philippine government reached US$1.7 million per year. According to Yap this estimate does not include expenses incurred in the performance of functions directly related to VAW. The health department, for instance, does not keep track of the medical expenses incurred by the public health system in treating cases of VAW.

Source: excerpted from Mission, Gina. n.d. "The Economic Cost of Violence against Filipino Women." Provides a summary of the research conducted by economist Ermi Amor Figueroa Yap. Available in English.

Illustrative Resources:

- ***How to make the law work? Budgetary Implication of Domestic Violence Policies in Latin America*** (International Center for Research on Women, 2003). Available in English.

- ***Health Systems Assessment Approach: A How-to Manual*** *(*Islam, M. 2007). See Chapter 7: Health Financing Module. Available in English.

- **M*anual for estimating the economic costs of injuries due to interpersonal and self-directed violence*** (World Health Organization and Centres for Disease Control and Prevention, 2008). Available in English.

- ***Financial resources management for the Health Sector*** (U4 Anti-Corruption Resource Centre). Available in English.

- ***Survey Tools for Assessing Performance in Service Delivery*** (Dehn, J., Reinikka, R. and Svensson, J., 2003). Available in English.

- ***Gender Responsive Budgeting and Women's Reproductive Rights. A Resource Pack*** (UNFPA and UNIFEM, 2006). Available in English, French and Spanish.

- ***Paying for Reproductive Health Care: What Is Needed, and What Is Available?*** (Potts, M., Walsh, J., McAninch, J., Mizoguchi, N. and Wade, T.J. 1999). *Family Planning Perspectives* (25) Supplement: S10-S16. Available in English.

- ***Cost-Effective Analysis: What You Always Wanted to Know But Were Afraid to Ask*** (Norman, R., Spencer, A. and Feder, G.) *Family Violence Prevention & Health Practice*. Available in English.

V. How do we develop and implement health programmes at the facility level that address violence against women and girls?

- Conducting analyses, developing a committee of stakeholders for coordination, reforming laws and drafting policies and protocols are only the first steps in creating a comprehensive health sector approach to violence against women and girls. None of these will have any impact unless they are used to enhance response services across a network of providers and health facilities and to build prevention strategies. It is also necessary to engage managers and other high-level staff to address the issue and to secure organizational "buy-in" at a senior and strategic level within the health-care setting (WHO, 2010a).

- When deciding how to develop and implement services for survivors at the facility level, it is important to consider the theoretical models for programming that include:

    - An ecological approach: understanding risks and protective factors at the individual, relationship, community and society levels.
    - A multisectoral approach: linking health programming with other key sectors involved in prevention and response.
    - A systems approach: ensuring that building capacity of health facilities to address violence against women and girls is system-wide, not just limited to specific training of key providers. A system-wide approach includes addressing the policies, protocols, infrastructure, supplies, staff capacity to deliver quality medical and psychosocial support, staff training and other professional development opportunities, case documentation and data systems, the functioning of referral networks, safety and danger assessments, among other items that are relevant to specific contexts and programmes. (See Heise, Ellsberg and Gottemoeller, 1999; Velzeboer et al., 2003; Bott et al., 2004.)
    - An integrated approach: that seeks to improve health service delivery by incorporating violence programming into existing health programmes.

- Strategies for programme development should also consider issues such as:

    - Human resource capacity, management and staff skills at any one facility
    - Infrastructure, equipment and supplies at any one facility
    - Service availability outside of the facility and coordination capacity of the relevant network
    - Legislative or policy frameworks and funding

- It is important to keep in mind that some experiences show that **if comprehensive care is not provided in one specific place, survivors may be deterred from accessing needed care**, as travel time, costs and transport present a hardship, particularly for rural women (Claramunt, 2003).

- Other experiences, however, have shown that **quality of services might be the most important factor for women in choosing where to go**. (For more information, see quality of care in guiding principles.)

- **Wherever services are provided, health facilities should follow basic steps outlined below in ensuring that their programming is well designed and delivered by competent and sensitive staff.**

A. Build institutional capacity of health facilities.

1. Identify the needs of the facility through an assessment.

Improving the health sector response to gender-based violence has implications for many aspects of the way a clinic functions. For example, ensuring adequate care for women who experience violence may require private consultation spaces, written policies and protocols for handling cases of violence, client flow that facilitates meaningful care, access to emergency contraception, and a directory of referrals in the community. One way to assess what resources exist in a clinic is to have an independent observer visit the clinic and assess the situation through firsthand observation. Another way to do this is for a group of staff to complete a checklist or self-administered questionnaire that includes resources that are important for providing quality care to survivors of violence.

Some methods that can be used include:

- **Clinic observations**

- **Confidential interviews** with clinic staff are an excellent source of information about the infrastructure, protocols and capacity of the health care facility. However, they require time and confidentiality assurances, and staff may not want to get involved in critical evaluations of the facility that employs them.

- **Questionnaires/ management checklists** are an easy, resource friendly monitoring mechanism. A management checklist can be used for monitoring what measures an institution has taken to ensure an adequate response for women experiencing gender-based violence.

- **Review of protocols and policies**

Assessment and Monitoring Checklist of Minimum Key Elements of Quality Health Care for Women Victims/Survivors of Gender-Based Violence

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

1. **Institutional values and commitment:** Has the institution made a commitment to addressing violence against women, incorporating a ―system's approach? Are senior managers aware of gender-based violence against women as a public health problem and a human rights violation, and have they voiced their support for efforts to improve the health service response to violence?

2. **Alliances and referral networks:** Has the institution developed a referral network of services in the community, including to women's groups and other supports? Is this information accessible to all health care providers?

3. **Privacy and confidentiality:** Does the institution have a separate, private, safe space for women to meet with health care providers? Are there protocols for safeguarding women's privacy, confidentiality and safety, including confidentiality of records? Do providers and all who come into contact with the women or have access to records understand the protocols?

4. **Understanding of and compliance with local and national legislation:** Are all providers familiar with local and national laws about gender-based violence, including what constitutes a crime, how to preserve forensic evidence, what rights women have with regard to bringing charges against a perpetrator and protecting themselves from future violence, and what steps women need to take in order to separate from a violent spouse? Do health care providers understand their obligations under the law, including legal reporting requirements (for example, in cases of sexual abuse) as well as regulations governing who has access to medical records (for example, whether parents have the right to access the medical records of adolescents)? Does the institution facilitate and support full compliance with obligations?

5. **Ongoing provider sensitization and training:** Does the institution provide or collaborate with organizations to provide ongoing training for staff around gender-based violence, harmful norms and practices, legal obligations and proper medical management of cases?

6. **Protocols for caring for cases of gender-based violence:** Does the institution have clear, readily available protocols for screening, care and referral of cases of gender-based violence? Were these protocols developed in a participatory manner, incorporating feedback from staff at all levels as well as clients? Are all staff aware of and able to implement the protocols?

7. **Post-exposure prophylaxis, Emergency contraception and other supplies:** Does the institution have supplies readily available, and are staff properly trained on their dissemination and use?

8. **Informational and educational materials:** Is information about violence against women visible and available, including on women's rights and local services women can turn to for help?

9. **Medical records and information systems:** Are systems in place for documenting information about violence against women as well as collating standardized data and service statistics on the number of victims of violence? Are records kept in a safe, secure manner?

10. **Monitoring and evaluation:** Does the institution integrate mechanisms for ongoing monitoring and evaluation of their work, including receiving feedback from all staff as well as from women seeking services? Are there regular opportunities for providers and managers to exchange feedback? Is there a mechanism for clients to provide feedback regarding care?

Source: Adapted from Bott, S., Guedes, A., Guezmes, A. and Claramunt, C., 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals.* NY, NY: International Planned Parenthood Federation: Western Hemisphere Region. Available in English and Spanish.

Case Study: Agency for Healthcare Research and Quality (AHRQ, USA)

The Agency for Healthcare Research and Quality has been supporting, through partnerships, rigorous research to improve the health care response to domestic violence in the United States. They have contributed to:

- Identifying gaps in research and pointing to the need for a stronger evidence base in the areas of screening, detecting and providing services to survivors.

- Helping health care workers screen for and identify women who have experienced domestic abuse.

- Creating tools that help health care workers counsel and provide services to survivors.

- Developing tools for assessment and evaluation of domestic violence programs.

The evaluation tools (DELPHI) were developed by AHRQ based on consensus and are for use in hospital-based settings. They include:

1. Hospital Policies and Procedures
2. Hospital Physical Environment
3. Hospital Cultural Environment
4. Training of Providers
5. Screening and Safety Assessment
6. Documentation
7. Intervention Services
8. Evaluation Activities
9. Collaboration

To learn more about the AHRQ, see the website.

Illustrative Tools:

- **How to Conduct a Situation Analysis of Health Services for Survivors of Sexual Assault** (South African Gender-based Violence and Health Initiative and Medical Research Council of South Africa). This guide provides tools and outlines steps for conducting a situation analysis of the quality of health services for victims/survivors of sexual assault. It includes a *facilities checklist* for collecting information on the infrastructure of the facilities where survivors are managed and where medico-legal/forensic examinations take place, including medication, equipment and tests available at the facility. It also

includes a *standardized health care provider questionnaire* designed to be used in face to face interviews with health care providers who manage the care of survivors. Note that, the tool does not address stigma and discrimination, the time a patient waits to be seen by a provider, or what happens after the provider has completed the examination. Available in English.

- **Clinic Interview and Observation Guide (**International Planned Parenthood Federation/Western Hemisphere Region). This assessment tool gathers information on the human, physical, and written resources available in a clinic. The first half of the guide consists of an interview with a small group of staff members (for example, the clinic director, a doctor, and a counselor). This section includes mostly closed-ended questions about services, including: the clinic's human resources; written protocols related to gender-based violence screening, care, and referral systems; and other resources, such as whether or not the clinic offers emergency contraception. The second part of the guide involves an observation of the physical infrastructure and operations of the clinic, such as privacy in consultation areas, as well as the availability of informational materials on sexual violence. Available in English and Spanish.

- **STI/HIV Self-Assessment Module** (International Planned Parenthood Federation/Western Hemisphere Region). This self-assessment module contains a questionnaire designed to assess whether an organization has the necessary capacity, including management systems, to ensure high quality sexual and reproductive health services. The questionnaire allows staff from different levels of an organization to assess the extent to which their organization has addressed a multitude of issues relevant to gender-based violence, including sexual violence. Available in English and Spanish.

- **Management of Rape Victims Questionnaire** (Azikiwe, Wright, Cheng & D'Angelo, USA). This self-administered questionnaire was designed for programme directors of pediatric and adult hospital emergency departments to report on their department's management of care for rape survivors. The 22 questions gather information concerning the department's volume of rape cases, screening for STDs, emergency contraception policies, medications offered or prescribed for emergency contraception, non-occupational HIV post-exposure prophylaxis policies, medications offered or prescribed for HIV post-exposure prophylaxis, and patient follow-up. Available for purchase in English from Elsevier.

- **Using Mystery Clients: A Guide to Using Mystery Clients for Evaluation Input** (Pathfinder International, 2006). This guide provides background on the concept of mystery clients and details the process of conducting and reporting on mystery client interviews within health facilities. Available in English.

- **Standardized Interview Questionnaires and Facilities Checklist** (Christofides, Jewkes, Webster, Penn-Kekana, Abrahams & Martin, South Africa). This face-to-face interview questionnaire was designed to gather information from health care providers who care for rape survivors. The questionnaire contains 5 sections that collect information on: the demographic characteristics of providers; the types of services available for rape survivors; whether care protocols for rape survivors are available at the facility; whether the practitioner had undergone training in how to care for rape survivors; and practitioner's attitudes towards rape and women who have been raped. Responses to particular items are used to develop a scale that measures the quality of clinical care. In addition, the assessment tool includes a checklist that the fieldworkers complete at each health care center noting the presence or absence of equipment and medicines and the structural quality of the facilities. The Interview Questionnaires and the Facilities Checklist are available in English.

- **Quality of Care Composite Score** (Christofides, Jewkes, Webster, Penn-Kekana, Abrahams & Martin, South Africa). The Quality of Care Composite Score is a self-reported measure used at the individual practitioner level to assess the clinical care provided by doctors and nurses who care for rape victims in terms of indicators of preventive strategies for sexually transmitted infections and prevention of pregnancy, counseling, and the quality of forensic examinations. It consists of 11 items such as treatment of sexually transmitted infections and clothing or underpants ever sent for forensic testing. Available in English.

- ***Ver y Atender! Guía Practica para Conocer cómo Funcionan los Servicios de Salud para Mujeres Victimas y Sobrevivientes de Violencia Sexual*** (Troncoso, E., D. Billings, O. Ortiz and C. Suarez/UNFPA and Ipas, 2006, Latin America)**.** This guide includes a tool that can be used to conduct a facility based assessment of services or referrals that could/should be offered for survivors; protocols and processes; capacity for conservation and collection of data; and HIV diagnosis and Post-Exposure Prophylaxis for different age groups. Available in Spanish.

- ***A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers*** (Billings/UNFPA, 2001). This Guide includes information on undertaking a situational analysis on p. 44. Available in English, French and Spanish.

- ***Evaluating Domestic Violence Programs*** (United States Agency for Healthcare Research and Quality). This instrument facilitates a formal performance assessment of a hospital's domestic violence programme and was developed by a panel of experts focused on examining structure and process measurements. The evaluation tool measures nine categories which

are explained through online instructions: hospital policies and procedures; hospital physical environment; hospital cultural environment; training of providers; screening and safety assessment; documentation; intervention services; evaluation activities; and collaboration with other service providers. The materials, including the facility assessment tool are available in English.

- ***Twubakane Project Inventory to Assess Facility Readiness to Manage Gender-based Violence*** (IntraHealth, 2008). Available in English and French.

2. Develop policies, written protocols and strategies to support integration of violence against women and girls services throughout the facility.

- While each facility will want to draft its own policies and protocols for care according to the nature and scope of service, these polices and protocols should wherever possible be based on policies and protocols that exist at the national and sub-national levels, in order to ensure that health providers across a variety of agencies and institutions are working according the same general principles and guidelines that promote women's safety, health and well-being.

- When drafting policies and protocols, facilities should bear in mind several lessons learned about **good practice**:

    - Involve sensitized and trained staff in the development of policies and protocols in order to improve quality and effectiveness of services.

    - Distribute policies and protocols to all staff members, not just those providing direct services, and whenever useful, post summaries of policies and protocols (e.g. those on confidentiality) in the clinic to educate clients about standards and procedures for care.

    - Be sure to monitor the implementation and usefulness of policies over time through periodic staff feedback, review of client records, etc., in order to determine when and how policies and protocols may need to be revised (Bott et al., 2004).

- Every facility will need to determine the various policies and protocols that should be developed for that particular setting, but in general all facilities should address the following:

Type of Policy or Protocol	Why this type of policy or protocol is important and what it needs to contain	Examples
Sexual	Every health care organization	See the Office of the

Harassment	should have a written policy that prohibits sexual harassment by staff members against other staff members and against clients. The policy should state what types of actions are prohibited and should include a clear definition of sexual harassment, the procedures for reporting a case of sexual harassment, and the consequences of violating the policy. Health care organizations cannot adequately address the issue of gender-based violence if they cannot ensure respect for the rights of their own staff members and clients. A sexual harassment policy that has a clear procedure for handling violations is therefore an essential part of this effort.	Special Advisor on Gender Issues and the Advancement of Women for examples of sexual harassment policies of UN agencies. See an overview of sexual harassment procedures and policies in medicine in the US.
Client privacy and confidentiality	Every health care organization should have written policies that explain how staff should protect client privacy and confidentiality. These policies should address issues such as where in the clinic and under what circumstances staff members are allowed to discuss information about clients with other staff or with clients themselves. The policies should address the circumstances under which providers are allowed to share information about clients with other people, including family members. The policy should also address the confidentiality of medical records and should explain whether or not providers are required to get parental consent for certain services, and whether or not adolescents can keep their personal and medical information confidential from their parents.	See Ensuring Privacy and Confidentiality in Reproductive Health Services: A Training Module and Guide for Service Providers (2003), PATH and Global Health Council.
Treating cases of violence	Ideally, health care organizations should develop protocols for caring	See Minimal Elements of a Domestic Violence

against women, including sexual abuse and rape	for women who experience gender-based violence, including rape. These protocols can help providers know how to respond to a woman's disclosure of violence in a caring and supportive way, that preserves her human and legal rights. In cases of sexual violence, for example, the protocol should include guidelines about the provision of emergency contraception and testing for sexually transmitted infections. Such protocols may increase the chances that women will receive adequate treatment, especially when health care professionals have misconceptions about issues such as sexual abuse, emergency contraception and STIs/HIV.	Protocol & Implementation of a Domestic Violence Protocol from the Family Violence Prevention Fund. See the model protocol to guide medical and sexual assault history taking, forensic and general examination, and lab exams, which includes six forms from the Sexual Assault Nurse Examiner Programme in the United States. See the Diagnostic and Treatment Guidelines from the American Medical Association for Domestic Violence.
Handling situations of risk and crisis	Health care organizations that want to strengthen their response to the issue of violence against women should develop protocols for caring for women who are in situations of crisis or high risk. This includes clients who appear to be at high risk of suicide, homicide, injury or extreme emotional distress. A protocol for situations of risk and crisis should include a discussion of how to identify risk factors, how to ensure that women get at least the basic assistance that they need, and who among the staff can provide emotional counseling and safety planning.	Model Protocol On Safety Planning for Domestic Violence Victims with Disabilities From the Washington State Coalition against Domestic Violence. See the Employee Domestic Violence Policy and Procedure: Guidelines for Increasing Safety and Providing Support from the Family Violence Prevention Fund. Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings from the Centers for Disease Control. SASA! Health Care Provider Training Manual See the safety planning

		section on p. 33.

Adapted from Bott, S., Guedes, A., Guezmes, A. and Claramunt, C., 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals.* NY, NY: International Planned Parenthood Federation: Western Hemisphere Region, p.86. Available in English and Spanish.

Example: Though there is a limited evidence-base to draw upon, one study in South Africa found that practitioners who offered better quality care (such as: HIV testing and counseling; sexually transmitted infection treatment; forensic testing; referrals for counseling; and abortion counseling) were more likely to perceive rape as a serious medical problem. These practitioners were also more likely to have previously worked in a clinic with rape treatment protocol, and generally had additional experience caring for rape survivors (Christofides et al., 2005 cited in Martin, 2007 and in Population Council, 2008b).

3. Conduct staff sensitization and training and ensure on-going staff support.

- Building the capacity of staff is the cornerstone of any facility's ability to address violence against women and girls in an ethical and effective way. Too often, especially in resource-poor settings, staff does not receive adequate training and support: if they receive training at all, it is often a single training with limited to no follow-up.

- In general, facilities should consider the following key activities to build staff capacity:

    - **All staff**, from facility administrators to service providers to support staff, should first be **sensitized** about issues related to violence against women and gender discrimination. Evidence suggests that health professionals are as likely as any other members of society to hold views that may be detrimental to the welfare of survivors, such as blaming the victim. Staff also need to have a basic understanding of the nature and scope of violence against women and girls, the dynamics of abuse, risk factors and consequences.

    - **Specialized staff,** including all medical professional providing direct services to survivors, should receive additional and ongoing **training** on key elements related to intake, examination, record keeping, etc.

    - **Specialized** staff should also receive ongoing **support** to manage the challenges of working with survivors, through supervision, in-service trainings, case reviews, etc.

Example: Woman Friendly Hospital Initiative in Bangladesh. As of 2002, the Bangladesh Woman Friendly Hospital Initiative had been launched in 30 of the

country's hospital facilities. As a part of a larger project aimed at decreasing maternal mortality rates, the management of violence against women was identified as a priority in this project. Importantly, emphasis was placed on enhancing technical skills, as well as the attitudes and behaviours of hospital staff in order to offer respectful, equitable, timely, adequate and appropriate care to victims. It was believed that if they could be assured of such attention, women would be more likely to use these services for health care treatment and would have their injuries properly documented. It was also recognized that "the medical legal aspects of sexual violence needed to be developed more extensively and that the personnel … who do the examinations … needed to be trained specifically on this topic". In order to do so, a six-day special training workshop was developed, one day of which was focused on "exploring the attitudes, values and assumptions related to violence against women … [and another] on sexual assault and the clinical and the forensic management of affected women."

Source: excerpted from: Du Mont, J. and White, D., 2007. *The Uses and Impact of Medico-legal Evidence in Sexual Assault Cases: A Global Review*. Geneva, Switzerland: WHO, pg. 44. citing Afsana, 2006; Haque, Y.A., 2001; Haque, Y.A. and Clarke, M., 2002.

3a. Step One: Conduct staff assessments.

- Prior to implementing sensitization and training, it is useful to conduct staff knowledge, attitudes, and practice (KAP) assessments to determine the level, scope and type of sensitization and training that will need to be conducted for different staff members (reception, nurses, doctors, specialists). In addition, this information can be used to documents a baseline so that health programmes can measure changes in providers' knowledge, attitudes, and practices over time. The KAP staff assessment should cover:

    - Personal perceptions, attitudes and beliefs related to violence against women and girls
    - Knowledge of gender issues and human rights
    - Understanding of the legal framework, national policies and protocols
    - Technical skills (medical and non-medical) related to addressing violence against women and girls

- Methods for collecting information on providers' knowledge, attitudes, and practices are described below, and include surveys and gathering qualitative data through group discussions or other participatory methods with providers. Qualitative data can provide an in-depth understanding of providers' perspectives. Quantitative data makes it easier to measure change over time.

KAP Staff Assessment	Comparative Usefulness	Sample Tools

Method		
Surveys	Surveys offer information about: • whether, how often and when providers have discussed violence with clients; • what providers think are the barriers to screening; • what providers do when they discover that a client has experienced violence; • providers' discriminatory or stigmatizing attitudes; • attitudes toward women who experience violence; • knowledge about the consequences of gender-based violence; and • what types of training providers have received in the past.	When conducting surveys, it is best to use or adapt already designed and validated instruments and questions, including from the: **Gender-Equitable Men (GEM) Scale** (Horizons and Promundo). The scale measures attitudes toward gender-equitable norms in order to provide information about prevailing norms in a community and the effectiveness of programmes hoping to influence them. It can be adapted for use with health care providers. Available in English, Spanish and Portuguese. **Personal Assessment for Advocates Working with Victims of Sexual Violence** (The National Resource Sharing Project and the National Sexual Violence Resource Center, 2010). This tool was developed to assist those working with victims of sexual violence in identifying strengths and strategies to improve their practice. The assessment is available in English. **The Attitudes Towards Rape Victims Scale** (The Arizona Rape Prevention and Education Project). These scales are self administered instruments designed to assess individuals' attitudes towards rape victims rather than towards rape in general. Available in English. **The Sexual Violence Research Initiative** compiled a comprehensive package of programme evaluation tools and methods for assessing service delivery, knowledge, attitudes, practices and behaviours in sexual violence projects and services. By making such materials available to service providers, managers, researchers, policy makers and activists, among others, the hope was that evaluation could be more easily incorporated into project and programme plans. The assessment instruments are drawn from articles in peer-reviewed journals that report findings from evaluations of health care-based services and interventions for women victims/survivors of sexual violence, written in English or Spanish, published between January 1990 and June 2005. The instruments are available from the evaluation section of sexual violence research initiative website.
Semi-structured interviews	SSIs offer insight into providers' knowledge, attitudes and	**International Planned Parenthood Federation, Western Hemisphere Region's (IPPF/WHR) Survey of Provider Knowledge, Attitudes and Practices** (KAP):

	practices; and offer the potential for digging deeper into any challenges, barriers, concerns that may affect ability to provide care.	This face-to-face interview is designed for administration to women's health care providers. It focuses on providers' knowledge, attitudes and practices concerning violence in the lives of their patients. There are approximately 80 questions (most close-ended), that cover a range of topics, including: whether, how often and when providers have discussed violence with clients; what providers perceive of as barriers to screening; what providers do when they identify a client who has experienced violence; attitudes toward women who experience violence; knowledge about the consequences of gender-based violence; and the types of training providers have received in the past. Available in English and Spanish. **Forensic and Medical Care Following Sexual Assault Service Education Programme Evaluation Questionnaire**: This questionnaire is designed to assess medical personnel's knowledge and satisfaction concerning their abilities to treat sexual assault patients, and includes questions such as, how would you rate your ability in forensic evidence collection? It can be self-administered or used as an interview guide.
Qualitative, Participatory Methods	Qualitative methods offer insight into providers' knowledge, attitudes and practices; and offer insight into institutional practices and norms, as well as group dynamics and work flow.	Qualitative methods are various and might include focus group discussions, open-ended stories, mapping, role plays, Venn diagrams, etc. **Twubakane GBV/PREVENTING MOTHER TO CHILD TRANSMISSION (PMTCT) Readiness Assessment Toolkit: Focus Group Guides.** The guides for clients, service providers and the community are available in English and French. See the section on qualitative methods in the Monitoring and Evaluation module for ideas and examples of what can be used.

3b. Step Two: Provide staff sensitization and training.

After reviewing the outcomes of the KAP staff assessments, facilities can determine how best to offer sensitization and training. Some methods are:

- Holding intensive training workshops for staff with the help of outside experts or institutions;

- Sending selected staff to course or workshops in other organization or universities;
- Hiring new staff with specific expertise in the area of violence against women and girls;
- Arranging for ongoing training and support from individuals or organizations with specific expertise in areas such as psychology or law;
- Distributing written educational information to providers on a regular basis;
- Incorporating the issue of violence against women and girls into other training workshops for health staff

Excerpted from: Bott, S., Guedes, A., Guezmes, A. and Claramunt, C., 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals.* NY, NY: International Planned Parenthood Federation: Western Hemisphere Region, p.79. Available in English and Spanish.

- When providing staff sensitization and training, it is important to bear in mind that some staff are likely to have experienced violence themselves and/or perpetrated violence. Facilitators must be trained to anticipate and address personal issues that may come up during trainings. At minimum, emotional support should be available to training participants who request it during or after the training.

- The tables below present some of the key sensitization and training topics and objectives, as well as relevant training tools and other resources. For a review of training materials for health care providers, see the Capacity Project Resource Paper, *Gender-Based Violence Training Modules: A Collection and Review of Existing Materials for Training Health Workers*.

SENSITIZATION FOR ALL STAFF		
Topic	***Key Educational Objectives***	***Potential tools***
Human Rights and International and National Laws	○ Understand basic human rights related to health and violence against women and girls, and learn to apply a human rights perspective in the delivery of health services. ○ Learn about national laws related to violence against women and girls so that health care providers understand their obligations and women and girls can be	**A Human Rights-Based Approach to Programming: Practical Information and Training Materials (2010).** This manual produced through collaboration between UNFPA and the Harvard School of Public Health, provides step-by-step guidance on how to apply a culturally sensitive, gender-responsive, human rights-based approach to programming in each of UNFPA's three core areas of work: population and development, reproductive health, and gender. It also covers how to apply such an

	informed of their legal rights.	approach in the context of a humanitarian emergency. An accompanying set of Training Materials are also available for download. Available in English. **Women's Human Rights: A Manual for Education & Action on Domestic Violence and Sexual Assault (2003).** This set of training materials, by Women's Rights Network, is a training manual for human rights advocates. The manual aims to raise awareness of domestic violence and sexual assault as human rights abuses; enhance the leadership skills of anti-violence activists; and mobilize advocates to implement human rights strategies on violence against women within the United States. The training material involves a combination of lecture, video, and interactive group exercises, and covers reflective and action planning around use of human rights strategies to address violence against women in communities. Available in English. See also the entire **module on legislation** in English, French and Spanish.
Gender & **Social and Cultural Context**	○ Understand basic gender issues, including how power inequalities in intimate relationships and in the communities make women and girls vulnerable to violence. ○ Understand the cultural factors of vulnerability to violence within the context in which health providers are working. Examples in individual-level factors might be alcohol abuse, intergenerational sex, substance abuse; community-	***Oxfam Gender Training Manual (1994),*** is a comprehensive training resource that walks the reader through the training process with accompanying materials, including on: introductions, expectations, sharing experiences, developing consensus, building gender awareness and self-awareness (for both women and men), gender roles, women in the world, gender and development, gender sensitive appraisal and planning, gender and global issues, working with women and men, communicating gender, strategies for change and evaluation. It can be read online from Google Books or is available for purchase from the Oxfam site. **Gender, HIV and Human Rights: A Training Manual (2000).** This manual

	level factors might include extreme poverty, patriarchal norms, etc. (Hainsworth & Zilhão, 2009) *Note:* Training information should be based on existing research into attitudes on violence against women and girls, or if necessary, on focus groups with community members in order to understand community norms.	developed by UNIFEM is a valuable resource for community-based AIDS workers. The training manual consists of an Introduction; Section I on the challenges of the HIV/AIDS epidemic in the gender and human rights context; Section II on gender concerns in HIV and development; Section III on a human rights approach to HIV/AIDS; Section IV on learning from the workshops; and Section V, an Appendix of questionnaires and helpful websites. **Gender or Sex: Who Cares? (2001).** This resource pack published by Ipas and Health and Development Networks includes a manual, curriculum cards and overhead transparencies/handouts, provides an introduction to the topic of gender and sexual and reproductive health. While the resource pack focuses on youth, its participatory tools can be used with a variety of audiences. Available in English and Spanish. **Inner Spaces Outer Faces Initiative Toolkit: Tools for Learning and Action on Gender and Sexuality (2007).** This resource, by Cooperative for Assistance and Relief Everywhere, Inc. (CARE) and International Center for Research on Women (ICRW), is for development and health programme staff. The toolkit is a compilation of training, reflection and monitoring activities for programme staff to identify, explore, and challenge social constructions of gender and sexuality in their own lives and those of their partners, in programme interventions, and within their organizations. Available in English.
Basic Engagement Skills	○ Know how to provide support and refrain from blaming the victim. Health staff should learn to identify and reject stigmatizing attitudes regarding women's experience of violence, and	**Communication Skills in Working with Survivors of Gender-Based Violence (2004).** This training manual, developed by Family Health International (FHI), the RHRC Consortium, and the International Rescue Committee (IRC) for service providers attending to gender-based-violence (GBV)

	counter any norms that accept violence as deserved or even desired, such as "women enjoy punishment." (Kim and Motsei, 2002) ○ Learn key messages about to deliver to clients based on human rights principles, i.e. right to live free from violence, so that violence is never justified and never "their fault," right to refuse sex, etc. ○ Build skills to face highly emotional issues with empathy and understanding. Learn to accept women's and girls' emotional reactions to violence and reassure the survivors that these emotions are normal and justified.	survivors. The manual includes a detailed 5-day communication skills training of trainers curriculum, with materials, agendas and handouts that may be used by participants to conduct future training. The manual covers the basics of GBV, engagement strategies for working with GBV survivors, service provider responsibilities, community referrals, methods to support service providers, and the evaluation process. Available in English. **Caring for Survivors Training Manual (2010).** This manual developed by UNICEF has two parts. Part One of this series of training modules focuses on how multisectoral actors can engage with survivors in a supportive and ethical way. The manual is based on World Health Organization Guidelines. Available in English.
Basic responsibilities of health sector staff	○ Recognize the importance of the health sector in providing care to survivors ○ Understand the health impacts of various types of violence against women and girls ○ Understand the roles of different health staff in providing care ○ Understand the basic models for addressing violence against women within the health sector.	**Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals: Module on Gender-Based Violence (2005).** This set of training materials, by the World Health Organization, is for improving the awareness, knowledge and skills of health professionals around gender-based violence (GBV). The module provides general information on GBV and the role of professionals and the health care system in preventing and responding to GBV. The module also includes examples of good practice at the health facility, community and policy levels, facilitation notes and various tools, resources, and references. Available in English. **Ensuring Privacy and Confidentiality in Reproductive Health Services: A Training Module and Guide for Service Providers (2003),** PATH and Global Health Council. Manual contains tools, resources and guidelines on the role of health care workers

		in addressing violence; guidance to help health workers and managers set up programmes; and tools for assessment, monitoring and evaluation and screening. Available in English.

SPECIALIZED TRAINING FOR SELECT STAFF		
Topic	***Key Educational Objectives***	***Illustrative Tools***
Medical Management of Sexual Assault	***Health providers should learn how to:*** • provide confidential, private, non-judgmental and empowering care and support • take a history and document this appropriately • look for major injuries and provide appropriate treatment • assess the risk of pregnancy and provide post-coital contraception, or assist decision-making around pregnancy continuation or termination when indicated and legal • provide prophylaxis for the prevention and treatment of sexually transmitted infections • provide pre-HIV and post-HIV test counselling and perform a HIV test, if post-exposure prophylaxis for HIV is offered • provide details of the law on rape, what will happen if an assault is reported to the police and the different roles of the police, prosecution and defence attorneys, the judge and what a victim would have to do in court • test for Hepatitis B and provide vaccination, if this is part of the policy • provide information to victim/survivors on all tests, treatment regimens and side-effects • determine the victim/survivor's immediate mental health needs, and provide appropriate support including information on rape trauma syndrome • make a referral to a source of on-going	**Caring for Survivors Training Manual (2010).** This manual developed by UNICEF has two parts. Part Two of the manual addresses medical interventions for sexual assault survivors and is based on World Health Organization Guidelines. Available in English. **Guidelines for Medico-legal Care for Victims of Sexual Violence (2003).** This set of guidelines, by the World Health Organization, is intended for health care professionals and health policy-makers. The guidelines provide professionals with relevant knowledge and skills for the management of sexual violence victims; guidance on developing services and standards for health care and forensic services; and include a sample consultation form. The guidelines may be used for reference, planning health services or policies, as training material, and may be adapted as relevant. Available in English. **Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons (2004).** This set of training materials developed by the World

	support ***Relevant staff also should receive additional specific training in medico-legal examination in order to:*** • undertake a sexual assault examination • collect evidence, using crime kits where available and competently improvise if they are not, and ensure it is passed to the relevant person with the chain of evidence preserved • thoroughly document findings, including completion of a case record/ report • competently communicate with the victim/survivor so that all actions are described before they are performed and consent for them is obtained • understand court procedures and give evidence competently in court	Health Organization and the United Nations High Commission for Refugees, is intended for use by health care providers and trainers of health care providers. The manual desribes best practices in clinical management of rape survivors (women, men and children) in emergency situations to guide the development of protocols, planning care services or training. It explains how to perform a thorough physical examination, record the findings and provide medical care to a sexual abuse survivor. Available in English, French and Arabic. **Clinical Care for Sexual Assault Survivors, (2009).** This training tool developed by the International Rescue Committee is based on international standards and is aimed at improving the clinical care of sexual assault survivors in low resource settings. Available in English. **Woman-Centered Abortion Care: Reference Manual (2007).** This manual published by Ipas is for healthcare personnel including sexual- and reproductive-health clinicians, trainers, managers, educators, social workers, outreach workers and others. The reference may accompany abortion-care training or serve as a learner resource and should be used by trained clinicians with the accompanying Woman-Centered Abortion Care: Trainer's Manual. The manual is organized into two sections that provide guidance on quality of care for women seeking

		abortion services and technical information for clinical providers or abortion services. Available in English. ***For additional tools, search the database.***
Screening and Case Management for Domestic Violence	○ Practice using a culturally adapted screening tool, preferably through role plays and other participatory methods. ○ Address any injuries or reproductive health problems ○ Know how to conduct safety assessments ○ Provide emergency support as needed and referrals to shelters and other care.	**Family Violence Nursing Curriculum (2004).** This curriculum developed by the Minnesota Center Against Violence and Abuse, USA provides nursing faculty with essential curricular information to develop competence in preventing, assessing and responding to family violence across the lifespan. Sections cover the scope of the problem, definitions, dynamics, health care implications, integrating into routine assessment, interventions, legal and ethical issues and prevention. Available in English. **Responding to Domestic Abuse: A Handbook for Health Professionals (2005).** This handbook developed by the Department of Health, United Kingdom gives practical guidance to health care professionals on how to work with patients whom may have experience or are experiencing domestic abuse. As well as discussing support for abused women, the handbook covers the basic information that health care professionals need to know to respond effectively to children who have experienced or are experiencing domestic abuse. Available in English. **Family Violence Prevention Fund**

		Technical Tools and Materials. These include: clinical practice recommendations for adult and child health settings; an electronic business case tool for health institutions seeking to create comprehensive domestic violence programmes; papers on health privacy principles that protect victims, coding and documentation strategies, and more; screening and response training videos; comprehensive resource and training manuals; clinical reference tools; and patient and public education materials. All materials are available in English.
Counselling/ Psycho-social Support for Survivors	• A gendered analysis of violence against women • Crisis intervention techniques • Support group methods • Trauma, coping and survival • Current understandings of well-being and social inclusion • Confidentiality • Communication skills and intervention techniques • The availability of state and community resources • Non-discrimination and diversity • Empowerment	**Counseling Guidelines on Domestic Violence (2001).** This guide, developed by CIDA and the Southern Africa AIDS Training Programme is for professional and volunteer counselors and other service providers with limited counselling experience in the context of HIV. Part of a series of counselling booklets, the guidelines are based on the experience of domestic violence counsellors from Southern Africa. The guidelines cover issues including: an overview of domestic violence, its link with sexually transmitted diseases and HIV, the nature of effective counselling generally, counselling domestic violence survivors, and survivors living with AIDS, as well as a summary of the opportunities and consequences for action against domestic violence. Available in English. **Les violences basées sur le genre: Manuel de formation à l'attention des écoutantes du réseau Anaruz** (2006). This

		guide developed by the Anaruz Network in Morocco is intended for social workers and individuals working in counseling centres. Available in French. **Trainer's Manual for Rape Trauma Counselors in Kenya, Liverpool VCT** (2006) developed by the Kenyan Ministry of Health, United Nations Population Fund and Liverpool VCT is for trainers working with counsellors and other health care providers delivering HIV services. The manual provides guidance for facilitating a counselling programme comprising three modules including practice with skills and counselling simulations. The manual includes a sample training agenda, course purpose and objectives, overview of different topics, methods and assessment tools. Available in English. **Asian Women, Domestic Violence and Mental Health A Toolkit for Health Professionals (2009).** This toolkit was developed by the Department of Health in the United Kingdom to guide health care workers in providing contextually appropriate counseling services to South Asian populations. Available in English. **The Power to Change: How to set up and run support groups for victims and survivors of domestic violence (2008).** This manual was produced by NANE, AMCV, Associatione Artemisia, NGO Women's Shelter, and Women's Aid Federation of England as participating organizations of the

		Daphne Project. It outlines key considerations required for establishing and running support groups for survivors of domestic violence, including three possible models that can be used as a basis of running such groups. Available in English, Estonian, Hungarian, Italian, Portuguese and Serbian.

- For additional manuals, guides and trainings in various languages, search the tools database.

3c. Step Three: Provide on-going supervision and support to specialized staff.

- Working with survivors of violence can be challenging for health care providers in many ways. It requires that health care providers use a wide range of clinical skills, for which they may not have received extensive medical training. In addition, listening compassionately to and supporting survivors often requires that health care providers step out of their 'comfort zone' of patient engagement. This may be particularly challenging for providers who have themselves been exposed to violence. It also means that health care providers are continuously confronted with stories of violence, which may over time can lead to accumulated levels of stress in the provider, and ultimately to 'vicarious trauma' and/or 'burn out.'

    - **Vicarious trauma** is a term used to describe a situation in which a provider experiences trauma symptoms similar to the original victim after hearing about the victim's experiences with abuse. Professionals who experience vicarious trauma may show signs of exaggerated startle response, hyper vigilance, nightmares, and intrusive thoughts although they have not experienced a trauma personally.

    - Over time, vicarious trauma may lead to **burn out**, or emotional exhaustion from working with survivors. The physical warning signs of burnout can include headaches, fatigue, lowered immune function, and irritability. A clinician experiencing burnout may begin to lose interest in the welfare of clients, be unable to empathize or feel compassion for clients, and may even begin to feel aversion toward the client.

- As a result of these challenges, health care providers working with abused women and girls should have access to a variety of strategies to reduce stress, including teamwork, satisfactory labour conditions and structures, continuing education, psychological care and preventive vacations.

- Health care providers should also have access to on-going **professional supervision**. Supervision is a key strategy for ensuring that service providers are working optimally and are using self-reflection and communication to manage the personal and professional challenges of their work. Professional supervision has the following aims:

    - To provide service providers with the opportunity to discuss their interaction with survivors to ensure quality of service to clients
    - To provide service providers an opportunity to share their experiences, reflect on their work, and solicit support
    - To ensure that service providers are maintaining professional distance and are not becoming emotionally overwhelmed.

- Methods for professional supervision might include:

    - **Individual supervision:** This is a process by which as supervising professional reviews cases with the service provider, through verbal discussion and review of interview notes. The supervising professional is tasked with the responsibility of helping the service provider utilize techniques that meet the needs of the survivors while also helping the service provider to maintain professional distance. Individual supervision is also useful in helping the supervising professional to identify any personal issues that the provider may have that may affect their capacity to work with survivors (i.e. personal exposure to violence) and provide referrals for appropriate care.
    - **Case conferences:** Case conferences are an opportunity for a service provider to present to colleagues in a structured format any specific challenges that the service provider may have experienced working with a particular survivor. The goal of a case conference is to seek the professional insights and opinions of colleagues, especially those colleagues with extensive experience or special expertise.
    - **Peer supervision:** Peer supervision is more involved than case conferences, and provides service providers the opportunity to talk with one another about their work, and share experiences and challenges. Peer supervision is an opportunity for peers to exchange strategies for overcoming challenges. Peer supervision also helps to promote cohesion among service providers.

- **Peer support groups:** Peer support groups are the most informal of all types of supervision. They are designed to provide a way for service providers to talk among themselves about their feelings regarding their work, and to offer each other mutual support. Peer support groups do not include supervisors (who should have their own peer support group). Peer support groups focus more on the emotional needs of the service provider than on case management. It is important that supervisors encourage peer support groups by allotting regular time for co-workers to gather informally during work hours. (Adapted from IRC and FHI, 2000. "Communication Skills in Working with Survivors of Gender-based Violence: A Five-day Training Manual", Day 4.)

Lesson learned: When PLAFAM, IPPF/WHR's association in Venezuela, began screening its clients systematically for gender-based violence, an unexpected challenge surfaced: the emotional toll on providers that resulted from dealing with gender-based violence on a daily basis. After intense sensitization and training, the providers were prepared to listen sympathetically to their clients' stories and to offer them counselling and/or referrals, but they were not prepared to deal with how hearing about violence would affect them. PLAFAM quickly recognized that providers, too, need an outlet to talk about the situation that they confront in order to reduce the emotional stress and potential for burnout. Starting **monthly support groups** for providers not only created this outlet, but also gave the providers a chance to discuss problematic professional issues that they encountered in working with victims of gender-based violence.

Excerpted from: Bott, S., Guedes, A., Guezmes, A. and Claramunt, C., 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals.* NY, NY: International Planned Parenthood Federation: Western Hemisphere Region, p. 135. Available in English and Spanish.

Illustrative Tools:

- **Caring for Survivors Training Manual**, Module 8 (United Nations Children's Fund). 2010. Available in English.

- **Communication Skills in Working with Survivors of Gender-based Violence: A Five-day Training Manual**, Day 4 (International Rescue Committee and Family Health International, 2000). Available in English.

- **Helping Ourselves to Help Others: Self-care Guide for Those Who Work in the Field of Family Violence** (Claramunt/PAHO/WHO,1999). Available in English.

- ***Insights into the Concept of Stress*** *(Bryce, P./PAHO, 2001).* This resource, developed by the Program on Emergency Preparedness and Disaster Relief

of the Pan American Health Organization, provides disaster response personnel with basic knowledge and skills on the principles of stress and critical incident stress management. As a companion to the Stress Management in Disasters (SMID) book, the resources assist emergency response personnel to recognize stress and manage their emotional responses to traumatic situations, such as disasters. Although the book was developed for emergency and disaster response personnel, the principles may be modified and applied to prevent and address traumatic stress within the broader community, including with children and adolescents. Available in English.

Additional Resources:

- **Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals** *(*Bott, S., Guedes, A., Guezmes, A. and Claramunt/International Planned Parenthood Federation: Western Hemisphere Region, 2004). Available in English and Spanish.

- The National Online Resource Center on Violence Against Women has several resources related to supporting staff who work with survivors, including:

    - **Guidebook on Vicarious Trauma: Recommended Solutions for Anti-violence Workers**, Jan I. Richardson, Centre for Research on Violence Against Women and Children, National Clearinghouse on Family Violence (2001). Attempts to recognize the unique experiences of anti-violence workers in Canada, promoting individual, equity, and organizational supports. This guidebook explores the response to vicarious trauma within certain communities and cultural groups.

    - **Organizational Prevention of Vicarious Trauma**, Holly Bell, Shanti Kulkarni, and Lisa Dalton, Families and Society: The Journal of Contemporary Human Services (October-December 2003). This article discusses the importance of work environment in the development of vicarious trauma problems for domestic and sexual violence workers.

    - **Trauma, Post-Traumatic Stress Disorder and Secondary Trauma**, Barbara Whitmer, Education Wife Assault (2001). This article clearly defines trauma, post-traumatic stress disorder (PTSD), and secondary trauma and how secondary trauma affects those who work with traumatized clients.

    - **Vicarious Trauma: Bearing Witness to Another's Trauma**, Terri S. Nelson, gives a brief discussion about what vicarious trauma is and how important it is that advocates/counselors be aware of it, recognize the warning signs, and take care of ourselves.

4. Build facility infrastructure

- Building infrastructure essentially means ensuring that the health facility is physically equipped to manage cases of violence against women and girls. This includes:

    - **Private consultation rooms available 24 hours**. Providers should have a soundproof place where they can speak with survivors without other family members present, and where other clients cannot overhear. The rooms should be arranged and decorated in order to promote the comfort of the survivor and should not be marked in any way indicating they are rooms for sexual violence-related care.
    - Trained **security guards or police** should also be available on the facility premises to ensure the survivor's safety and to act as a liaison for women who choose to file a formal report.
    - **Bathroom in a non-public area**, preferably with bath/shower for sexual assault victims to use after an examination. Care kits with items, such as soap and clean clothing along with other essential and comforting items can also be provided.
    - **Availability of specialized equipment**. There is a range of specialized equipment that should be in place, especially for documenting physical injuries and conducting sexual assault forensic examinations. Some basic equipment includes (Christofides et al., 2006):

        - Examination couch
        - Angle lamp
        - Speculum
        - Colposcope
        - Examination gloves
        - Sharps container
        - Lockable cupboard/ refrigerator for storage of evidence
        - Lockable medical supply cabinet
        - Patient gowns
        - Sanitary towels
        - Emergency clothing
        - Rape kits
        - HIV rapid test
        - Pregnancy kits
        - Swabs
        - Blood Tubes
        - Paper bags
        - Linen
        - Camera and film
        - Microscope

    - **Availability of appropriate medications.** Basic medications should be available at no cost and service providers should be well-trained in how and when to administer them. In addition to basic analgesia, tranquilizers, and anti-emetics, providers should make the following available:

Medication	Key Points on Administering
Emergency Contraception (EC)	EC should be available to all female survivors of rape who are of reproductive age, and who are: not pregnant, not consistently using a reliable form of contraception, and who show signs of secondary sexual development (Kilonzo & Taegtmeyer, 2005). A pregnancy test is not required prior to administering EC. A pregnancy test is desirable, however, to determine eligibility. It is important to reassure clients that the EC pills will cause no harm to an existing foetus or to the course of the pregnancy (WHO, 2004b). In environments where dedicated EC drugs are not available, health providers can offer combinations of oral contraceptive pills. WHO advises "there are no restrictions for use of ECPs in cases of rape" (WHO, 2004b). EC can be administered within 120 hours of unprotected intercourse, but is most effective at an earlier stage, so provision is a priority, along with HIV prophylaxis (Kenya MoH, 2004). An antiemetic can be offered alongside EC to reduce the chance of vomiting. The most common regimens of EC include levonorgestrel and combined oral contraceptive pills. WHO (2005) also identifies the insertion of a copper-bearing IUD within 5 days of the rape as an efficient form of emergency contraception. However, this may not prove a valid option in resource-poor settings, and may cause additional trauma to the survivor. ➢ **Fact Sheet on Emergency Contraception** (World Health Organization). Available in Arabic, English, French, Mandarin (Chinese) Russian and Spanish.
Sexually Transmitted Infections (STI) prophylaxis	Survivors of sexual abuse are vulnerable to a number of sexually transmitted infections (STIs). When appropriate, WHO recommends that patients be tested for chlamydia, gonorrhoea, trichomoniasis, syphilis and hepatitis B, although this may vary according to local environments and protocols. WHO does not recommend the routine prophylactic treatment of all patients, on the understanding that survivors experience different degrees of exposure to infection and there is scant evidence on the effectiveness of STI prophylaxis provision to abuse survivors (WHO, 2003b). However, medical management protocols in high STI-prevalence settings differ on this issue. The incubation periods of different STIs vary, and follow-up tests are advisable. Treatment may relieve a source of stress, but the decision about whether to receive prophylactic treatment or wait for results of STI tests should be made by the survivor (WHO, 2005d). Post-exposure prophylaxis of STIs should be commenced at an early stage of treatment, but need not be administered at the same time as the initial doses of PEP and EC as the pill burden may prove uncomfortable, and may reduce adherence to drug courses. The STI prophylaxis should, however, be prescribed and taken

	within 24 hours (Kenya MoH, 2004). It has been found that many patients do not complete their PEP treatment due to side effects (Martin et al., 2007). Antiemetics can reduce feelings of nausea. When STI testing is not feasible, the Kenyan MoH recommends that post-exposure prophylaxis of STIs should be commenced at an early stage of treatment (within 24 hours). To reduce the pill burden and to encourage adherence, the doses should be spread out and taken with food and antiemetics to reduce nausea (Kenya MoH, 2004; WHO, 2005d). The STIs most commonly contracted by abuse survivors include chlamydia, gonorrhoea, trichomoniasis and syphilis. National protocols may differ on the drug regimens provided for each STI. Different doses are recommended for non-pregnant adults (men and women), pregnant women, and for children. A pregnancy test should be administered to women prior to prescription of prophylactics in order to determine their status. The epidemiology, diagnosis and transmission modes of STIs in children differ from those in adults (WHO, 2003b). Routine administration of STI prophylaxis is recommended in high prevalence settings, although the dosage levels are child-specific. WHO observes that STI cultures may take up to one week to emerge, and therefore recommends a follow-up visit in cases where sexual abuse has recently occurred. ➢ **Sexually Transmitted Infections** website page (World Health Organization)
Post-exposure prophylaxis (PEP) for HIV	Post-Exposure Prophylaxis involves the administration of one or a combination of anti-retroviral drugs (ARVs) to HIV negative persons for a period of 28 days after exposure to the HIV virus. The **administration of PEP within 72 hours** of sexual penetration, followed by a course of PEP drugs, is thought to significantly reduce the likelihood of sero-conversion (Roland et al., 2001). Although there is limited evidence of the effectiveness of PEP among survivors of sexual violence, the drugs have been proved effective after consensual sex in high-risk groups (Kenya MoH, 2004). PEP is recommended for men, women, boys and girls who have experienced oral, anal or vaginal penetration. Fixed dose combinations are recommended, where available, as they reduce the number of pills to be taken and thus increase compliance (Kenya MoH, 2004). WHO points out that PEP is an ever-changing practice, and that health workers should remain aware of current recommendations and adhere to local guidelines. Studies have demonstrated low

	efficacy if PEP is commenced after 72 hours from exposure (Kenya MoH, 2004). In such circumstances, survivors should be availed of all other aspects of post-rape care, with the exception of PEP. Because of the high risk of HIV transmission in high prevalence settings, it is recommended that PEP should be available at the first point of entry to a health facility (Kilonzo & Taegtmeyer, 2005). The short window of opportunity (72 hours) also emphasizes the need for an efficient referral system if the first point of contact (FPC) is other than a health facility. Non-availability of voluntary counseling and testing (VCT) at time of presentation may be a serious bottleneck, and because most patients present to hospital after-hours, VCT should be made available 24-hours a day (Kim et al., 2007). In rural areas, few patients are able to return to hospital after the initial presentation. Therefore, wherever possible, all diagnostic tests and treatment should be provided on the first visit. For those who are HIV negative, a full 28-day course of PEP should be dispensed on the first visit. Same-day provision of anti-emetics and medication counselling are important for encouraging adherence (Kim et al., 2007a; Ipas, Armonie and UNFPA, 2010). **Regimens for children** can consist of syrups or tablets, or a combination of both (Kenya MoH 2004; WHO). Children require lower dosage than adults, and with tablets, weight bands can be used to determine paediatric doses, an approach that has "greatly simplified the appropriate and early administration of paediatric PEP" (Speight et al., 2005). Otherwise, the doses are calculated according to the child's weight and/or surface area. The dosage must be taken two or three times a day, depending on the regimen, and thus the guidance and co-operation of a guardian is required to ensure the child's compliance. Side-effects from ARVs are significantly less common in children than in adults (Ellis et al., 2005). Pediatric PEP protocols state that HIV testing need not precede PEP provision, to reduce delays (Malawi, Kenya and South Africa protocols). Children may be considered ineligible for PEP if they have a history of sexual assault, or if they show no physical signs of abuse. If the child tests positive for HIV, he/she should be referred for on-going medical care. If negative, the child is provided with a two-week course of PEP, followed by an appointment where the child is reviewed for side-effects and issued with another two weeks of PEP. HIV tests are recommended at 6 weeks and 3 months (Malawi, Kenya and South Africa protocols). Low rates of completion have been observed in both high and low-income environments. Studies

	worldwide have observed that many patients do not return to the healthcare setting for scheduled follow-up appointments (Martin et al., 2007). The Kenyan MoH (2004) advises that ARVs be provided for one week at a time, rather than the entire period of 28 days, in order to encourage re-attendance for clinical follow-up, counselling and adherence support. They do acknowledge that exceptions may need to be made in circumstances where the survivor lives far away, or is unlikely to return. A South African study that explored women's preferences for services after rape concluded that patients clearly prefer to receive all of their HIV prophylaxis at the initial visit (Christofides et al., 2005). The rural test site that practised this approach observed significantly higher rates of PEP completion than the urban test site that doled out weekly doses. The study results also implied completion is positively influenced by the provision of **antiemetics** (to counter the side-effect of nausea), information, and – even more importantly – a home follow-up service and the provision of food supplements. HIV diagnostic testing and counselling (DTC) is recommended to precede the administration of PEP. However, in circumstances where the 72-hour deadline is approaching, it is generally recognised that PEP will precede an HIV test, and will be discontinued in the event that the patient tests positive for the virus. The HIV test needs to be accompanied by appropriate **counselling to reduce any additional trauma**, and a delay of up to three days is permissible in cases where the patient is not psychologically prepared (Kenya MoH, 2004). Contrary to concerns about the potentially deterrent properties of HIV-testing, the need to test for HIV before receiving PEP did not deter South African women from seeking services (Christofides et al., 2005). **Follow-up HIV testing** is recommended at six weeks and three months from baseline. Links: ➢ **Post-exposure Prophylaxis** website page (World Health Organization). ➢ **Post-exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO Guidelines on Post-exposure Prophylaxis (PEP) to Prevent HIV Infection**. (WHO and ILO, 2007). Available in English and French.

Source: Excerpted from: Population Council, 2008b. *Sexual and Gender Based Violence in Africa: A Literature Review*, pp.17-19.

Lesson Learned: A global review of 30 studies on health-care based services, found that half of the women who experienced sexual abuse preferred to have both counselling and medication (Martin et al., 2007). A study of 155 women who had been raped and recruited through health facilities and 160 comparable women recruited from the community, with one urban and one rural site in South Africa, found that for most women who had been raped, the availability of HIV prophylaxis and counselling by sensitive providers were most important in determining choice of service (Christofides et al., 2005).

Additional Resources:

- **Guidelines for Medico-legal Care for Victims of Sexual Violence** (World Health Organization, 2003). See pages 23 and 25-27 for equipment and supplies lists. Available in English.

- **Sexual Assault Nurse Examiner (SANE) Development & Operations Guide** (Ledray/Office for Victims of Crime, U.S. Department of Justice, 1999). See pages 27-28 for facilities and supplies, as well as pages 170-174 for a sample supply list for a Sexual Assault Response Team programme. Available in English.

- **How to Conduct a Situation Analysis of Health Services for Survivors of Sexual Assault** (Christofides et al. 2006). See Appendix A: Facility Checklist. Available in English.

- **Post-exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO Guidelines on Post-exposure Prophylaxis (PEP) to Prevent HIV Infection** (World Health Organization and International Labour Organization, 2007). Available in English.

- **Occupational and Non-Occupational Post-exposure Prophylaxis for HIV Infection (HIV-PEP): Joint ILO/WHO Technical Meeting for the Development of Policy and Guidelines**, Geneva 5-7, September 2005 (World Health Organization and International Labour Organization, 2005). See pages 2-7. Available in English.

- **Rape and Sexual Assault** (Welch, J. and Mason, F./BMJ, 2007). Available in English.

- **Rape: How Women, the Community, and the Health Sector Respond** (Sexual Violence Research Initiative, 2007). Available in English.

- **Comprehensive Responses to Gender Based Violence in Low- resource**

Settings: Lessons Learned from Implementation (Keesbury J. and Askew I./ Population Council , 2010). Available in English.

5. Screening

- Screening is "asking women about experiences of violence/abuse, whether or not they have any signs or symptoms." (Bott et al., 2004) Without screening, health services mainly respond when survivors take the initiative to disclose.

- When done appropriately, screening creates a record of the main violence issues for the survivor, which in turn determines what care and support she needs from the provider doing the screening, and from others in the facility or the community. Routine screening increases the likelihood that providers can ensure appropriate care for survivors.

- Without routine screening, providers typically identify only a fraction of women requiring assistance with physical or sexual abuse. Routine screening for violence has increasingly been considered the standard of care within women's health services in the United States and other industrialized countries (American Medical Association, 1992; Buel, 2001).

- However, there are widespread concerns about the risks of routine screening, particularly in resource-poor settings where there is limited training to prepare providers to conduct screening (Garcia Moreno, 2002b) and/or lack of support to providers who routinely screen clients. Routine screening may harm women in settings where providers are insensitive to violence issues or are otherwise not equipped to respond appropriately, where privacy and confidentiality cannot be ensured, and where adequate referral services do not exist. Poorly implemented routine screening can put women at additional risk of violence (Bott et al., 2004).

- When considering whether to implement screening, providers should first understand the four basic approaches to screening:

    - **Universal screening** involves asking all women about abuse at all first visits. This approach demands that the minimum requirements for safety and quality of care are met.

    - **Selected integration** involves routine screening in specific service areas (e.g. emergency departments) or areas that can improve overall health outcomes (e.g. prenatal care, HIV and AIDS clinics, family planning, etc.) (Velzeboer, 2003). This can be a cost-effective way to identify women, but only if staff are well trained and motivated. It is also critical that any interviews with survivors be coordinated, so that the woman does not have to repeat the same story and potentially be retraumatized (Acosta, 2002).

- **High risk screening** involves screening groups of women who have been identified as being at high risk of violence. Depending on the setting, such groups often include girls in child marriages, domestic workers, girls in households without either parent, sex workers, women and girls in emergency settings, women with mental illness, those with disabilities and those who are HIV-positive.
- **Selective screening** is done only when there are signs or indications that violence may be occurring.

- Universal screening may not be feasible in most developing countries because of scarcity of resources. However, selected integration of routine screening into reproductive health, mental health and emergency services is recommended, as well as selective screening of women and girls exhibiting signs of abuse in other health services (Morrison, Ellsberg and Bott, 2007). Service providers must be trained in the health consequences of violence against women and girls and understand some of the possible health indicators of abuse.

- Regardless of which type of screening is implemented, health organizations have an ethical obligation to do no harm. They must be able to ensure basic precautions to protect women's lives, health, and well- being before they implement routine screening. Basic precautions include:
  - Protection of women's privacy and confidentiality.
  - Healthcare providers with adequate knowledge, attitudes, and skills to offer the following:
    - A compassionate, non-judgmental response that clearly conveys the message that violence is never deserved and women have the right to live free of violence.
    - Appropriate medical care for injuries and health consequences, including STI and HIV prophylaxis and emergency contraception post-rape.
    - Information about legal rights, and any legal or social service resources in the community.
    - Assessment of when women might be in danger and provision of safety planning for women in danger.
    - Safe and reliable referrals to services not available in the facility.

- In addition, health facilities that offer screening should have a written screening protocol, a method for documenting information collected during the screening, and a monitoring and evaluation system to assess the uptake in services and quality of care related to screening.

- When designing and using a screening protocol, health care providers should take into account barriers to disclosure among women and their community, such as the taboo of speaking about violence, feelings of shame and/or guilt, concerns about confidentiality, etc. Questions in the protocol should be adapted accordingly and tested for appropriateness. A study in the Dominican Republic showed that a general initial question about how things are going with the woman's partner worked well. A qualitative study in Kenya cited the "blurred boundaries between forced and consensual sex" as demanding more exact phrasing of questions that would elicit responses (Kilonzo et al., 2008).

Example: Consistent Screening in Venezuela Increased Identification of Women who Experienced Abuse

A study conducted in Venezuela found that the screening tool below, when used systematically with each client, identified that 38% of new clients were victims of violence as compared to only 7 % when counsellors relied on unsystematic screening. This study was conducted by International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) in collaboration with their Venezuelan affiliate, Asociation Civil de Planification Familiar (PLAFAM).

Box 1. Abridged screening form for victims of gender violence

Case number: Date: Name of counselor:

Introduction. You know, at PLAFAM we offer education and services about domestic violence, violence in the workplace, and violence in childhood. There are many types of violence that affect a great number of women, and many women living in violent situations have found it helpful to receive assistance for themselves and their children. We at PLAFAM are concerned about the well-being of our clients and we always ask these questions in a confidential manner.

1. Psychological/emotional violence in the family. Have you ever felt hurt emotionally or psychologically by your partner or another person important to you? (For example, constant insults, humiliation at home or in public, destruction of objects you felt close to, ridicule, rejection, manipulation, threats, isolation from friends or family members, and so forth.)

❑ Yes ❑ No Who _____

When _____ How _____

2. Physical violence. Has your partner or another person important to you ever caused you physical harm? (For example, hitting, cutting, or burning you?)

❑ Yes ❑ No Who _____

When _____ How _____

3. Sexual violence. Were you ever forced to have sexual contact or intercourse?

❑ Yes ❑ No Who _____

When _____ How _____

4. Sexual violence in childhood. When you were a child, were you ever touched in a way that made you feel uncomfortable?

❑ Yes ❑ No Who _____

When _____ How _____

Source: excerpted from Guedes et al., 2002b**.** "Addressing Gender Violence in a Reproductive and Sexual Health Program in Venezuela." in *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*, p. 266)

Additional Examples of Screening Tools:

- **Living Up to Their Name: Profamilia Takes on Gender-based Violence** (**Goldberg/Population Council, 2006).** See page13. Available in English.

- **Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals** *(*Bott, S., Guedes, A., Guezmes, A. and Claramunt, C./International Planned Parenthood Federation, Western Hemisphere Region, 2004). See pages 109-143. Available in English and Spanish.

- ***Screening for Domestic Violence: A Policy and Management Framework for the Health Sector*** (Martin, L. and Jacobs, T. 2003). See page 14. Available in English.

- **Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings** (Basile, Hertz, Back/Centres for Disease Control, 2007). This resources provides practitioners and clinicians with a current inventory of assessment tools for determining intimate partner violence (IPV) and/or sexual violence (SV) victimization. The guide was reviewed and finalized with contributions from IPV and SV experts and rape and education programme coordinators from the United States, and is presented in two sections on IPV tools and SV tools respectively. Each section provides a table listing the relevant tools, background information on its development, components, application and follow-up, psychometric properties and includes the actual assessment tool. Available in English (with 2 tools in Spanish).

- ***Screen to End Abuse*** includes five clinical vignettes (Family Violence Prevention Fund). This video demonstrates techniques for screening and responding to domestic violence in primary care settings. The film is 32 minutes and is available on VHS, CD and looped (for continuous play). Available in English.

Illustrative resources:

- **Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines** (World Health Organization, 2013). Available in English (pages 17-19).

- **Barriers in Screening Women for Domestic Violence: A Survey of Social Workers, Family Practitioners, and Obstetrician-Gynecologists** (Tower, L. 2006). Available in English.

- **Model Protocol on Screening Practices for Domestic Violence Victims with Disabilities** (Hoog, C. 2003). Available in English.

- **Improving Screening of Women for Violence: Basic Guidelines for Healthcare Providers** (Stevens, 2005). Available in English.

6. Ensure emergency and non-emergency services

6a. 24-hour forensic examinations

- Facility protocols should specify what medical forensic services are provided. Key services following a sexual assault include: treatment of injuries, **preservation of evidence**, prevention of unwanted pregnancies and sexually transmitted infections, and psychosocial support (Welch and Mason, 2007).

- **Forensic services should have minimal wait times**, be given priority services, have trained and accredited providers with a sufficient number of exams to maintain their level of proficiency in collecting evidence, documenting the assault, and addressing survivors' emotional needs (Ledray, 1999). Whenever possible, the **exam should be conducted by a woman**, as most survivors prefer to be examined by a woman (Welch and Mason, 2007).

- Women may not choose to enter into a legal process right away, therefore, forensic exams should be made available with the **option to keep forensic evidence on file** in a sealed envelope should a woman decide to press charges at a later date.

- Medical certificates should be made available free of charge. The WHO Guidelines recommend that **medical certificates should be valid for up to 20 years**, should a woman decide to claim compensation or make a criminal complaint at a later date.

- Forensic examinations should follow guiding principles in providing health services to survivors. In particular, women may fear reprisals if entering a legal process, therefore confidentiality surrounding forensic exams should be the paramount concern. In the United States, anonymous rape tests are available nationwide to address this issue. Testing for virginity should never be a part of the forensic examination, as it violates survivor's rights and autonomy.

- Studies done in the US showed that **watching a video** describing the forensic sexual assault exam may reduce survivors' stress during the exam (Martin, 2007).

- **Survivors should also be provided written information** in order to reinforce information given to them during their medical exam. Some survivors may be in shock at the time of initial treatment and therefore may not fully absorb all the information shared orally by a forensic examiner. Written information may include:

- What is involved in a physical examination process;
- Health risks after sexual assault and the need for testing and treatment;
- HIV risks;
- Treatment regimens and any side effects;
- Prevention of pregnancy;
- Psychological impact and coping strategies;
- Further support after sexual assault through community services and/or telephone helplines

(Excerpted/adapted from: Jewkes, R., 2006. "Paper for Policy Guidance: Strengthening the Health Sector Response to Sexual Violence", Unpublished.)

Illustrative Tools:

- ***Guidelines for Medico-legal Care for Victims of Sexual Violence*** (World Health Organization, 2003); see "Forensic Specimens" (pp. 57-63). Available in English.

- ***The Sexual Assault Forensic Examiner Coordinator's Handbook*** *(*Carman, R., 2010). Designed for Sexual Assault Forensic Examiner (SAFE) coordinators, examiners, and Emergency Department (ED) personnel such as nurses, social workers, and attendings, this Q & A handbook uses case studies and other practical tools to provide concrete guidance related to all aspects of SAFE programme operations. Available in English.

- ***Sexual assault nurse examiner (SANE) development & operations guide*** (Ledray, L. 1999). Washington DC: Office for Victims of Crime, U.S. Department of Justice. Available in English.

- ***Clinical Care for Sexual Assault Survivors*** (International Rescue Committee, 2009).. Available in English.

Additional Resources:

- ***Forensic Evidence for Sexual Assault: A South African Perspective*** (Martin, L. 2001). *International Journal of Gynecology and Obstetrics* 78 (Supplement 1), pgs. S105-S110.

- ***Rape and Sexual Assault*** (Welch, J. and Mason. F., 2007). BMJ; 334, pgs. Available in English.

6b. Safety assessment and planning

- A fundamental role for health providers is to assess the safety of a survivor and help her stay out of danger. Some key areas of danger for those experiencing violence may include:

- Imminent harm in the next minutes, hours or days
- Short and long-term risk of being killed
- Risk of self-inflicted harm, including suicidal thoughts and impulses
- Severe sexual and reproductive health consequences, such as unwanted pregnancy, sexually transmitted infections, etc.
- Danger to children who may be involved.

- Sample danger assessment questions are listed below. However, it is very important that providers design their safety assessment questions according to their cultural context, and field-test them for appropriateness and usability. It is also important that providers listen to patients when determining level of risk. Women's assessment of their own risk is just as important, if not more, than outcomes of a risk assessment tool in predicting future exposure to violence.

Sample Danger Assessment Questions for Intimate Partner Violence

1. Has the physical violence increased in frequency over the past year?
2. Has the physical violence increased in severity over the past year?
3. Does he ever try to choke you?
4. Is there a gun in the house?
5. Has he ever forced you to have sex when you did not wish to do so?
6. Does he use drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
7. Does he threaten to kill you and/or do you believe he is capable of killing you?
8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
9. Does he control most or all of your daily activities? For instance, does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car?
10. Have you ever been beaten by him while you were pregnant?
11. (If you have never been pregnant by him, check here ____)
12. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
13. Have you ever threatened or tried to commit suicide?
14. Has he ever threatened or tried to commit suicide?
15. Is he violent toward your children?
16. Is he violent outside of the home?

Excerpted from Bott, S., Guedes, A., Guezmes, A. and Claramunt, C., 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals*. NY, NY: International Planned Parenthood Federation: Western Hemisphere Region. pg. 92, and adapted from Campbell, 1998.

- After assessing each woman's level of danger providers can work with survivors to establish safety plans. There are different methods in attending to safety, with some settings prioritizing the survivor's control over implementing safety plans and others promoting more pro-active follow up to ensure continuity of care, safety and access to

support during a period where safety may be threatened (Council of Europe; 2008a). In all cases, **the health care provider should respect the survivor's ability to identify her own safety risks as well as possible strategies for mitigating those risks.** Where danger to children involved, the health care provider should follow facility and national protocols on their protection.

- Some key issues and strategies that providers and survivors may wish to think through when developing a safety plan include:

    - Possible escape routes and a place where the woman could go in case of emergency (e.g. the home of a family member or friend, ideally at an address not known to the perpetrator) if she needs to leave her home at some point in the future.
    - Know/memorize phone number(s) for organizations that provide help, if any exist in the area.
    - Know where to get emergency contraception and post-exposure prophylaxis to prevent STIs, including HIV in the case of sexual violence.
    - Notify one or more trusted neighbours to watch for signs of violence and to call the police or other community members if they notice anything unusual.
    - Talk to children about what to do and where to go for help in the case of a violent incident and rehearse an escape plan with them.
    - Decide what a woman needs to have ready if she needs to leave her home in a hurry (e.g. clothes, money, documents, keys).
    - Pack a bag with these items and store it somewhere in her home or with a friend or relative.
    - Come up with strategies for reducing risk once a conflict begins. For example, if an argument cannot be avoided, try to have it in a room with an easy exit.
    - Stay away from rooms where weapons are available. (Adapted from Bott et al., 2004, and Velzeboer et al., 2003)

- It may be useful to have a checklist on hand to review some of these safety issues with those at risk:

Safety Planning List

Here are some helpful items to get together when you are planning on leaving an abusive situation. Keep these items in a safe place until you are ready to leave, or if you need to leave suddenly. If you have children, take them. And take your pets, too (if you can).

Identification for yourself and your children

- ❑ birth certificates
- ❑ social security cards (or numbers written on paper if you can't find the cards)
- ❑ driver's license
- ❑ photo identification or passports
- ❑ welfare identification
- ❑ green card

Important personal papers

- ❑ marriage certificate
- ❑ divorce papers
- ❑ custody orders
- ❑ legal protection or restraining orders
- ❑ health insurance papers and medical cards
- ❑ medical records for all family members
- ❑ children's school records
- ❑ investment papers/records and account numbers
- ❑ work permits
- ❑ immigration papers
- ❑ rental agreement/lease or house deed
- ❑ car title, registration, and insurance information

Funds

- ❑ cash
- ❑ credit cards
- ❑ ATM card
- ❑ checkbook and bankbook (with deposit slips)

Keys

- ❑ house
- ❑ car
- ❑ safety deposit box or post office box

A way to communicate

- ❑ phone calling card
- ❑ cell phone
- ❑ address book

Medications

- ❑ at least 1 month's supply for all medicines you and your children are taking, as well as a copy of the prescriptions

A way to get by

- ❑ jewelry or small objects you can sell if you run out of money or stop having access to your accounts

Things to help you cope

- ❑ pictures
- ❑ keepsakes
- ❑ children's small toys or books

Source: National Women's Health Information Center. 2008. U.S. Department of Health and Human Services, Office on Women's Health. Available in pdf.

Example: The Nicaraguan Network of Women against Violence has developed **small cards for health providers to give to their clients**. Printed on these cards is the message: "If you are living with violence, there are ways out." They are small which makes them easily hidden and they provide basic information about safety plans (Velzeboer, 2003). Similarly, in the United States, the Family Violence Prevention Fund has produced safety cards to be distributed in health care facilities to let patients know how to improve their safety and health. These include the Reproductive Health Safety Card and the Patient Safety Card for Women. These cards are designed to help women recognize how their intimate relationships may impact their general and reproductive health as well as the health of their children. These cards also provide information for

safety planning and referral and are available in both English and Spanish. Go to the Family Violence Prevention Fund store to access the cards.

- If women are in immediate danger and cannot return home, it will be important to find them safe haven. It may be useful to create safe spaces within health services where women can stay until they can be referred to a shelter/safe space.

Example: Two beds in the psychiatric ward of the hospital in Aarohi, India have been reserved for emergency admission of women who cannot go back home and need temporary shelter before alternate shelter is found. This is particularly important for survivors, as finding shelter at night is difficult (UNFPA, 2009)

Illustrative Tools:

- For additional resources on safety planning, search the tools database.

- ***Violence Against Women Safety Planning List***. U.S. Department of Health and Human Services, Office on Women's Health (National Women's Health Center, 2008). Available in English.

- ***Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings*** (Centres for Disease Control, 2007) This resource, by KC. Basile, MF Hertz, and SE Back for the Centres for Disease Control, provides practitioners and clinicians with a current inventory of assessment tools for determining intimate partner violence (IPV) and/or sexual violence (SV) victimization. The guide was reviewed and finalized with contributions from IPV and SV experts and rape and education programme coordinators from the United States, and is presented in two sections on IPV tools and SV tools respectively. Each section provides a table listing the relevant tools, background information on its development, components, application and follow-up, psychometric properties and includes the actual assessment tool. Available in English (with 2 tools in Spanish).

- ***Safety Plan*** (North Carolina Coalition against Domestic Violence). Available in English.

- ***Model Protocol On Safety Planning for Domestic Violence Victims with Disabilities*** (Washington State Coalition Against Domestic Violence, 2003). Available in English.

- ***Inventory of Spousal Violence Risk Assessment Tools*** Used in Canada, Department of Justice. Available in English for purchase.

    - **Aid to Safety Assessment Planning (ASAP) The** Aid to Safety Assessment Planning is a manual that was created as a result of a partnership between the Victim Services and Crime Prevention Division, BC Ministry of Public Safety and the BC Institute Against Family Violence. The objective of this manual is to

reduce the risk of violence by providing a comprehensive and coordinated safety management strategy that victim service workers can use in cooperation with other relevant justice agencies to support women in making safety assessment decisions. It was designed to examine the risk factors from the victim's perspective and emphasizes the need for relevant agencies and the victim to work together and, where appropriate, share information on known risk factors. The manual and sample worksheet incorporates items from established tools such as the Spousal Assault Risk Assessment (SARA) and the Brief Spousal Assault Form for Evaluation of Risk (B-SAFER) to create appropriate safety plans. To order a copy of the ASAP manual, please visit the Centre for Counselling and Community Safety, Justice Institute of British Columbia website.

- **Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER)** The Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER) was developed collaboratively by the British Columbia Institute Against Family Violence, P. Randall Kropp, Ph.D., Stephen D. Hart, Ph.D., Henrik Belfrage, Ph.D. and the Department of Justice Canada. The development of the B-SAFER tool was based on a number of objectives: to facilitate the work of criminal justice professionals in assessing risk in spousal violence cases, guide the professionals to obtain relevant information necessary to assess level of risk, assist victims in safety planning and ultimately work to prevent future harm and more critical incidents.

- **Danger Assessment** The Danger Assessment is used by Victim Services in New Brunswick. In Nova Scotia, staff of transition houses, Victim Services and Child Welfare Services (under Department of Community Services) are trained to use the Danger Assessment tool, developed by Jacquelyn Campbell, Ph.D., R.N., F.A.A.N. from the United States. The use of this tool is part of the collaborative process through the High Risk for Lethality Case Coordination Protocol Framework. Information sharing is initiated with relevant agencies if any of the primary service providers designate a woman's file as high risk. The Danger Assessment tool is comprised of two parts: the first portion of the tool evaluates severity and frequency of abuse by providing the woman with a calendar of the previous year. The woman is asked to mark dates of past abuse on a calendar. Incidents are ranked from least to most severe. Indicators include: slapping, pushing, punching, kicking, bruises, "beating up" (i.e. burns, broken bones and miscarriage), threat to use a weapon and finally, use of a weapon with wounds. The second portion of the tool is a 20-item instrument which includes a weighted scoring system to count yes/no responses of risk factors linked with intimate partner homicide. For more information, please see the website.

6c. Emotional care and support

- Counseling is a critical intervention that can have positive benefit for survivors—including higher physical functioning, lower levels of depression (Tiwari, 2005 cited in

Ellsberg, 2006), higher self-esteem and assertiveness, and even decreased exposure to abuse (Laverde, 1987, cited in Ramsey , 2005).

- Providers should be trained to ask women directly about violence. In particular, women in antenatal/prenatal care and women showing certain conditions, such as injuries, anxiety symptoms, substance abuse, depression, sexually transmitted infections or gynaecological symptoms.

- Cognitive-behavioural therapy may be especially useful in reducing mental health problems associated with both intimate partner violence and sexual violence (WHO, 2010a). However, it is critical that those providing emotional care and support have adequate counselor training in issues related to the psychological impact of different types of violence against women and girls (Bott et al., 2004). Some interventions, including those for post-traumatic stress disorder require a psychologist or highly trained mental health specialist. Others, such as crisis-intervention have been shown not to be effective.

- Specialist experience and skills in violence against women should include, at minimum, knowledge about the following (also see counseling skills resources in staff training):

    - A gendered analysis of violence against women
    - Crisis intervention techniques
    - Trauma, coping and survival
    - Current understandings of well-being and social inclusion
    - Confidentiality
    - Communication skills and intervention techniques
    - An overview of criminal and civil justice systems
    - An update and review of relevant laws
    - The availability of state and community resources
    - Non-discrimination and diversity
    - Empowerment (Council of Europe, 2008a)

- The Council of Europe recommends that one specialist counseling service be available per 50,000 women (or at least one in every regional city) with referrals to other therapeutic services only to qualified professionals (Council of Europe, 2008a). Establishing counseling services in health facilities can not only improve accessibility for survivors, but can also have secondary benefits, such as raising the profile of the issue among health care providers.

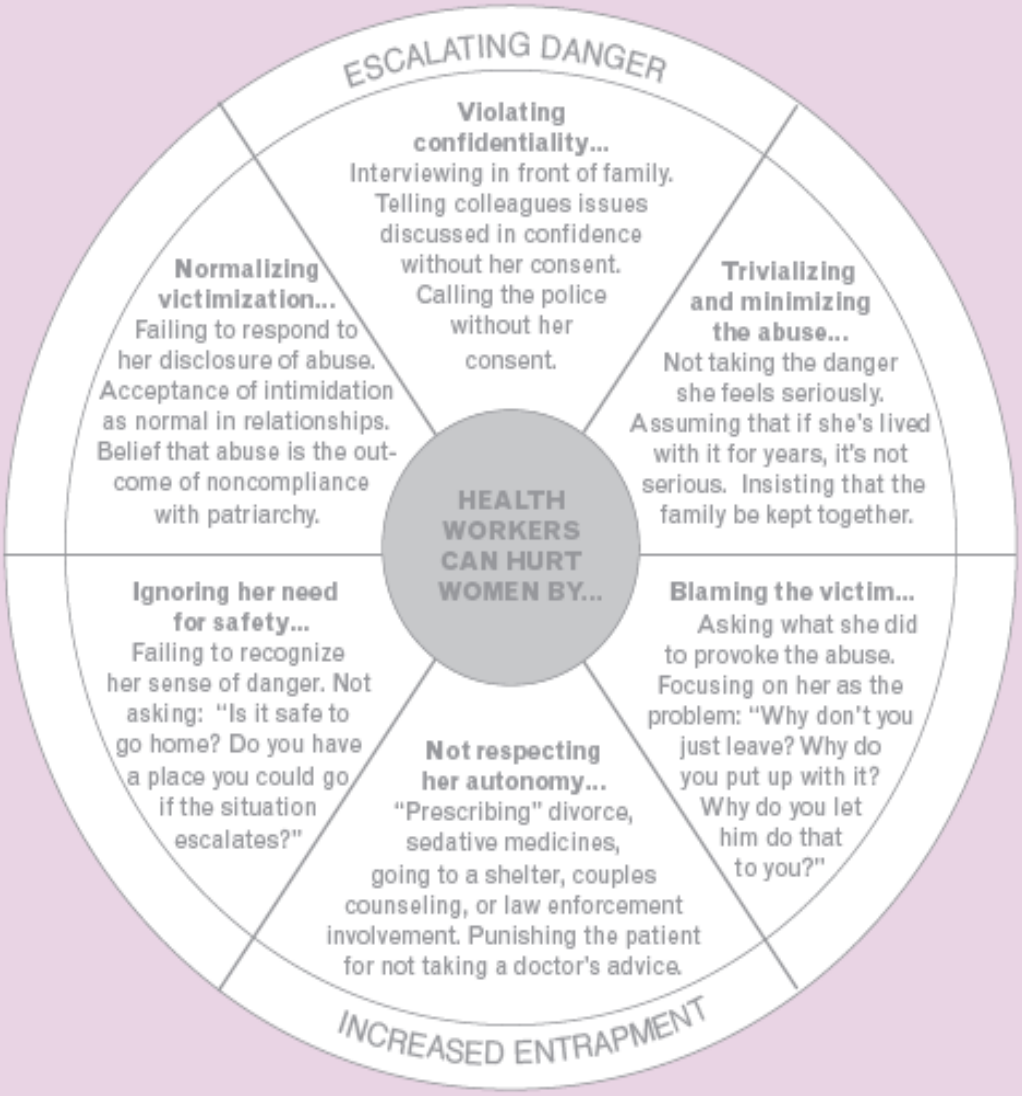
Example: In India, locating family counselling centres within hospitals has led the medical field to acknowledge that violence against women and girls is a legitimate health issue (UNFPA, 2009).

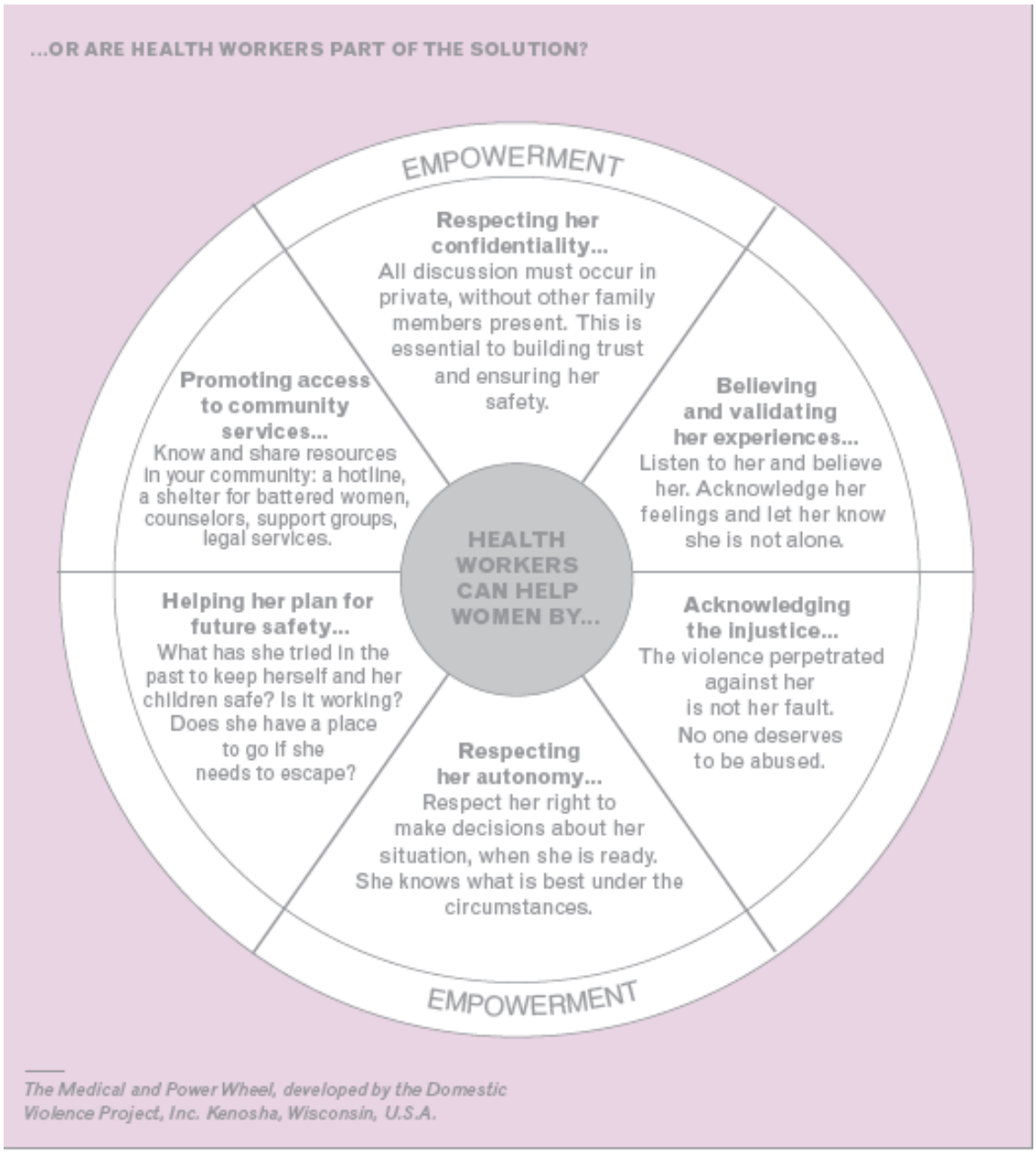
Example: In Honduras, 13 family counselling centres were established in regional health centres. Each was staffed with at least one social worker and psychologist and provides

both individual and group counselling for survivors, as well as training and prevention activities for health workers and community promoters (Velzeboer et al., 2003).

- However, in many development settings the Council of Europe standard may be unrealistic, and this standard may not address the needs of women living in hard-to-reach rural areas. It is therefore critical that **all health care providers working with survivors have a thorough understanding of supportive techniques for engaging with survivors** that are based on guiding principles. As the following diagrams illustrate, simply adhering to basic principles when working with survivors can have a therapeutic effect.

BOX 6-5. GENDER-BASED VIOLENCE: ARE HEALTH WORKERS PART OF THE PROBLEM?





Source: Velzeboer, M., Ellsberg, M., Arcas, C., and Garcia-Moreno, C., 2003. *Violence against Women: The Health Sector Responds*. Washington, DC: PAHO, pgs.70 & 71.

- If professional counsellors are not available, if there are barriers to accessing individual psychosocial support or as a complement to existing services, support groups can be created with health personnel serving as trained facilitators (Ellsberg and Arcas, 2001).

- While facilitators do not necessarily need to have advanced degrees in psychology, social work, or a related field, they should have specific training in violence against women issues, as well as in facilitating a support group, and should understand the

process for designing support groups, the stages of group development, the role of the facilitator, etc.

Case Study: Women's Support Groups as part of an Integrated Model of Care of Family Violence in Central America (Pan American Health Organization)

One of the support groups from the Program in El Salvador, Barrio Lourdes, documented what they learned:

To be independent
To value ourselves
To be more responsible with our children
To make responsible decisions for one self
To recognize our qualities
Not to be violent
To esteem ourselves
To put our abilities into practice
To say, "I am competent, I can do it"
To empower ourselves
To have our rights respected and not be abused
To love ourselves
To forgive
To liberate ourselves
To respect
To love
To have solidarity within the group

Support groups can be important to the psychosocial well being of survivors, particularly in resource-poor settings, where there may be fewer mental health providers. One of the main advantages of support groups is that they enable health centres to attend many more individuals than is possible with individual psychological care. Additionally, group facilitators do not necessarily have to be mental health professionals, although special training is necessary. Another advantage is that women are given the opportunity to help each other; to realize that they are not the only ones that suffer from violence; and to develop common ties, and in some cases, collective action. These are all important elements for overcoming violence. A programme by the Pan American Health Organization (PAHO) in Central America has tried to promote support groups through staff training and distribution of educational materials. In each one of the countries there is at least one successful pilot experience with support groups. In Central America, there are several organizations, for example, Centro Feminista de Información y Acción (CEFEMINA) in Costa Rica, with extensive experience in self-help or support groups for violence survivors. However, a review of the support groups in the region demonstrated a wide disparity in how generalized the support groups were within each country. An important realization was that the success or failure of groups had much more to do with the motivation and skill of the individual health workers than with the community characteristics, or professional training of facilitators.

One of the most comprehensive approaches was at the Polyclinic of Barrio Lourdes in El Salvador, where various support groups for survivors of violence were managed, including one for elderly women. What makes this experience noteworthy is that the groups are run by a physical therapist and special education specialist, although the center has several psychologists on staff. The facilitators were chosen not for their professional background but because of their interest in the topic and their ability to develop trust with people. For more information on lessons learned, see the document in English.

Source: excerpted from: Ellsberg, M. and Arcas, C., 2001. *Review of PAHO's Project: Towards an Integrated Model of Care for Family Violence in Central America. Final Project*. Stockholm, Sweden: Department for Democracy and Social Development: SIDA evaluation, pgs. 24-25).

Illustrative Tools:

- ***Caring for Survivors Training Manual*** (United Nations Children's Fund, 2010). Module 8. Available in English.

- ***Communication Skills in Working with Survivors of Gender-based Violence: A Five-day Training Manual*** (International Rescue Committee and Family Health International, 2000). Day 4. Available in English.

- ***Counsellor's Training Manual, Help & Shelter***, Guyana (Jackson, J.). Available in English.

- ***Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries*** *(*Bott, S., Guedes, A., Guezmes, A. and Claramunt, C./IPPF/WHR, 2004). See Section v.d: Women's Support Groups. Available in English and Spanish.

- ***Mental Health Responses for Victims of Sexual Violence and Rape in Resource-Poor Settings*** (Sexual Violence Research Initiative, 2011). Available in English.

- ***THE POWER TO CHANGE: How to set up and run support groups for victims and survivors of domestic violence*** (NANE, AMCV, Association Artemisia, NGO Women's Shelter, and Women's Aid Federation of England, 2008). This manual produced under the Daphne Project in Europe outlines key considerations required for establishing and running support groups for survivors of domestic violence, including three possible models that can be used as a basis of running such groups. Available in English, Estonian, Hungarian, Italian, Portuguese and Serbian.

- ***Counseling Guidelines on Domestic Violence*** (Southern African AIDS Training Programme, 2001) Harare, Zimbabwe. Available in English.

- ***Trainer's Manual for Rape Trauma Counselors in Kenya*** (Ministry of Health, Nairobi, Kenya, 2006). Available in English.

- Several guidelines and tools have been created for humanitarian emergencies on general issues related to providing care and support that may also be useful in non-emergency contexts. These include:

    - Guidelines on Mental Health and Psychosocial Support in Emergency Settings. These guidelines reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners. The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial well-being.

    - Psychological First Aid: Field Operations Guide. National Child Traumatic Stress Network and National Center for post traumatic stress disorder. An

evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism: to reduce initial distress, and to foster short and long-term adaptive functioning. It is for use by disaster responders including first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations.

- Coping with disaster – A guidebook to psychosocial intervention This manual outlines a variety of psychosocial interventions aimed at helping people cope with the emotional effects of disasters. It is intended for use by mental health workers (psychiatrists, psychologists, social workers, and other counselors), by primary medical care workers (doctors, nurses, and other community health providers), by disaster relief workers, by teachers, religious leaders, and community leaders, and by governmental and organizational officials concerned with responses to disasters. It is intended as a field guide or as the basis for brief or extended training programmes in how to respond to the psychosocial effects of disasters.

6d. Safe abortion

- The International Conference on Population and Development (1994) Programme of Action recognizes the importance of safe abortion, stating that "...abortion care should be an integral part of primary health care (para 7.6) and that "In circumstances where abortion is not against the law, such abortion should be safe (para 8.25)." At the Special Session of the United Nations General Assembly in June 1999, governments further agreed that "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health" (WHO, 2003a).

- Among the many other negative health outcomes of violence against women and girls, unwanted pregnancies are one problem that may be compounded by the fact that women and girls who experience violence are often less likely to access family planning information, contraceptives, and other forms of reproductive health care.

- Unwanted pregnancies can result in unsafe abortions when women and girls try to end their pregnancy themselves or through unaccredited or "back alley" services.

- Pregnancy risk should be assessed in all female survivors of reproductive age and appropriate emergency contraception provided. In settings where abortion is legal, termination of pregnancy should be discussed and health care facilities serving survivors of violence against women should either make no-cost or low-cost abortion services available, or should have referrals for women seeking abortion.

For guidance on abortion across the health care system, see:

- ***Safe Abortion: Technical and Policy Guidance for Health Systems*** *(*2003*).* World Health Organization. Available in Azerbaijani, Bosnian, English, French, Russian and Spanish.

Additional Resources:

- For a range of technical and policy guidance on **Preventing Unsafe Abortion** see the World Health Organization website.

- **Women-Centered Abortion Care: Reference Manual** (Hyman, A. and Castleman, L./Ipas, 2007). Available in English and Spanish.

- ***Violence, pregnancy and abortion: Issues of Women's Rights and Public Health*** (De Bruyn, M./Ipas 2003). Available in English.

7. Ensure medical records and an information system to document cases

- A health information system is needed to gather data for overseeing client care as well as for monitoring services. Each health facility providing services should keep statistics using a standardized data collection form.

- Client registration formats at a minimum, should collect information on:
  - The type of violence experienced
  - The sex of the person
  - The age of the survivor
  - The age and relationship of the perpetrator to the survivor (Velzeboer, 2003)

- Additional demographic information may be collected on whether the incident was rural/urban, and by population sub-group (e.g. indigenous; ethnic and racial categories; migrant; women with disabilities; other prominent or especially excluded groups).

- The case record should also include a careful description of the violence, including the type of assault, the number of aggressors and time of aggression. The write-up should as much as possible use the woman's own words and should avoid any language that is judgemental or critical of the survivor's observed behaviour or appearance that may be used against the women in any subsequent legal proceedings (Tavara, 2006).

- It is critical to guarantee complete confidentiality, not only on the files themselves (e.g. by using a patient number instead of the patient's name), but also by ensuring that all records are kept in locked files. Only select staff should have access to the keys for the files and management should develop a system for file distribution and sharing within the facility.

- IPPF/WHR has developed the following stamp to include on intake forms to indicate that a client has been screened for violence:

Date: ___/____/_____
In risk?: Yes ☐ No ☐
Accepted help?: Yes ☐ No ☐

	Ever	Last 12 months	Partner √ = yes
PSY			
PHY			
Sx			
CSA			

The four categories of gender-based violence, defined by a working group based on existing definitions in the literature and on the experience of IPPF/WHR affiliates, which can be specified using this tool: **PSY**: psychological violence; **PHY**: physical violence; **SX**: sexual abuse; **CSA**: denotes a history of childhood sexual abuse.

Source: excerpted International Planned Parenthood Federation, Western Hemisphere Region, 2000. "Tools for Service Providers Working With Victims of Gender-Based Violence." Available in English.

Example: In Malaysia, colour coding or stamping on registration files were two systems developed to protect clients' confidentiality (Rastam, 2002; Rogow, 2006; and Guezmes & Vargas, 2003, cited in Colombini, 2008).

Balancing Confidentiality with the Need for Complete Medical Records
International Planned Parenthood Federation/Western Hemisphere Region

One important challenge for many clinics is ensuring that providers are able to record detailed information about women's experiences of violence without revealing this information to a third party without the woman's consent. Participants in the IPPF/WHR initiative felt that abuse and violence have a major impact on women's sexual and reproductive health and are therefore an essential part of a woman's medical history that is necessary for ensuring appropriate care. On the other hand, some providers felt that they did not always want other staff members in the organization to know about the violence that their clients revealed. In fact, during the IPPF/WHR baseline study, some physicians said that they wrote down all information about violence on the clinical history form in code so that they could access this information during future consultations, but none of their colleagues in the clinic would know what the information meant. This appeared to be a particular challenge in larger clinics where women did not have their own personal health care provider but saw different providers depending on who happened to be available that day. In general terms, all three member associations decided that providers should write women's answers to gender-based violence screening questions on the clinical history forms in a manner that was clearly legible to other providers.

To protect women, the clinics strengthened the policies safeguarding the way that clinic records were stored and asked providers to make it clear to women who disclosed violence how the information would be recorded and used. Raising providers' awareness of violence as a health issue made it easier to convince them that this information should be part of a woman's medical record. Moreover, it was helpful to point out that medical records in their clinics contained all kinds of sensitive and confidential information, including contraceptive use, pregnancy status, and the results of exams for sexually transmitted infections. A breach of confidentiality regarding any of these sensitive matters can put a woman at risk. A history of violence or abuse should not be seen as shameful information to record (a concern of some providers).

Clinics have an ethical responsibility to protect the confidentiality of all medical records to a point where recording details of violence should not put women in danger. Nonetheless, the three IPPF member associations are still struggling to resolve a number of issues. For example, most have not developed systems to share information about violence between professionals from different services (such as counselling and medical services). For example, if a woman discloses a history of violence to a family planning counsellor during an intake procedure, how much of that information should be available to the physician who would attend to her sexual and reproductive health needs? In the member association clinics, information about a history of violence disclosed in counselling, medical and psychological services often remains in separate registries. During the follow-up evaluation of the IPPF/WHR initiative, the consultant recommended that when health programs maintain separate registries, they should consider recording a summary of other services received in the medical history form, just as physicians do when they refer clients to specialists in the medical field, unless women do not want this information recorded. However, some evidence suggests that service providers—rather than female clients—are the ones most resistant to sharing information among medical, legal and psychological services.

Source: excerpted from Bott, S., Guedes, A., Guezmes, A. and Claramunt, C., 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. New York: IPPF/WHR, pg. 57. Available in English and Spanish.

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)			

Source: excerpted from Billings/UNFPA. 2001. *A Practical Approach to Gender-based Violence: A Programme Guide for Heath Care Providers and Managers*, Appendix 9. Available in English, French and Spanish.

Illustrative Tools:

- ***A Practical Approach to Gender-based Violence: A Programme Guide for Heath Care Providers and Managers*** (Billings/UNFPA, 2001). Includes guidance on data collection. Available in English, French and Spanish.

- **The Domestic Violence and Sexual Assault Data Resource Center** has numerous examples of incident report forms and case management forms from the majority of states in the United States. Sample forms are available in English.

- **Gender-based Violence Information Management System Project Tools.** The GBVIMS is a multi-faceted initiative being undertaken in humanitarian settings to enable humanitarian actors to safely collect, store, and analyze reported GBV incident data. The GBVIMS includes: a workbook that outlines the critical steps agencies and inter-agency GBV coordination bodies must take in order to implement the system; an Excel database (the "Incident Recorder") for data compilation and trends analysis; and a global team of GBV and database experts from UNFPA, UNHCR and the International Rescue Committee for on-site and remote technical support. For more information about the tools, see the website.

8. Establish a monitoring and evaluation framework for levels of service activity and quality of care

- Monitoring and on-going evaluation of service quality is key to improving quality of care and is described in greater detail in the monitoring and evaluation section of this module. Agency protocols on service delivery roles and standards should be used to inform monitoring and evaluating strategies. All monitoring and evaluating efforts must be systematic and structured, should use process and impact indicators, and tools must be developed which will be used in standardised manner throughout the services in order to collect data. Monitoring and evaluating should also involve multiple stakeholders, particularly survivors (Jewkes, 2006).

- Identified individuals with sufficient seniority and authority should be designated to oversee monitoring and evaluation processes, and should be prepared to investigate and address problems to improve quality of services. Service providers may require training and other support in inputting and interpreting data. Information about the results of monitoring should be made available to all relevant staff (Jewkes, 2006).

- To ensure that monitoring and evaluation is part of any programme or intervention, there are important steps to be taken, including:

    - conducting situation analyses/needs assessments before or while the programme/intervention is being planned;
    - developing a monitoring and evaluation framework that explains how the programme will work; how it will reach its goal and objectives and how it will be determined whether the programme is reaching those objectives and contributing to the goal;
    - developing a monitoring and evaluation plan that lays out the process for how the programme or intervention will be tracked, and how it will be examined or

assessed overall; and

- the collection of data at the beginning of the programme (baseline) and at the end of the programme. (For more information about these basic steps, see the module on Monitoring and Evaluation.)

- Monitoring and evaluation should look at all elements of the system-wide approach to health, including the policies, protocols, infrastructure, supplies, staff capacity to deliver quality medical and psychosocial support, staff training and other professional development opportunities, case documentation and data systems, the functioning of referral networks, safety and danger assessments, among other items that are relevant to specific contexts and programmes. (See Heise, Ellsberg and Gottemoeller, 1999; Velzeboer et al., 2003; Bott et al., 2004.)

Illustrative Resource:

- For information on monitoring and evaluation of health services and quality of care, see the monitoring and evaluation section of this module.

9. Ensure coordination and referrals

- All health facilities should engage in coordination at the facility-level and at the community level.

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

  - Community-level coordination ensures that representatives from the health facility are part of a larger multisectoral network of providers and activists. Community-level coordination assists health facilities in linking with and working collaboratively with a local coordination network to:
    - Establish ethical and safe referral pathways;
    - Make rational and efficient use of local resources by avoiding duplication of efforts and harmonizing services;
    - Develop allies and minimize discord;
    - Promote transparency among providers;
    - Improve monitoring of multisectoral responses;
    - Link with sub-national and national coordination mechanisms.

- Successful community-level coordination is a challenge that requires active participation and commitment of those within health facilities who **have the authority** to make decisions on behalf of the facilities.

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

    - The needs of survivors and those at risk of violence are the primary focus of coordination work;
    - The coordination process should be well-structured in order to respect the time and participation of coordination partners. There should be sufficient human and financial resources allocated towards coordination; the meeting time and place should be specific and accessible; coordination meetings should be based on clear objectives and ground rules; and roles and responsibilities of coordination partners should be clear.
    - Coordination should also be action-oriented and motivational, as well as provide an opportunity for reflection, social cohesion, and networking.

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

- When establishing a referral directory, health facilities can follow the steps outlined below:

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

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

STEP 3: *Call or (ideally) visit each institution to gather key information about its services.* To ensure that you gather up-to-date information about each institution, and to have the opportunity to see the services firsthand, it is best to conduct a brief, informal interview in person with a staff member from the organization where services are provided. After describing your own work in the area of gender-based violence, you should ask a series of key questions to identify whether and how the institution can be used for referrals.

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

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

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

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

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

Source: excerpted from Bott, S., Guedes, A., Guezmes, A., and Claramunt, C., 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. New York: IPPF/WHR, pg. 61. Available in English and Spanish.

Example: Staff of Profamilia in Santo Domingo, Dominican Republic created a referral system of local organizations working with victims of violence listing services offered, populations served, hours of operation and means of contact. Having this referral system helped to alleviate providers' concerns that if they opened a discussion on violence, they would have no services to offer to the woman. Furthermore, building this referral network helped strengthen Profamilia's relationships with other organizations (Goldberg, 2006).

Contact Profamilia for additional information.

The following is a tool that can be used to collect information about referral agencies:

SAMPLE FORMAT FOR A DIRECTORY OF REFERRAL ORGANIZATIONS

Adapted from a form created by Susana Medina, PLAFAM

CONTACT INFORMATION	
Full name of the institution:	Family Planning Association
Acronym:	PLAFAM
Type of institution:	Non-governmental organization
Address:	Calle Minerva, Qta. PLAFAM, Las Acacias, and Calle La Paz, Casco Colonial de Petare, Edf. 3-19, Mezzanina
Telephone:	Central clinic: 693-9358/6032/5262 Petare clinic: 271-7268
Fax:	693-9757
Email:	Plafam@plafam.org
Director:	Dr. Beatriz Castresana
Director's title:	Executive Director
Information source:	Susana Medina
Title:	Gender-Based Violence Project Coordinator
Date information updated:	November 12, 2003
Overview of the institution:	PLAFAM is a nonprofit, civil society organization whose mission is to promote family planning and to improve the sexual and reproductive health of the Venezuelan population, especially among low-income women and men.
DESCRIPTION OF SERVICES RELATED TO GENDER-BASED VIOLENCE	
Characteristics of the population served:	Women, children and adolescents who live in all of the metropolitan area of Caracas, Los Teques, Valles del Tuy
Types of services:	1. Counseling and emotional support services 2. Psychological services: crisis intervention and long-term therapy 3. Support groups for survivors of gender-based violence. 4. Emotional support services for child survivors of gender-based violence 5. Legal services 6. Sexual and reproductive health care
Hours:	Services available from Monday to Friday, 8:00 am to 1:00 pm and 2:00 pm to 4:00 pm
Procedures for obtaining services:	Medical services are provided on a first-come, first-served basis, or by prior appointment by telephone. Drop-in crisis intervention is available during office hours, or by phone appointment.
Costs of the services:	(check before making the referral)
Referral sites:	Police Department Section on Minors, Walk-In Clinics, Youth Referral Center
Type of staff who provide services to victims of violence:	Psychologists, doctors and lawyers
Other activities related to violence:	University seminars on gender-based violence; workshops to sensitize and train professionals such as police and forensic physicians; production of materials and publications on gender-based violence

Excerpted from: Bott, S., Guedes, A., Guezmes, A. and Claramunt, C., 2004. *Improving the*

Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries. New York: IPPF/WHR, p. 63. Available in English and Spanish.

Additional Resources:

- ***Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries*** (Bott, S., Guedes, A., Guezmes, A. and Claramunt C./ International Planned Parenthood Federation, Western Hemisphere Region, **2004)**. See Section III.e.: Developing Referral Networks. Available in English and Spanish.

- ***Bridging Gaps—From Good Intention to Good Cooperation*** (Women Against Violence Europe, 2006) This manual is a resource for service providers across sectors addressing violence against women. The manual offers guidance and recommendations on multi-agency cooperation in the protection of domestic violence survivors. The manual is organized into 15 chapters covering: background information on violence against women; multi-sector service provision and multi-agency cooperation; general and sector-specific standards for practice; violence prevention and safety planning; survivor involvement in programmes; actions and models for multi-agency cooperation. Available in English; 116 pages.

- ***Guidelines on Coordinating GBV Interventions in Humanitarian Settings*** (Ward, J. 2010). New York: Gender-based Violence Area of Responsibility Working Group. Available in English.

- ***Community of Practice in Building Referral Systems for Women Victims of Violence***, (Jennings, M./UN Relief and Works Agency for Palestine Refugees in the Near East, 2010). Available in English.

10. Develop educational and informational materials and conduct community outreach about availability of support services.

- Health providers should disseminate information within facilities, especially in waiting areas and bathrooms, about violence against women and girls. These materials might include pamphlets, posters, a short video, etc., and should be adapted in settings where clients may be non-literate.

- Materials should include information on:
    - Availability of trained providers who can be asked for help regarding any form of violence clients have experienced
    - Patient rights within health services, including privacy and confidentiality
    - Nature, health impacts, and services available for various types of violence, including:
        - Family violence
        - Intimate partner violence

        - Sexual violence, including rape
        - Childhood sexual abuse
    - Laws about violence against women
    - Sexual and reproductive health and rights
    - Women's rights
    - General human rights
    - Where to get other services (special police units, hotlines, free legal assistance, women support groups, shelter, etc.)

- In designing materials, it is important to remember that women who are in abusive situations may be endangered if they bring home written information about violence. In addition to the materials above, providers may want to make small cards available to women that they can hide in their clothing and that only provides phone numbers and addresses of services, without any other identifying information that could put a survivors at risk (Bott et al., 2004).

- Health facilities should also conduct community outreach about the availability and importance of accessing services in timely manner. Community awareness campaigns can increase utilization of services and make services more efficient (Kim et al., 2007a). Working at the community level helps overcome barriers that rural and poor women in particular may have in accessing services (Naved, 2006) and can build trust in local health providers and the services they offer.

Example: Staff at a health centre in Nepal offering violence against women and girls services held community meetings, schools, and village gathering places to talk about the unacceptability of violence against women and girls and the services they offered to meet the needs of survivors. Additionally, peer educators encouraged survivors to go for services. These activities led to an increase in clients seeking services (UNFPA, 2009).

- Health facilities should identify outreach workers who can share information at the community level. These outreach workers can be directly linked with the health facility, or can be accessed through other networks with which the facility coordinates. Links can be created between local organizations, women's groups and other important community stakeholders.

Example: The Thohoyandou Victim Empowerment Programme in South Africa conducts campaigns on where and how to report abuse, directly linking communities with existing medical services. Additionally, case management teams follow and monitor survivors (Ndhlovu et al., 2006, cited in Population Council, 2008b).

Example: In the Justo Rufino Barrios Clinic in Guatemala City, health promoters use the waiting rooms to perform short theatrical skits. These skits introduce the topic of violence

and encourage patients to talk to their health providers if they need help (Velzeboer et al., 2003).

Illustrative Tools

- ***Sample Safety Card***, Family Violence Prevention Fund, USA. Available in English.
- ***Health Communications Materials Database*** (Media Materials Clearinghouse). Materials available in a number of languages.
- ***GBV Prevention Network Communications Materials.*** Materials available in a number of languages and from different African countries.
- ***South Asia Advocacy Materials compiled by UNIFEM.*** Materials available in English, Hindi and Telegu.
- ***Until Women and Children Are Safe*** (Women's Aid). A number of leaflets and resources are available for free by filling in the order form.

11. Develop community-based prevention programming

- It is crucial in the fight against violence against women and girls to create links between communities and health services and support the participation of health care providers in broader prevention efforts and advocacy (USAID, 2006).

- Public health education campaigns at the community level can serve as a preventive factor by letting women and men know that violence is unacceptable (Luke, 2007) and by also educating them about the consequences of violence for themselves and their children (Guedes, 2004). These campaigns should at minimum seek to:

    - Promote gender-equitable, nonviolent sexual partnerships;
    - Increase women's ability to make decisions about the timing and nature of sexual relationships;
    - Decrease tolerance for violence by raising awareness of it as a human rights and public health problem;
    - Encourage victims of abuse to seek help and to disclose violence to service providers.

- Methods for community-based prevention through the health sector include:

    - Clinic and community-based education and other support programmes. Efforts using radio programmes, theatre, videos, pamphlets, talks and other mediums, such as microcredit (e.g. SASA! and Radar/IMAGE);
    - Mass and multi-media behaviour change campaigns, such as edutainment programmes (e.g. Soul City and Sexto Sentido);

- Programmes for men aimed at promoting gender equitable relationships and changing norms, attitudes and behaviours (e.g. Program H and Men as Partners);
- Gender-based violence prevention within HIV/AIDS and adolescent reproductive health programmes (e.g. Stepping Stones, ReproSalud) (Bott, Morrison and Ellsberg, 2005a).

Case Study: Profamilia at Work to Address Violence against Women (Dominican Republic and Colombia)

In the Dominican Republic Profamilia has successfully increased awareness on violence against women and girls through outreach to media, women's groups and communities. Efforts have also been made to increase knowledge on women's rights. For example, in 1997 a law to increase the protection of violence, especially domestic violence against women and children was passed. Recognizing that this new legislation would mean very little if women did not know their rights, Profamilia took on the task of disseminating its contents. In order to explain the new law and the process for reporting violence, three different publications were compiled and disseminated. With the aim of reaching a wide audience, each publication was designed for populations with varying degrees of literacy (Population Council, 2006).

In Colombia, Profamilia maintains a strong role across the country in providing sexual and reproductive health services. An important part of their work focuses on addressing sexual violence. They provide integrated advisory, medical and psychosocial, legal and centres of attention and referral services to survivors. The organization has also launched a major campaign *A Viva Voz* mainly aimed at adolescents through the engagement of well-known pop stars and the use of multimedia.

Resources:

Sexual and Reproductive Rights from A to Z: for Health Care Providers Focusing on Intra-family and Sexual Violence (2007). The training guide and module are available in Spanish.

Student Booklet on Sexual Violence (2007). Available in Spanish.

Tools:

- For more information about community-based prevention see community mobilization in the Prevention Module.
- ***Intimate Partner and Sexual Violence Prevention Course*** (Violence and Injury Prevention and Disability/ World Health Organization). Available in English.

- ***VicHealth Review of Communication Components of Social Marketing/Public Education Campaigns Focusing on Violence Against Women*** (Donovan and Vlais/RJD Consulting for ViCHealth, 2005). Available in English.

- ***Making a Difference: Strategic Communication to End Violence against Women*** (UNIFEM, 2003b). Available in English.

- ***How to Mobilize Communities for Health and Social Change*** (Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, 2003). Available in English.

- ***GBV Prevention Network Communications Materials*** (Gender-based Violence Prevention Network). Materials available in a number of languages.

- ***A Field Guide to Designing a Health Communication Strategy*** (JHU School of Public Health, Center for Communication Programs, 2003) provides general tips on how to construct a communications strategy that is not specific to violence against women, but provides a methodology that can be adapted. Available in English.

- ***Gateway to Health Communication & Social Marketing Practice*** (Centers for Disease Control and Prevention). Available in English.

12. Ensure Funding

- The costs of integrating violence against women and girls programming into health services will vary according to the setting, because it depends on the services already available, e.g. the extent of training of service providers in counseling and/or gender sensitivity, and whether the facility already has the capacity to provider appropriate post-sexual violence services, such as provision of emergency contraception, the collection of medical/forensic evidence (e.g. rape kits), STI and HIV testing, and post-exposure prophylaxis (PEP) for HIV/AIDS and treatment for STIs.

- The costs to be considered include the following **start-up one-time costs**. This list assumes that the normal equipment and supplies for basic sexual and reproductive health services are in place.

    - Any remodeling of facilities that is needed to provide the necessary privacy, usually outfitting a private room for counseling, or a room dedicated solely to the constellation of post-rape services that is not marked to ensure client safety and confidentiality.

    - Adaptation of screening tools and protocols, which might necessitate the time of a researcher to verify culturally appropriate language and ways to surmount cultural barriers to disclosure.

    - Training of health providers to apply protocols and provide initial gender-sensitive, sympathetic counseling.

- Time of health sector staff to set up the appropriate linkages and referral systems with police, judiciary, and psycho-social services.

- For post-sexual violence services, coordination with the legal system demands medico- infrastructure and equipment, e.g. laboratories to take biological samples, and any other items stipulated by law or that may help provide evidence in a case.

- The following **recurrent costs** must be considered if the service is to be sustainable. These must be built into budgets. Some of the recurrent costs will be fixed, but others will vary according to the number of women expected to use the service. As community-based education campaigns raise awareness about violence against women and girls and women's rights, the numbers of women using the service should increase steadily.

    - If the facility sets up a special service for violence against women and girls that did not exist previously, there will be annual operating costs.

    - Many services have added a psychologist to the team to provide counseling and serve as the main person helping to direct women and girls to other sectors and support services.

    - The need for training and support of health personnel dealing with cases is ongoing, to avoid burnout and maintain quality of services.

    - Given skills and time constraints of many of the health providers doing the initial screening, many services in the literature added psychologists to existing services. Given the human resource constraints of most public sector health services, it is difficult to provide these additional support services without additional funding. (Hainsworth & Zilhão, 2009)

    - For resource poor settings low-cost alternatives are suggested when psychosocial support is lacking, such as peer support groups for women.

    - If post-sexual violence services are added, the cost of any additional laboratory tests and standard treatments, supplies, and medicine (e.g. HIV PEP, emergency contraception, STI treatment) as well as the costs of gathering of evidence for the juridical system according to national standards.

Source: excerpted/adapted from: UNFPA. N.d**.** *Addressing Violence Against Women and Girls in Sexual and Reproductive Health Services: A Review of Knowledge Assets*, pgs.28-29.

Case Study: South Africa Costs Services to Provide Better Care for Sexual Assault Survivors

In South Africa, the following cost analysis measured the additional cost of strengthening the existing post-rape services. After conducting formative research, a five-part intervention model was introduced in a district hospital in rural South Africa. This intervention cost $84,612 over three years. The major cost items were the initial investment in training and development, and the salaries of the Post Exposure Prophylaxis Coordinator and Study Nurse. Thus, the routine service delivery costs (total costs minus initial training and development costs) were $52,345 (ZAR 366,420) over the three years, which translates into an estimated annual cost of $17,449 (ZAR 122,140).

Program costs

Item	Cost 2006 ZAR	US$
Capital		
Computers	10,000	1,429
Printer/fax	3,000	429
Office furniture	3,275	468
Training and development	225,866	32,267
Office rent	21,780	3,111
Personnel		
PEP Coordinator	72,600	10,371
Study Nurse	127,050	18,150
Consumables and overheads		
Local transport	38,115	5,445
Project Advisory Committee meetings	3,480	497
Phone/email/fax	43,560	6,223
Stationery and photocopying	43,560	6,223
Total	**592,286***	**84,612**

The introduction of the model resulted in, among others: an increase in the volume of rape cases presenting to hospital (from 8 to 13 cases per month); improved efficiency of services with rape survivors; improved quality of services (e.g. exams, provision of pregnancy testing, emergency contraception, sexually transmitted infection treatment, voluntary counselling and testing, post exposure prophylaxis, counselling and referrals), and; an increased role for nurses.

The results of this study suggest that it is possible to improve comprehensive services for the medical management of sexual assault, including post-exposure prophylaxis within a public sector hospital, using existing staff and resources, and that with additional training, nurses can play an expanded role in this care. There have been few such studies conducted in an African setting, and the findings are important for understanding how the health system is currently coping with high levels of sexual violence in communities – and how they might be improved.

Source: excerpted/adapted from: Kim, J., et al., 2007a. *Developing an Integrated Model for Post-Rape Care and HIV Post-Exposure Prophylaxis in Rural South Africa*. Washington, D.C.: Population Council, Rural AIDS & Development Action Research Programme, School of Public Health, University of Witwatersrand, South Africa and Tshwaranang Legal Advocacy Centre, South Africa).

Illustrative Resources:

- ***Gender Responsive Budgeting and Women's Reproductive Rights: A Resource Pack*** *(*UNFPA and UNIFEM, 2006). Available in English, French and Spanish.

- ***Gender Responsive Budgeting in Practice: A Training Manual*** (UNFPA and UNIFEM. 2006a). Available in English.

- ***Hospital Costing Model Manual*** (Newbrander, W. and Lewis, E., 1999). Available in English.

B. Integrate survivor support and assistance into sexual and reproductive health programmes

- Most women will seek some form of reproductive health service (e.g. family planning, maternal and child health care, routine gynecological care, abortion services and STI (including HIV) counseling, testing and treatment) at some time in their life and there are clear links between sexual and reproductive health and violence. Providers serve a sexually active population; pre-natal care services in particular tend to have the highest national coverage, and are most apt to reach highly marginalized and vulnerable women and girls.
- **The linkages between violence against women and girls and sexual and reproductive health risks are bi-directional**. That is, gender inequalities and violence against women and girls are among the key factors in reproductive health vulnerabilities for women and girls, while sexual and reproductive health issues such as unintended pregnancy can increase violence against women and girls risks and serve to compound the effects of other aspects of gender discrimination.

- In general, reproductive health programmes should follow the steps outlined in Section A: Build institutional capacity to address violence against women and girls in hospitals, health clinics, and other primary and secondary health facilities when integrating violence against women programming into their services. At a minimum, implementation of quality violence against women and girls screening and counseling, as well as referrals to appropriate services for follow-up, are key components in the constellation of reproductive health interventions needed to address violence against women and girls.

Case Study: Manuela Ramos Engages Community-based Women's Groups in Peru to Better Serve their Needs

Manuela Ramos launched ReproSalud in 1995 as a USAID-funded rural reproductive health programme. ReproSalud used a form of participatory rural appraisal, by working with community-based women's groups (such as mothers' clubs) to identify women's

reproductive health needs through "auto-diagnosis workshops." Following these workshops, they held community meetings to design strategies to address the needs that women identified. ReproSalud ultimately responded to a range of health, social and economic concerns. Domestic violence and forced sex within marriage repeatedly emerged as themes and became a focus of many activities, including workshops for women and men on gender. ReproSalud also established a microcredit programme for women. By 2002, ReproSalud had reached over 123,000 women and 66,000 men.

Evaluators gathered baseline and midpoint data in 70 intervention sites and 25 control sites, including: a) baseline and midterm surveys among a random sample of households (baseline n =4,099 women, 3,192 men; midterm n = 3450 women, 3193 men); b) service utilization statistics at local health facilities; and c) semi-structured interviews with women, men, youth, village leaders, health officials, and local authorities. The evaluation measured individual-level, family-level, and community-level "empowerment outcomes." Family level outcomes included changes in levels of domestic violence, satisfaction regarding sexuality, shared decision-making, and women's social and geographic mobility. Quantitative findings were complemented with extensive qualitative data.

The survey found that gender-equitable attitudes and practices increased significantly in both intervention and control communities (14 out of 15 indicators versus 12 out of 15 indicators). The use of reproductive health services also rose 100-400% during a one-year period in intervention sites, compared to 39-51% in control communities. Evaluators noted that the project coincided with a period of strong investment by the Ministry of Health, which made it difficult to isolate the effects of the project. However, differences between the intervention and control sites were more pronounced in the qualitative data. Those findings suggested that ReproSalud had produced dramatic changes in social relations and men's behaviour through the communities. Respondents spoke at length about decreased alcohol consumption, domestic violence, and forced sex in all intervention villages studied.

Source: excerpted from Morrison, Ellsberg, and Bott, 2004, and also accessed through Bott, n.d.

- Addressing violence against women and girls through reproductive services is also an essential prevention strategy. Reproductive health services are ideal channels to detect women and girls experiencing violence or at high risk of violence, and counsel or refer them to prevent a first experience of violence, or work with them to prevent recurrence.

Example: The International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) and the Asociacion Civil de Planificacion Familiar (PLAFAM) in Venezuela used three strategies to address violence against women and girls within their reproductive health services. The first strategy was training staff. Providers were trained to ask questions to assess a survivor's current safety and assist with the development of a safety plan. Additionally, clinicians were trained to: recognize signs

of violence through examining marks on the body; be responsive if a woman decides to disclose that she is being abused; and to provide related counseling and referrals. The second strategy was developing materials for clients on violence and sources of support, including the *Institutional Directory of Gender-based Violence Service Providers*. The third and final strategy was collaborating with community alliances to create a law outlawing violence against women.

The systematic screening practices revealed that over one-third of new clients were identified as having experienced abuse compared to only 7 percent previously (Guedes et al./Population Council, 2002b).

PLAFAM has been recognized by the World Health Organization in 2000 and IPPF in 2003 and 2010 for its technical assistance to three Latin American countries working to integrate services for survivors of gender-based violence in sexual and reproductive health.

See the full report in English.

- In addition, when men or boys accompany their partners or wives to reproductive health services, it is an important opportunity to involve them in reducing risks and prevention of violence against women and girls (as long as women and girls agree with their involvement). For more information on strategies to engage men and boys in ending violence against women, see the full module.

1. Family Planning services

- Many family planning services have clients who have been exposed to violence against women and girls (Watts and Mayhew, 2004). Women/girls having unprotected sex may do so because they are subject to threats, coercion, physical violence, or sexual violence. Addressing violence against women and girls will help make family planning programmes more effective. If violence is stopped, women will have a wider range of contraceptive methods to choose from, might have greater success in negotiating with male partners to use condoms, and in general will be empowered to communicate more with their partners on equal footing regarding reproductive choices.
- One sign of high risk would be when screening determines that women/girls are having unprotected sex when they do not want children, women who experience intimate partner violence may have less control over use of contraception (Cripe et al., 2008). Survivors who have access to family planning services should have the option of hormonal injections in order to use contraception without the knowledge of partners (Gee et al., 2009).

- Infertility services should also screen for violence against women and girls. In most societies fertility is highly prized, and in many, women suffering from infertility may be subject to violence from their husbands, or the husbands' family (Yildizhan et al., 2009).

- Reaching men as partners in family planning services can also be an important entry point to address respectful relationships and intimate partner violence.

2. Maternal and child health programmes

- The negative consequences of violence for pregnant women and their infants, coupled with the evidence of high rates of violence against pregnant and postpartum women in many countries, make a strong argument for routine screening for intimate partner violence in maternal and child health services. As many as 1 in 4 women experience physical or sexual violence during pregnancy (Heise et al., 1999).

- An evaluation of interventions in prenatal clinics in the US to identify and address abuse found that two groups of pregnant women who received either: (i) a referral card and a brochure about abuse; or (ii) counselling and mentoring during their pregnancy, reported lower levels of physical violence after several months. Because of the similar outcomes for both groups, the evaluators concluded that the screening assessment may itself be the most effective intervention to prevent abuse to pregnant women. The assessment signals that abuse is serious and of concern to the health care provider, and that help is available if needed (Mcfarlane et al., 2000, cited in Haider, 2009).

- Pregnancy and the postpartum period offer a "window of opportunity" to identify and assist survivors because health professionals may see clients on several occasions (Macy et al., 2007). Where trained providers are in place, screening can be implemented by using a simple abuse assessment protocol during prenatal care.

- Adolescent girls in particular should be considered high risk for violence and screened appropriately (Reichenheim et al., 2008), as well as women and girls who have experienced miscarriages (de Bruyn, 2003).

- In settings where midwives or traditional birth attendants provide care for women and girls at the community level, there should be training for early detection of abuse and appropriate referrals for assistance.

Example: Midwives Break Cultural Taboos Surrounding Rape (Mauritania)

Midwives and imams have helped break cultural taboos about the discussion of rape in Mauritania. Prior to 2003, survivors of rape in Mauritania were thrown in jail while the perpetrators went free. Correcting that gross injustice—and getting society to recognize the problem of rape at all—began with the grass-roots efforts of four Mauritanian midwives, who could no longer ignore the stories they were hearing from their clients. With UNFPA support, the first statistics on sexual violence in Mauritania were collected,

and a centre was established to respond to the multiple needs of survivors. Breaking the taboos surrounding the discussion of rape was the first step in addressing the problem. Local imams lent their support to the effort, convincing government officials, judges, the police and members of the community that protecting women and easing the suffering of those who are most vulnerable was a religious obligation.

See a short video on this initiative.

Source: excerpted from UNFPA, 2006. *Ending Violence Against Women: Programming for Prevention, Protection and Care*, p. 72.

Example: Reducing the Social Causes of Maternal Morbidity and Mortality in Chiapas, Mexico

The Family Violence Prevention Fund and Asesoria, Capacitacion y Asistencia en Salud partnered to develop a coordinated health response to abuse during pregnancy in order to reduce morbidity and mortality of both pregnant women and their babies. Strategies to achieve this goal include: training regional health care providers and traditional birth attendants to identify and assist women abused during pregnancy; producing a culturally and linguistically accessible training module and video for indigenous women in Mexico; facilitating linkages between formal health care facilities and local lay health care providers; producing and implementing a protocol for screening and responding to abuse during pregnancy; and identifying and evaluation promising practices that could be replicated in other regions beyond Mexico.

For additional information, see the website.

Source: excerpted from: Guedes, A., 2004. "Addressing Gender-Based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis." Washington, DC: USAID Interagency Gender Working Group, pg 43.

3. Routine gynecological check-ups

- Women who have experienced physical or sexual violence from their intimate partners are in general three times more likely to have a symptom of gynecological morbidity (Campbell, 2002). Other traditional practices, such as FGM/C, vaginal drying, etc. may also cause women chronic pain from gynecological conditions.
- Since women are often ashamed to disclose violence, especially with an intimate partner, training should alert providers to probe for possible sexual violence when women have repeated gynecological issues such as reproductive tract infections. Pelvic exams also give the opportunity to note vaginal or anal lesions, or bruises in the genital area, and should trigger sensitive, supportive questioning to help women get

support to address the sexual violence and to leave the abusive situation if she so decides.

4. Safe Abortion services

- In countries where abortion is legal, abortion providers should always screen for violence against women and girls. Some women who have undergone rape will present this as the reason for wanting the abortion, especially in countries where abortion is restricted and rape is one of the legal causes. In other cases where women do not mention violence, screening for violence against women and girls is still appropriate, since some women may seek services because they do not want more children with a violent partner, or because they have experienced rape, sexual abuse or incest are too ashamed to disclose.

Illustrative Tools:

- ***Abuse during Pregnancy: A Protocol for Prevention and Intervention, 2nd Edition*** (McFarlane, J., Parker, B. and Cross B., 2002). This module is targeted to nurses and nurse midwives to enable them to prevent abuse, interrupt existing abuse and protect the safety and well-being of pregnant women. Available in English.

- ***Tools for Improving Maternal Health and Safety*** (Family Violence Prevention Fund)**.** The website includes access to information on the dynamics of domestic violence; implementing a domestic violence programme in health care settings; training resources; educational materials and links to other resources in English and Spanish.

- ***Violence and Maternal Health in Multicultural Contexts*** (Asesoría, Capacitación y Asistencia en Salud; Centro de Investigaciones y Estudios Superiores en Antropología Social, Mexico). See the power point and access the tools and audio recordings on the Family Violence Prevention Fund's Website.

Additional Resources:

- **"Basta!"** (International Planned Parenthood Federation/Western Hemisphere Region). Videos and tools on gender-based violence for health care providers primarily in sexual and reproductive health services. Available in English and Spanish.

- ***Addressing Gender-based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis*** (Guedes, A., 2004). Washington, DC: USAID, Bureau for Global Health. Available in English.

- ***Reproductive Health Services and Intimate Partner Violence: Shaping a Pragmatic Response In Sub-Saharan Africa*** (Watts, C., and Mayhew, S., 2004). International Family Planning Perspectives 30, no. 4: 207-13. Available in English, French and Spanish.

- ***Delivering Post-rape Care Services: Kenya's Experience in Developing Integrated Services*** (Kilonzo N, Theobald SJ, Nyamato E, Ajema C, Muchela H, Kibaru J, Rogena E, Taegtmeyer M., 2009). Bulletin World Health Organization 87, no. 7: 555-9. Available in English.

- ***The Refentse Model for Post-Rape Care: Strengthening Sexual Assault Care and HIV Post-Exposure Prophylaxis in a District Hospital in Rural South Africa*** (Kim, J.C., Askew, I., Muvhango, L., Dwane, N., Abramsky, T., Jan, S., Ntlemo, E., Chege, J. and Watts, C./Population Council, 2009). Available in English.

- ***Violence, Pregnancy and Abortion - Issues of Women's Rights and Public Health*** (De Bruyn/Ipas, M. 2003). *IPAS.* Available in English.

- ***Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*** (Interagency Working Group, 2010). Available in English and Spanish.

- ***An Evaluation of Interventions to Decrease Intimate Partner Violence to Pregnant Women*** (McFarlane, J., Soeken, K. and Wiist, W., 2000). *Public Health Nursing*, Vol. 17, No. 6, 443-451. Available in English.

C. Link HIV and AIDS and violence against women and girls programming

1. Understand the linkages between HIV and AIDS and Violence against women

- Since HIV and AIDS emerged over 25 years ago, the percentage of HIV-positive people who are girls and women has increased globally. The 'feminization' of the HIV epidemic has resulted in more women than men living with HIV. In sub-Saharan Africa, young women aged15-24 are as much as eight times more likely than men to be HIV positive. In Asia overall, women account for a growing proportion of HIV infections: from 21% in 1990 to 35% in 2009 (UNAIDS, 2010).

- Studies are consistently showing a statistical association between experiences with violence and HIV infection:

    - In all settings in various countries, women who had experienced intimate partner violence were more than two times likely to be at risk of HIV/STI infection compared to those with no history of intimate partner violence (Devries K et al., 2010).

- In India, women who had experienced both physical and sexual violence from intimate partners were over three times more likely to be HIV positive than those who had experienced no violence (Silverman, 2008)
- In Rwanda, women who had been sexually coerced by male partners were 89% more likely to be HIV positive (van der Straten A et al.1995 and 1998)
- In South Africa, women seeking routine antenatal care who had experienced physical or sexual violence were 53% more likely to test HIV positive and those experiencing high levels of gender power inequality in relationships were 56% more likely to test HIV positive (Dunkle, 2004).
- In the United Republic of Tanzania, women seeking voluntary counseling and testing who had experienced violence were also more likely to be HIV positive; among women under 30 years, those who had experienced violence were about 10 times more likely to be HIV positive *(*Maman, 2009*)*.

➢ For additional statistics, see the 2009 Global AIDS Alliance Fact Sheet.

- Although there has been increased attention in recent years to understanding linkages between HIV and AIDS and violence against women, the evidence base still remains weak due to gaps in information (Harvard School of Public Health, 2009). This is at least partly due to the nature of the fundamental issues involved with these dual pandemics: sex and violence (CWGL, 2006). In many contexts around the world sex and violence are viewed to be private concerns and not community or governmental issues. The silence that typically accompanies these dual pandemics makes it difficult for women to access information and services for treatment, care and prevention of *both* HIV and violence. This in turn makes accurate data collection about the intersection of violence and HIV difficult (CWGL, 2006).

The United Nations Trust Fund to End Violence against Women Investing in Evaluation and Learning on the linkages of VAW and HIV

The limited evidence-base on what works to address violence against women and girls and HIV prompted the United Nations Trust Fund to open special grant-making windows in 2005 and 2006 on 'reducing the twin pandemics of HIV/AIDS and violence against women'. With generous support from Johnson & Johnson, the UN Trust Fund established a cutting-edge learning initiative with seven of the successful applicants, who were brought together as a 'learning cohort' to develop and showcase effective practices in three main areas to address the intersections: 1) understanding and Influencing knowledge, attitudes and practices of men and women, 2) improving services and reducing barriers to support and treatment, and 3) laying the foundations – the Contribution of research.

The grantees in the cohort include:

Breakthrough (India) - *At the Intersection of Gender-Based Violence – Empowering Women against HIV/AIDS, and the Stigma and Discrimination Resulting from Infection.*

Equal Access (Nepal) - *A Grassroots Call to Action to End Stigma and Discrimination on Violence against Women and HIV/AIDS Using the Voices of affected Women.* See the impact assessment and watch a video on this initiative.

Raks Thai Foundation (Thailand) - *Supporting HIV-affected Women to Reduce and Respond to Sexual Violence (SHAW).*

Civil Resource Development and Documentation Centre (Nigeria) - *Bridges to End Gender Based Violence as Strategy for HIV/AIDS Prevention & Stigma Reduction.* Watch a video on their work.

Colectiva Mujer y Salud (Dominican Republic) - *Reducing the Risk and Vulnerability of Women to HIV/AIDS and Violence on the Dominican-Haitian Border*

Women's Affairs Department, Ministry of Labour and Home Affairs, Government of Botswana - *Reducing the Twin Pandemics of Violence against Women and HIV/AIDS*

Institute of Gender and Development Studies (Trinidad and Tobago) - *Breaking the Silence: Child Sexual Abuse and HIV Infection: A Multi-Sectoral Intervention*

The initiative places particular emphasis on monitoring and evaluation to generate evidence across the projects that can eventually enable adaptation and upscaling. To this end, the cohort of grantees has been accompanied since the early planning and design stages by lead experts at PATH (Program for Appropriate Technology in Health, Washington D.C.) to assist with baseline survey development, selection of indicators and survey tools, and development of monitoring and evaluation plans, with ongoing tailored support and site visits to the projects provided by the UN Trust Fund Secretariat and UNIFEM expertise in the area of HIV.

The Trust Fund has supported a number of other projects to improve the evidence-base on the linkages, including research conducted by Fundación para studio e Investigación de la Mujer in Argentina, Brazil, Chile and Uruguay on the feminization of HIV. See a video on their work.

Learn more about these initiative and others supported by the United Nations Trust Fund to End Violence against Women and Girls by visiting the website.

- Nevertheless, the growing body of data suggests that **violence against women and girls is linked to an increase in HIV risk.** Broadly, the evidence shows:
    - significant overlap in prevalence

- intimate partner violence as a risk factor for HIV infection among women and men
- past and current violent victimization increasing HIV risk behaviours
- violence or fear of violence from an intimate as an impediment or as a consequence of HIV testing
- fear of partner violence as a barrier to accessing and uptaking prevention of mother to child transmission (PMTCT) services
- partner violence as a risk factor for sexually transmitted infections (STIs), which increases the rate of HIV infection
- women who have violent partners are less likely to negotiate condom use and more likely to be abused when they do.
- economic violence may increase the risk of acquiring HIV by deepening gender inequalities and increasing vulnerability.
- various adverse health effects related to intimate partner violence compromise women's immune systems in a way that increases their risk of HIV
- abusive men are more likely to have other sexual partners unknown to their wives
- women who have experienced childhood sexual abuse are more likely to engage in HIV risk behaviours as an adolescent/adult.

Sources: excerpted from Kimberly A. Scott, *Rapporteur*, Planning Committee for a Workshop on Violence Prevention in Low- and Middle-Income Countries. 2008. Institute of Medicine; Harvard School of Public Health, 2009. Final Draft Report; Devries et al., 2010; Maman, personal communication, 2010; and WHO/UNAIDS, 2010)

	Specific Forms of Violence and Risk of HIV
Type of Violence	**HIV Risk**
Sexual Assault	Sexual assault increases the vulnerability of HIV infection amongst women and girls in both direct and indirect ways. Directly, sexual assault can result in trauma and tissue tearing that facilitates HIV infection. This is pronounced amongst young women and girls whose reproductive tracts are not yet mature (CWGL, 2006). Indirectly, the threat of sexual assault makes it difficult for women and girls to negotiate condom use and/or try to refuse sex all together (Black, 2001 cited in Ward et al., 2005; USAID and UNICEF, 2005). Experiencing sexual assault can also increase the likelihood of future risk taking behaviours such as: unprotected sex, multiple partners, substance use, and sex work (Ward, 2008). Additionally, in many contexts, the stigma attached to being sexually assaulted can prevent women and girls from seeking medical treatment, including post-exposure prophylaxis (CWGL, 2006).
Coerced Sex	Girls who have experienced coercive first sex may be more likely to be HIV-positive (Harvard School of Public Health, 2009). Across the world between 7 and 48% of young women and girls report that their first sexual experience was coerced (Krug et al. eds., 2002; Reza et al./CDC and UNICEF, 2008; and WHO/UNAIDS, 2010). As with sexual assault, sexual coercion often involves unequal power relations, which

	limit the extent to which a woman or girl can exercise control over condom use or take other measures to protect herself from HIV infection. In some parts of the world, 'Sugar daddies'—older men who seduce girls into sexual relationships in exchange for food, money, and/or gifts, often prefer to exploit those who they believe are virgins and therefore HIV-negative (Ward, 2008). To the extent that these men fail to use protection, they put girls at risk of contracting HIV. Adolescent girls who have experienced sexual coercion may also be more likely to be non-users of contraception and to have unintended pregnancies.
Intimate Partner Violence	In cases of intimate partner violence, inequality of power within the sexual relationship is linked to the risk of HIV transmission (Jewkes et al., 2010). For example, when intimate partner violence is present fear of violence and abuse can prevent women and girls from negotiating safe sex, even when they fear a partner may be HIV-positive. This is especially dangerous given that abusive men are more likely than non-abusive men to have multiple sex partners, be adulterous, and to have STI symptoms (Dunkle et al., 2005 & Martin et al., N.d. cited in Makunda, 2009). A study using data from 96 countries demonstrated that women who had experienced intimate partner violence were more than two times as likely to contract HIV (Watts cited in Hale and Vasquez/Development Connections, International Community of Women Living with HIV/AIDS and Un Women, 2011).
Child Marriage	Because of biological factors, young wives are more physically vulnerable than mature women to contracting sexually transmitted infections, including HIV, from an infected partner—a danger which only increases given the fact that young girls are even less likely to be able to negotiate safe sex with their partners than older women (Ward, 2008). A study conducted in Rwanda found that 25 percent of girls who became pregnant at age 17 years or younger were infected with HIV, even though many reported having sex only with their husbands. According to the study, the younger the age at sexual intercourse and first pregnancy, the higher was the incidence of HIV infection (Excepted from USAID and UNICEF, 2005, pg. 9 citing UNICEF 1994 in Black, 2001 cited by Ward et al., 2005). Additionally, a study conducted in Uganda found that girls aged 13 to 19 years who were HIV positive were twice as likely to be married as girls who were HIV negative (Otoo-Oyortey and Pobi, 2003 cited by Ward et al., 2005).
Trafficking	Epidemics of sexually transmitted infections, including HIV, have increased the demand for sex with children, who are believed to be less likely to be infected than adults. While overall data is not available on the risk of HIV transmission related to trafficking, sexual exploitation is a high-risk factor for HIV (Ward, 2008).
Female Genital Mutilation/ Cutting	Female genital mutilation/cutting may also contribute to the risk of HIV infection among women and girls. This is because of the unsterilized instruments sometimes used to perform such procedures, and also because the scarred or dry vulva of a woman who has undergone female genital mutilation is more likely to be torn during intercourse, which can facilitate transmission from an infected partner (Centre for Reproductive Rights, 2005 cited in Ward, 2008). More 3 million girls are at risk of FGM/C every year (WHO, 2008a). For country statistics on FGM/C, see: the Multiple Indicator Cluster Survey (UNICEF), the Demographic and Health Surveys (MEASURE) and Female Genital Mutilation/ Cutting: Data and Trends (Population Reference Bureau, 2010).

	For more information and tools for medical professionals to address FGM/C, see the World Health Organization website page on Female Genital Mutilation and Other Harmful Practices.
Other Harmful Traditions	Traditional practices across the world that both support and intensify violence against women and girls can contribute to HIV transmission. These include: • *Polygamy* is when a person has more than one spouse. In most parts of the world, the most common practice of polygamy is polygyny, where a husband has multiple wives. Unprotected sex with multiple concurrent partners is a proven risk factor for HIV transmission and in cases of polygyny the husband may not use condoms with his wives. • *Wife inheritanc*e is when a widow is given to a male family member of the deceased husband. Cases of wife inheritance usually involve unequal power relations where a woman or girl may be forced into the practice. This lack of power may increase the chances of sexual assault or coerced sex. These unequal power relations can also limit the extent to which a woman or girl can exercise control over condom use or take other measures to protect herself from HIV infection. • *Widow Cleansing* is when new widows are forced to have sex with a member of their late husband's family or with a member of the community as a cleansing rite after the death. With this practice emphasis is placed on the sex being unprotected. This practice increases HIV risk factors through: a) the unequal power relations where a woman or girl may be forced into the practice and b) the lack of condom use.
Discrimination in Property and Inheritance Laws	In some parts of the world property ownership is traditionally passed patrilinearly. Because of these traditions even women who do inherit property may be at risk of eviction or 'property grabbing' by extended family (Ward, 2008). The impacts of HIV/AIDS, for example the premature death of a husband, may serve to accelerate disinheritance and/or property grabbing. For widows and their children, this practice is particularly harmful given that the related economic vulnerability can force them into situations of transmission risk. For example, HIV-orphaned girls who become heads of households may be forced into sex work in order to survive and support their siblings (Fleishman, 2002).
Discrimination in Education	Lack of education appears to have an effect on female vulnerability to HIV: According to one study, "women with at least a primary education are three times more likely than uneducated women to know that HIV can be transmitted from mother to child" and "completion of secondary education was related to lower HIV risk, more condom use and fewer sexual partners, compared to completion of primary education." (World Bank, 2002, and Boler and Hargreaves, 2006, in Action Aid, 2007 cited in Ward, 2008).

- Just as violence against women and girls can increase their risk of HIV transmission, **HIV infection can also increase the risk of violence against women** and girls and worsen the effects of other forms of gender discrimination. A study conducted in four countries in Asia Pacific found that HIV positive women are significantly more likely

than men to experience discrimination, violence and be forcefully removed from their homes (Amnesty International, 2004, cited in CWGL, 2006). Across the world many women have reported experiencing different forms of violence following the disclosure of their HIV status, or even after disclosing that they have gone for HIV testing (Harvard School of Public Health, 2006). Fear of these repercussions can prevent women from being tested, revealing their status and/or seeking treatment care and support.

- HIV positive women face various forms of violence, because of their HIV status - physical, psychological and economic abuse, in addition to: being shunned or rejected by family and the community; eviction from home and loss of assets; denied access to their children and forced sterilization; ill-treatment by service providers; loss of livelihoods and denied work opportunities; and abuse by police, including extortion (Hale and Vasquez, 2010).

  To see hear about the experiences of HIV positive women, see the videos produced by the Salamander Trust.

- Given the acknowledged intersections between the pandemics of violence against women and girls and HIV/AIDS, it is clear that the integration of prevention and response programming requires a **two-way process** where:

  a) **HIV programmes incorporate violence against women and girls interventions; and**
  b) **Violence against women and girls services incorporate HIV interventions.**

Example: The **United States President's Emergency Plan for AIDS Relief (PEPFAR)** was launched in 2003 and, to date, is the largest effort by any nation to address a single disease. During its first five years the focus was on establishing and scaling up prevention care and treatment programmes in low-resource settings. In recognizing that addressing gender issues is an essential component to reducing the vulnerability of both women and men to HIV infection, the President's Emergency Plan for AIDS integrates gender through the following five cross-cutting gender strategic areas: 1) Increasing gender equity in HIV/AIDS programmes and services, 2) Reducing violence and coercion, 3) Addressing male norms and behaviours, 4) Increasing women's legal protection, and 5) Increasing women's access to income and productive resources.

See the President's Emergency Plan for AIDS Relief five-year strategy (2009-2014).

See the 2006 report on Gender-based Violence and HIV/AIDS.

From 2007-2010, PEPFAR supported an initiative to further the evidence-base and improve services for sexual and gender-based violence in Rwanda, South Africa and Uganda. To read more about this initiative see a brief produced by AIDSTAR-One and the project overview produced by implementing partner Population Council.

Download the baseline study, reports and tools associated with this initiative from the Population Council website.

See **Gender-based Violence and HIV: Emerging Lessons from the PEPFAR Initiative in Tanzania. 2012**, by Center for Strategic and International Studies. Available in English.

In 2010, PEPFAR committed an additional $30 million to scale-up gender-based violence prevention programming in the Democratic Republic of Congo, Mozambique and Tanzania.

Source: excerpted from the PEPFAR website and AIDSTAR-One.

Case Study: Liverpool Voluntary Counseling, Care and Treatment (LVCT) in Kenya Addresses the Intersections

is a non-governmental organization at the forefront of integrating gender and violence against women and girls' interventions into national HIV/AIDS policy and programming in Kenya, particularly through the development, implementation, evaluation and scale-up of comprehensive post-rape care services.

An initial diagnosis phase of operational research revealed that the state of post-rape care services in the community was characterized by poor community understanding of the boundaries between forced, coercive and consensual sexual intercourse; no regulatory framework, policies or standard documentation systems; inconsistent service delivery of both medical and psychosocial support interventions; and limited human and technical capacity.

In response, the programme developed and piloted a standard of care for rape survivors in three diverse district hospitals with VCT facilities. The standards included protocols for physical examinations, legal documentation, clinical management and counselling; client flow pathways and job aides; and a post-rape carepackage including essential drugs (PEP, emergency contraception and STI treatment) and an evidence-collection kit. The standard also introduced a chain of custody for evidence, and standard data-collection and monitoring tools.

In the initial evaluation phase, 84% of 784 survivors seen in three pilot sites arrived within the 72 hour window for receipt of PEP; 99% of those who were eligible received drugs. Notably, survivors who received initial trauma and HIV counselling were more likely to complete HIV PEP medication. These services have since been scaled-up to create integrated post-rape care within HIV services in government facilities. The comprehensive package offered includes long-term psychosocial care, HIV pre- and post-test counselling, PEP-adherence counselling and preparation for interface with the criminal justice system.

One important element in advocating for scale-up was a study to estimate expected costs for scaling-up the services within existing policy frameworks and standards. These estimates provided the basis for discussions with the Ministry of Finance and Planning to advocate for funding for scale-up. Generating cost and benefit analyses thus proved to be

an important tool for approaching policy-makers to allocate funding for roll-out of the intervention.

Read more about the post-rape care services, public health model.
Download the National Guidelines on Sexual Violence.
Download the training manual for rape trauma counselors.

Visit the LVCT website.

Source: excerpted from Maman et al., 2006. *Addressing Violence against Women in HIV Testing and Counseling: A Meeting Report.* Geneva, Switzerland. WHO, p. 17 and *Addressing violence against women and HIV/AIDS What works?* 2010. WHO and UNAIDS.

Additional Resources:

- ***Addressing Violence against Women and HIV/AIDS: What Works?*** (WHO and UNAIDS, 2010). Available in English.

- **Gender and HIV/AIDS Web Portal**. UN Women in collaboration with UNAIDS has developed this comprehensive gender and HIV/AIDS web portal to provide up-to-date information on the gender dimensions of the HIV/AIDS epidemic. The site aims to promote understanding, knowledge sharing, and action on HIV/AIDS as a gender and human rights issue. Available in English.

- ***What Works for Women and Girls: Evidence for HIV/AIDS Interventions***, launched by Open Society Institute (OSI) at the XVIII International AIDS Conference with presentations by authors Jill Gay, Karen Hardee, Melanie Croce-Galis and Shannon Kowalski, is a comprehensive review of successful HIV programming for women and girls spanning 2,000 articles and reports with data from more than 90 countries. Published by OSI's Public Health Program, this valuable resource contains—in one centralized, searchable location—the evidence of successful gender-specific programming from global programmes and studies, with a focus on the Global South. Available in English.

- **AIDStar-One: AIDS Support and Technical Assistance Resources** (USAID). This website provides a promising practices database, including programmes aimed at reducing violence and coercion. Available in English.

- ***AIDS Portal*** (UK Consortium on AIDS). This website facilitates knowledge sharing and networking in the response to HIV and AIDS, by providing links to literature, tools, organizations and people. Available in English and Spanish.

- ***HIV/AIDS and Gender-Based Violence Literature Review*** *(*Harvard School of Public Health, Program on International Health and Human Rights, 2006). Available in English.

2. Broad policy and practice recommendations for integrating violence against women and girls and HIV and AIDS programming

2a. Overview

To reduce violence against women and girls and HIV, long-term interventions that address structural factors, gender inequalities and harmful gender norms are essential, as are shorter-term efforts focused on prevention of violence and HIV and provision of adequate and quality responses.

Implementing a comprehensive approach includes developing policies, systems, and services, as well as community support mechanisms to prevent and respond to violence against women and girls and HIV. This section presents sample actions in the key areas of legal and policy reform, health systems reform, and health-based community mobilization. For each area, suggested activities for integration are specifically identified for violence programmers and for HIV programmers, as well as intersections—or points of mutuality—in violence and HIV programming. These points of mutuality represent responsibilities that both violence programmes and HIV programmes should assume in their programming.

Despite a limited evidence-base on what works, emerging promising practices and practitioner consensus, identify several key considerations to address the dual pandemics, including:

- Implementing measures at all levels to promote gender equality and preventing as well as redressing violence against women and girls should be incorporated as important targets in national HIV strategies and plans.
- HIV prevention, treatment and care efforts should include an assessment of impact on violence against women and girls and gender inequality. Links between reducing poverty, increasing gender equality, reducing violence against women and girls and reducing HIV should be explicitly acknowledged and addressed in strategic plans for all relevant sectors.
- National strategic plans should explicitly recognize the community level as a key focal point of change.
- support should be provided for the development of regional networks of organizations and practitioners, with a focus on supporting inclusion of gender equality and eliminating VAW as an integral part of HIV programming.
- Existing approaches that have been shown to be effective or promising should be adapted, replicated and scaled up. A solid evaluation component must be included and is key to building up the evidence base in this field. Building on existing examples, other locally relevant interventions to address structural drivers must be encouraged and evaluated.
- Sustainable funding must be allocated for such programmes.

- Programmes designed to reduce violence in the context of HIV prevention should consider the full range of diversity of persons experiencing and perpetrating gender-based violence.
- Integrating VAW into HIV programming should be informed by a human rights approach, and should tackle stigma and discrimination.
- Access to quality, comprehensive post-rape care services including PEP should be ensured, according to WHO guidelines.
- Post-rape care should be implemented, based on the various existing evidence-based models appropriate to the setting, and with multisectoral linkages.
- Support should be provided to young women and men for active HIV prevention that specifically incorporates gender-based violence prevention and gender equality perspectives.
- Programmes must be developed to address the high levels of violence and related HIV risk experienced by adolescents who sell sex.
- Programming must recognize that sex workers experience violence from a range of perpetrators, including clients, individuals such as brothel owners or other go-betweens who control clients' access to sex workers or sex workers' access to clients (controllers) and law enforcement. Perpetrators also include longterm partners, relatives, neighbours and other members of the community.
- The programmatic response should not be limited to sex workers, but should include the full scope of those involved in sex work, VAW and HIV prevention, including the law enforcement, clients, partners, controllers and family.
- Interventions also need to address stigma and discrimination against sex workers in the broader community, in the media and in law and policy.
- Programmes should include a strong monitoring and evaluation component that can contribute to strengthening the evidence base for addressing the intersections of VAW and HIV/AIDS.
- It is important to monitor gender equality and reducing VAW incidence as positive process and outcome indicators related to reducing HIV risk.
- It is also important to monitor increased VAW incidence as a potential adverse outcome of HIV-related interventions.
- Reporting should be improved so that there is a systematic way of assessing the extent and progress or deterioration in type and level of VAW, specifically including violence.

Source: extracted and slightly modified from Addressing Violence against Women and HIV/AIDS, What Works? (WHO and UNAIDS, 2010).

2b. Law and Policy Reform

- In order for the integration of HIV/AIDS and violence against women and girls programming to be successful, governments must fully commit themselves to protecting and promoting women's human rights in relation to violence and HIV/AIDS prevention, treatment and care, including the following:

	Policy Recommendations		
	Violence Against Women and Girls	**Violence and HIV**	**HIV**
Legal and Policy Reform	• Formulate policies to ensure training on violence against women and girls in all medical schools and other educational programmes for health professionals, including information on rights to post exposure prophylaxis, antiretrovirals, etc. • Develop a standard policy for medical management of sexual violence. • Develop a standard policy for screening various types of violence, including sexual assault, female genital mutilation, and domestic violence.	• Create policies that ensure appropriate and consistent health response to survivors of violence and access to sexual and reproductive health services and to voluntary HIV testing and services for everyone, including those under the age of 18. • Develop policies to ensure the support, recognition, and regulation of professionals and paraprofessionals providing health services to survivors of violence and people living with HIV. • Draft policies that ensure a higher number of female doctors and nurses.	• Make sure that national AIDS councils are staffed with women and that thematic groups related to women are developed with the councils and that national AIDS council action plans have concrete measures to combat discrimination and violence against women and girls. • Develop policies that prohibit mandatory testing of women, including sex workers, prisoners, etc.

Source: Ward, J., 2008. "Designing Programming to Address GBV and HIV in East, Central, and Southern Africa: A Framework for Action", Draft Working Paper, UNFPA, Nairobi.

- A meeting of expert organizations and country representatives organized by UNFPA, UNDP, UN Women, UNAIDS, and WHO, with Sonke Gender Justice Network, Men Engage, and the ATHENA Network was held in Istanbul, Turkey (2011). This meeting was a follow-up to a first consultation held the previous year in Kenya. Both meetings were dedicated to reviewing and advancing work on "Integrating Strategies to Address Gender-Based Violence and Engage Men and Boys to Advance Gender Equality through National Strategic Plans on HIV and AIDS." To review the presentations of this conference, country action plans and additional

resources, see the dedicated page on the Salamander Trust website.

Recommendations for Legislation

Legislation should address sexual and domestic violence and HIV and AIDS directly, in addition to other civil and political rights (e.g. marriage, inheritance, property) that can reduce risk and protect women and girls from experiencing abuse and/or becoming vulnerable to acquiring HIV.

Though HIV transmission and exposure have been criminalized in a number of countries with the intent of protecting women and girls, it is not only a violation of human rights, but has proven especially detrimental to women in the following ways:

1. Women will be deterred from accessing HIV prevention, treatment, and care services, including HIV testing
2. Women are more likely to be blamed for HIV transmission
3. Women will be at greater risk of HIV-related violence and abuse
4. Criminalization of HIV exposure or transmission does not protect women from coercion or violence
5. Women's rights to make informed sexual and reproductive choices will be further compromised
6. Women are more likely to be prosecuted
7. Some women might be prosecuted for mother-to-child transmission
8. Women will be more vulnerable to HIV transmission
9. The most 'vulnerable and marginalized' women will be most affected
10. Human rights responses to HIV are most effective

For an explanation of each of these points, download the full document in English, French, German, Nepali, Polish, Portuguese, Russian and Spanish.

Source: extracted from Athena Network. 2009. *10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women.*

Legislative reforms and/or introduction of new legal provisions are needed in the areas of:

- Civil law (e.g. orders of protection, compensation)
- Criminal law (e.g. consent)
- Evidence and Procedure (e.g. corroboration, cautionary rules, records and facts)
- Sentencing (e.g. minimums, aggravated offences and compelling circumstances)

For detailed guidance on legislation, see the tools below and the full module on legislation in English, French and Spanish.

Case Study: Innovative Training on HIV/AIDS, Sexual Violence and the Law in Rwanda

In response to the sexual violence that occurred during Rwanda's 1994 genocide, WE-ACTx (Women's Equity in Access to Care and Treatment) launched a legal programme on the rights of persons living with HIV/AIDS in Rwanda. WE-ACTx sponsored an eight-week skills-building workshop aimed at training paralegals and community representatives of WE-ACTx's 24 local partner NGOs, who serve tens of thousands of HIV-positive clients. This training was the first of its kind in Rwanda to focus on the topic of HIV/AIDS with a subsection on sexual violence. WE-ACTx created the workshop in direct response to requests by clients and staff of partner NGOs for legal advocacy training around HIV issues. A team of three US and European volunteer lawyers with expertise in international human rights, women's legal issues and sexual violence worked with HIV and survivors organizations, Rwandan lawyers, Rwandan law schools, paralegal groups, and several NGOs focused on Rwandan legal reform. The Rwandan Ministries of Justice and Gender and representatives of AIDS agencies also backed the project.

During the sexual violence module, the participants learned how to respond to and assist a child who has been sexually abused, including preservation of evidence and how to use the child abuse hotline. Participants also learned and practiced ways to increase security and confidentiality in the *gacaca* process in order to encourage women to testify against their rapists in these local genocide tribunals. WE-ACTx worked with Rwandan partners to create a handbook, *Know Your Rights: HIV/AIDS and the Law*, that will help paralegals and their clients access the legal system. WE-ACTx also recognized the importance of working with the Minister of Gender and the academic community to expand the legal programme to the rural provinces, municipal officials, judges, and public health officials, and to include training for local officials in anti-discrimination and laws against sexual violence.

For more information about this WE-ACTx program, contact Megan McLemore at meegwie@gmail.com or Anne-Christine d'Adesky at acd@we-actx.org.

Source: excerpted from Global AIDS Alliance, 2006. *Zero Tolerance: Stop the Violence Against Women and Children, Stop HIV/AIDS.* Washington, D.C.: Global AIDS Alliance, pg. 22.

Illustrative Tools:

- ***Legislation Contagion: Building Resistance*** (Pearhouse, R./*Canadian HIV/AIDS Legal Network, 2008). HIV/AIDS Policy & Law Review.* Vol. 13, No. 2/3, December, 1 and 5-10. Available in English.

- ***Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS – Volume One: Sexual and Domestic Violence*** (Canadian HIV/AIDS Legal Network, 2009). Available in English.

- ***Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS – Volume One: Sexual and Domestic Violence***

Module 1: Rape and Sexual Assault *(*Canadian HIV/AIDS Legal Network, 2009). Available in English.

- ***Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS – Volume One: Sexual and Domestic Violence Module 2: Domestic Violence*** *(*Canadian HIV/AIDS Legal Network, *2009)*. Available in English.

Additional Resources:

- ***Policy Analysis Tool: Addressing Gender-Based Violence and Integrating Attention to Engaging Men and Boys for Gender Equality in National Strategic Plans on HIV and AIDS*** (ATHENA, HEARD, Sonke Gender Justice Network and Salamander Trust, 2010). Available in English.

- ***Zero Tolerance: Stop the Violence Against Women and Children, Stop HIV/AIDS*** (Global AIDS Alliance, 2006). Available in English.

- ***Scaling Up for Zero Tolerance: Civil Society Leadership in Eliminating Violence Against Women and Girls in Ghana, Rwanda and South Africa*** *(*Global AIDS Alliance, 2008). Available in English.

- ***Reducing Women's and Girls' Vulnerability to HIV/AIDS by Strengthening their Property and Inheritance Rights*** (International Center for Research on Women, 2006). ICRW, Washington, DC. Available in English.

- ***Estrategias nacionales sobre VIH y violencia contra las mujeres en America Latina y el Caribe: un reto impostergable*** *(*Luciano, D./Development Connections, 2007b). Available in Spanish.

2b. Health Systems Reform and Service Delivery

- It is important that health systems are reformed in a way that ensures service delivery addresses needs related to *both* HIV/AIDS and violence against women and girls.

	Violence Against Women and Girls	***Both*** Violence and HIV	**HIV**
Health Systems Reform	• Prepare protocols and develop and implement training on victim-friendly forensic examination. • Collect and monitor sex and age disaggregated data on violence and domestic violence. • Guarantee free access to 24-hour sexual assault services, including psychological support services, sexually transmitted infection treatment, post-exposure prophylaxis, and emergency contraception.	• Create and implement training for all health providers on HIV and violence screening, treatment, danger assessment and safety planning, and emotional support, including with children. • Create standards for upgrading infrastructure of health facilities to ensure confidentiality and privacy. • Ensure access to treatment for violence and HIV by addressing women's and girls' mobility, distance from clinics, safety issues around transport and overall cost of travel; consider mobile and decentralized treatment centers in rural areas as well as home visits by health/social workers. • Providers should be trained in rights-based approached, including codes of conduct informed choice and consent, and confidentiality and disclosure. • Ensure violence and HIV staff has adequate resources, such as screening tools and directories to refer victims to other services, including legal or counseling services. • Integrate violence services into antenatal, sexually transmitted infection, and family planning services. • Ensure that children and adolescents have equal access to child and youth friendly health services. • Ensure that post exposure prophylaxis is available not only to sexual assault survivors, but also as part of a comprehensive sexual and reproductive health service available for women whose partners are living with HIV and	• Collect and monitor sex and age disaggregated data on HIV. • Train voluntary counseling and testing counsellors to monitor for violence and ask questions about partner violence, develop safe disclosure plans, and expand couples counseling and testing. • Address the problems of obtaining and adhering to antiretroviral treatments for women who suffer intimate partner violence, through for example including questions on adherence monitoring forms that explore intimate partner violence. • Ensure the female condom is available in addition to the male condom. • Ensure treatment of AIDS-related illnesses and opportunistic infections; treatment information and treatment adherence; prevention and treatment of sexually transmitted diseases; nursing, home and palliative end-of-life care; prevention of mother to child transmission. • Ensure availability of prevention services (counseling, HIV testing)

		who may have engaged in risky sexual behaviour.	

Source: Ward, J., 2008. "Designing Programming to Address GBV and HIV in East, Central, and Southern Africa: A Framework for Action", Draft Working Paper, UNFPA, Nairobi.

Example: The South African Gender-Based Violence and Health Initiative The South African Gender-based Violence Health Initiative (SAGBVHI) is a national, specialist partnership of organizations and individuals working on violence against women and girls and health issues. This initiative has contributed to the improvement of the health response to violence against women and girls in South Africa and has also contributed to the integration of violence against women and girls and HIV services by developing a 2-day training programme for health professionals on post exposure prophylaxis (Guedes, 2004).

For detailed guidance on post-rape care, see the section on services for sexual assault survivors.

Illustrative Tools:

- ***Development Connections: A Manual for Integrating the Programmes and Services of HIV and Violence Against Women*** *(*Luciano, D./Development Connections and UNIFEM, 2009). Available from in English and Spanish. See also the Development Connections website for additional resources, including an on-going online course.

- ***An Essential Service Package for an Integrated Response to HIV and Violence Against Women*** (Women Won't Wait, 2010). Available in English.

- ***Operational Guide on Gender & HIV/AIDS: A Rights Based Approach*** *(*UNAIDS Interagency Task Team on Gender & HIV/AIDS, 2005). Available in English.

- ***Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: Manual for Trainers and Programme Managers.* 2006**, by EngenderHealth and International Community of Women Living with HIV/AIDS (ICW), is for experienced trainers and facilitators working with sexual and reproductive health (SRH) and HIV/AIDS programme managers and health workers. The manual provides guidance for a four-day training and two-day planning workshop on offering comprehensive care and support to HIV-positive women and adolescent girls. The manual includes an overview for trainers, detailed training modules, handouts and references that may be adapted to the local context and cover integrated SRH counselling within programmes that link

SRH and HIV/AIDS. Available in English, French, Spanish, Portuguese, and Russian; 239 pages.

- ***Resource Pack on Gender and HIV/AIDS*** (UNAIDS,2006), by the Inter-agency Task Force on Gender and HIV/AIDS, is for development practitioners and policy-makers. The Resource Pack provides programming and advocacy guidance on addressing gender inequality and its negative impact on national HIV/AIDS programmes. The pack contains an operational guide with a conceptual framework, tools and checklists for gender-sensitive and rights-based programming; a review paper for expert consultation 'Integrating gender into HIV/AIDS Programmes'; and 17 fact sheets on gender-related aspects of HIV/AIDS.

- ***Addressing Gender-based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis*** *(*Guedes, A./Bureau for Global Health, 2004). Available in English.

- ***Delivering Post-rape Care Services: Kenya's Experience in Developing Integrated Services*** (Kilonzo, N., Theobald, S.J., Nyamato, E., Ajema, C., Muchela, H., Kibaru, J., Rogena, E. and Taegtmeyer, M. , 2008). Available in English.

- ***Strategic Interventions: Intersections between Gender-based Violence and HIV/AIDS*** (Muthien, B. 2003). Available in English.

- ***The Refentse Model for Post-Rape Care: Strengthening Sexual Assault Care and HIV Post-Exposure Prophylaxis in a District Hospital in Rural South Africa*** *(*Kim, J.C., Askew, I., Muvhango, L., Dwane, N., Abramsky, T., Jan, S., Ntlemo, E., Chege, J. and Watts, C./Population Council, 2009). Available in English.

- ***Gender-based Violence and Reproductive Health and HIV/AIDS: Summary of a Technical Update*** *(*USAID, 2002.). Available in English.

2c. Prevention

The majority of research and programmes on HIV prevention have focused on changing individual knowledge, attitudes and behaviour without an analysis on how social norms and lived realities affect men and women differently. Where research has acknowledged difference in vulnerability of women and girls to HIV infection, it has often been in the

context of increased risk due to biological factors without acknowledging socio-economic factors. Early advocacy around the alarming pace at which women were being infected had the intention of highlighting inequality between men and women as an important driving factor for women's increased risk, though often it inadvertently placed the responsibility of preventing the spread of HIV back on women without acknowledging the role of men (Campbell, 1995; Shefer, 2005). The expectation that changing knowledge and attitudes can enable women to refuse or negotiate safe sex ignores the complex reality that women and girls live in (e.g. early marriage, weak economic opportunities and dependency on intimate partners, high rates of abuse), which limit their ability to make their own decisions even when they have the knowledge and skills related to preventing HIV.

Popular HIV prevention strategies have been directed to people who possess a certain level of control and autonomy in the decision-making over their sexuality and other areas of their life; this fails to take into consideration the situation of women and girls (Krishnan et al., 2007 as cited in Luciano, 2009). This has been especially notable in the widely used Abstinence, Be Faithful, and use Condoms (ABC) method of prevention. Abstinence, Be Faithful, and use Condoms programmes aim to create individual behaviour change. Their method of doing so typically fails to address the external factors that limit the sexual autonomy of women and girls and place them at risk of HIV infection. In many contexts across the world, women and girls cannot abstain from being raped, cannot stop their husbands or partners from being unfaithful, and lack the power within their abusive relationships to negotiate the use of condoms. Prevention programmes which focus on marriage, such as those which focus on 'abstinence until marriage' as a form of prevention, are also problematic. These programmes fail to address the reality that in some countries married women have higher HIV prevalence than those who are not married (Human Rights Watch, 2005, cited in Ward, 2008).

Building on lessons learned, key approaches to prevention of violence against women and girls and HIV include: raising overall community awareness, mobilizing community-based efforts, providing support for evidence-based advocacy; and carrying out mass media campaigns that improve knowledge, attitudes, and practices of community members with regard to promoting and protecting girls' and women's rights to be free from violence and HIV and AIDS.

Recommendations for Programming on Violence against Women and Girls and HIV			
	Violence Against Women and Girls	***Both*** Violence and HIV	HIV
Community Mobilization	• Develop strategies to improve the community response to violence and enlist community groups in efforts to provide sensitive	• Integrate violence against women and girls and gender activities into HIV and reproductive health community-	• Ensure sexuality education is comprehensive and evidence-based, from presenting biological facts to providing an

	community-based responses to victims and promptly refer them to health services.	based education and behaviour change communication efforts. • Develop specific interventions targeting the needs of young married girls who are not necessarily being reached by adolescent health services and other sexual health education methods. • Raise awareness about sexual violence and exploitation relating to HIV.	opportunity for girls and boys to discuss, challenge and analyze gender relations, gender equality, girls' empowerment, mutual respect. • Ensure access to information about safe-sex practices and reproductive health services. • Ensure community leaders' involvement in the process of developing and implementing strategies to address HIV.

Source: Ward, J., 2008. "Designing Programming to Address GBV and HIV in East, Central, and Southern Africa: A Framework for Action", Draft Working Paper, UNFPA, Nairobi.

Communication messages and tools must take into consideration the context in which beneficiaries are living in and what kind of influence this has over their abilities to act on certain types of knowledge and information (UNAIDS Interagency Task Team on Gender and HIV/AIDS, 2005). Messages should also avoid supporting harmful stereotypes about women, men or any marginalized community that promote stigma.

  - For example, the following HIV testing and counselling message recently appeared in an industrialized country: "What kind of mother could have given her baby HIV? An untested one." Messages like this stigmatize women by suggesting that it is a mother's fault if her child is HIV positive (IGWG and USAID, 2004, cited in WHO, 2009a, pg. 13). This type of stigma causes discrimination, which can lead to the violation of human rights.

- Avoid stigma by developing positive messages that promote and encourage the shared responsibility of women and men for sexual, reproductive and health choices (e.g., condom use, HIV testing, and antiretroviral prophylaxis) and for providing care to people living with HIV or AIDS and their families (WHO, 2009a).

- The following acronym **ACCEPT** is useful when determining whether violence and HIV messages adhere to basic principles of good communication:

  ***A**ffirm what is ignored and undervalued.*
  ***C**orrect ignorance, inaccuracies and lies.*

***C**hallenge dominant norms, perceptions and stereotypes that are degrading and perpetuate inequality.*
***E**mpower for action.*
***P**resent the negative into something positive.*
***T**ransform dominant perceptions and stereotypes.*

Source: UNAIDS Interagency Task Team on Gender & HIV/AIDS, 2005. *Operational Guide on Gender & HIV/AIDS: A Rights Based Approach*, p. 33.

- There have been a variety of efforts aimed at community mobilization and behaviour change related to HIV and violence against women using a variety of combined approaches (promoting rights and addressing underlying risk factors such as poverty and inequality); using different mediums (education in and out of school, mass media) and focusing on different key sub-groups of the population (e.g. men, adolescents). These efforts often incorporate a combination of different approaches and aims, including:
    - addressing the **environmental risk factors** such as poverty and gender inequalities
    - **promoting rights** which include raising awareness on the linkages of violence and HIV/AIDS within violence against women and girls programmes **provide formal and informal educational opportunities on HIV/AIDS and violence against women and girls, through curricula reform issues into school curricula** or informal educational activities.

- Illustrative examples include:

Focus Area	Case Example
Engaging Men and Boys	Africare's male empowerment project, "**Man enough to care?**", is designed to address the imbalance in rural Zimbabwe between male and female care giving for people living with HIV, by expanding men's roles in home-based care. The project has trained 120 men to be home care volunteers and to provide basic nursing care, infection control and psychosocial support. Carers also encourage positive living, assist in the preparation of wills, and offer bereavement counselling. It was found that associating values and activities such as caring, nursing and the protection of families from HIV transmission with traditionally male characteristics like strength, machismo and power encouraged men to play a more active part in HIV prevention and AIDS-related care. By supporting male volunteers as secondary carers, the project sought to increase men's willingness and ability to provide primary care to their own family members, reduce the burden on women and girls, and increase the quantity and quality of support and care for people living with HIV in rural communities (excerpted from WHO, 2009a.

	Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs. Geneva, Switzerland: WHO, Department of Gender, Women and Health, p. 69). **Program H.** Program H focuses on helping young men question traditional norms related to manhood and on promoting the abilities of young men to discuss and reflect on the "costs" of inequitable gender-related views and the advantages of more gender equitable behaviours. Intervention activities include two main components: (1) a field-tested curriculum that includes a manual and an educational video for promoting attitude and behaviour change among men, and (2) a lifestyle social marketing campaign for promoting changes in community or social norms about what it means to be a man (Excerpted from Horizons Program and Instituto Promundo, 2006). ➢ Download the Program H manuals in English, Hindi, Portuguese, Spanish and Vietnamese. ➢ Download the **Young Men and HIV Prevention: a Tool Kit for Action (Promundo and UNFPA)**, Available in English, Portuguese and Spanish. **Men as Partners**. Established in 1996 by EngenderHealth, the Men as Partners Programme aims to decrease the sexual transmission of HIV and other sexually transmitted infections, unintended pregnancy and violence against women and girls by engaging men and boys in the caring for their health and the health of their partners and families. See the case study and evaluation. ➢ Download the training manual in English. **I'm Worth Defending** is a Kenyan non-governmental organization that works in the area of rape prevention through education, training, and support for public, organizations, and individuals. I'm Worth Defending integrates HIV/AIDS and violence against women and girls programmes through the following activities: Anti-rape Self- Defence, Assertiveness and Boundaries Setting Training for Women, Girls and Children; Engaging Boys and Men to end SGBV; Training on Human Rights; Advocacy, networking and collaboration with other stakeholders both locally and internationally; and Capacity building, Advocacy and lobby for the rights of women and children.

Engaging Communities	**Raising Voices** works in the area of violence against women and girls both in Uganda and regionally. Their work includes programme design and development, creation of programme tools and communication materials, and providing technical support and capacity building on violence against women and girls, HIV and human rights. One of their largest programmes, including with a strong evaluation component is called SASA! or now in "Now!" in Swahili. Read a case study on their community mobilization effort, SASA!. With the support of the United Nations Trust Fund to End Violence against Women, SASA! is being scaled up to reach communities across Uganda. See a short video describing their work. ➢ See a full case study on SASA! ➢ See the film used as part of their mobilization efforts. ➢ Download the accompanying resources. **Stepping Stones** workshops in more than 40 countries—primarily in Africa—promoting discussion and awareness about violence and HIV, have effected a reduction in male perpetration of intimate partner violence through community-based education working with men. ➢ See evaluations of Stepping Stones. ➢ Access the manual from South Africa in English. ➢ Download other language versions and adaptations from the website.
Communications for Social Change through education, entertainment and mass media (radio, television soap operas, internet)	**Soul City South Africa** and Soul City Regional support mass media "edutainment" to raise awareness and understanding of gender issues, HIV, violence against women and girls and people living with HIV. ➢ See the programme description and evaluation. Nicaragua-based **Puntos de Encuentro** (Meeting Points) produced *Sexto Sentido*, a widely popular half-hour weekly telenovela, or soap opera. The show, which has been broadcast in Costa Rica, Honduras, and the United States, features characters and themes that encourage viewers to question the legitimacy traditional ideas regarding gender roles, and men's and women's relationships to the home, the workplace, and society at large. In addition, Puntos de Encuentro also launched

	an ongoing campaign called “Necesitamos Poder Hablar” (“We need to be able to talk”) which focuses on *machismo* as a risk factor for the incidence of sexual abuse and the transmission of HIV. *Breakthrough* ***(India):*** Breakthrough is an India and U.S.-based international human rights organization that mainstreams discussions about violence against women and girls and HIV/AIDS by translating them into popular media-based message formats. Within its first full year of existence, Breakthrough had produced *Mann ke Manjeerée: An Album of Women’s Dreams* (2000), an acclaimed album and series of music videos that explored a mother and daughter’s escape from domestic violence and other themes that challenged cultural taboos and stereotypes. In 2005 they launched their “What kind of man are you?” multimedia campaign, asking men for the first time directly to wear condoms to protect their wives from HIV infection and explaining that out of the 2 million women in India who are infected with HIV/AIDS, most have contracted it from their husbands. This campaign composed of print ads, radio spots, in-theatre PSAs and billboards, has been translated into seven languages. The campaign has reached 75 million people and prompted more than 8,000 text messages and other inquiries to Breakthrough’s anonymous query hotline. In 2008 Breakthrough launched an award winning campaign, Bell Bajao or Ring the Bell, asking men and boys to bring domestic violence to a halt by performing this simple bystander intervention. Through their public service announcements on television, radio and press, online multimedia campaign and educational materials and travelling video van, over 129 million people had been reached by the end of 2010. At the 2010 Clinton Global Initiative annual meeting, a commitment was announced to take Bell Bajao to global scale with the full support of the United Nations Secretary-General. Breakthrough has also trained more than 75,000 rights advocates. Their combined efforts have resulted in a 49 percent increase in the number of people that are aware of the Protection of Women from Domestic Violence Act in India and a 15 percent increase in access to services for survivors. ➢ Access the “What kind of man are you?” multimedia campaign. ➢ Read the Bell Bajao! Case Study. ➢ See the “Is this Justice” multimedia campaign against HIV discrimination evaluation.

	➢ Access the Bell Bajao/Ring the Bell Campaign. ➢ Access additional resources on violence against women. ➢ Download the "Strength in Action: An Educator's Guide to Domestic Violence" in English. ➢ Download the Rapid Audience Assessment Survey Report. ➢ Download the Most Significant Change Stories Report. Download the Baseline Survey on Domestic Violence and HIV/AIDS. **Minga Peru's Intercultural Radio Educative Project to Prevent and Control Domestic Violence and HIV/AIDS.** Minga Peru, a non-governmental organization supported by the United Nations Trust Fund, implemented an Intercultural and Educational Radio Project to address HIV/AIDS and violence against women and girls in rural communities and schools of the Peruvian Amazon. The overall objective was to reduce the number of cases of violence and HIV/AIDS in rural communities and schools in the Peruvian Amazon through the use of an on-air and on-the-ground communication strategy that was implemented from January 2006 to March 2008. 174 schoolteachers in 24 rural schools were trained by Minga Peru to integrate issues of domestic violence and HIV/AIDS in the secondary school curriculum, directly spurring class discussion on these issues – in multiple courses -- with some 4,650 students. These ground-based, year-round educational efforts in rural schools were complemented with Minga's popular on-air, intercultural radio educative programme, *Bienvenida Salud* (Welcome Health) which purposely incorporated themes of domestic violence, HIV/AIDS, and others in its thrice-weekly broadcasts. Several students in each participating school were trained as radio correspondents, in-charge of encouraging youth in their respective communities to listen to *Bienvenida Salud* and then provide feedback, including proposing new subjects for inclusion and treatment on the radio programme. The radio correspondents, along with their teachers and Minga's cadre of community-based *promotoras (*local women acting as agents of change) undertook training and other programmatic activities on the topic of domestic violence and HIV/AIDS for their respective communities. The project capitalized on the popularity and credibility of Minga's thrice-weekly radio programme (*Bienvenida Salud*), its on-the-ground community resource persons (community *promotoras*), and strategically

	leveraged it with a school-based initiative, involving teachers, students, and community members to prevent and reduce domestic violence and HIV/AIDS, empower victims of violence (mostly children and women), and reduce prejudice, stigma, and discrimination associated with being HIV-positive. An independent assessment of Minga's Intercultural Radio Educative Project found that the project had made a positive impact in the lives of participating communities. (Excerpted from Singhal, A. and Dura, L. 2008. "Listening and Healing: An Assessment of Minga Peru's Interculural Radio Educative Project to Prevent and Control Domestic Violence and HIV/AIDS" *Report Submitted to Minga Peru/ United Nations Trust Fund to End Violence against Women*, p.5)
Empowering women and girls	**IMAGE: The Intervention with Microfinance for AIDS and Gender Equity.** The Intervention with Microfinance for AIDS and Gender Equity is a programme in South Africa that addresses the environmental HIV risk factors of poverty and gender inequalities, including violence against women, by combining participatory training in gender awareness with a small scale loan programme. See a short write-up on the evaluation and the fuller evaluation. ➢ Download the training manuals, Volume I and Volume II. Community-based HIV/AIDS/STD Response through Capacity-building and Awareness (CHARCA)**.** Community-based HIV/AIDS/STD Response through Capacity-building and Awareness is a joint United Nations system project in partnership with the National AIDS Control Organization (NACO) of India. It aims to reduce the vulnerability of young women (aged 13-25 years) in the general population to the risk of HIV infection. It is being implemented in six localities in India. The key activities are: (1) awareness creation, (2) capacity building, (3) strengthening services, (4) creating an enabling environment, (5) building support structures. As a general population intervention, Community-based HIV/AIDS/STD Response through Capacity-building and Awareness works with young women as well as a range of groups that influence the lives of young women, including groups of young men, groups of older women and positive people's networks (Excerpted from UNODC). See the baseline survey. See the final report.

Additional Tools:

- For an additional list of continually updated resources, search the tools database by subject (e.g. prevention and/or HIV)

- See also the dedicated programming modules on men and boys, prevention, adolescents and education.

- ***Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies*** *(*Joint United Nations Programme on HIV/AIDS Inter-Agency Task Team on Education. 2008). This toolkit aims to help education staff from development cooperation agencies, including development and humanitarian-oriented multilateral and bilateral agencies as well as non-governmental organizations and other civil society organizations, to support the process of mainstreaming HIV and AIDS into education sector planning and implementation. It provides resources and support to assess the progress countries have made with respect to HIV and AIDS mainstreaming; to identify entry points and opportunities; and to establish priorities for advocacy and action. It is designed to be used as a reference tool or a resource for training and discussion. Though not focused explicitly on violence against women it can be adapted to local needs and context. Available in English.

- ***Inter-linkages between Culture, Gender Based Violence, HIV and AIDS and Women's Rights: Training Manual*** (SAFAIDS and Oxfam, 2008). This training manual is intended for use by community workers and counselors. It provides information and activities to encourage reflection on the linkages between culture, gender-based violence, the violation of women's rights and the spread of HIV in the African context. Available in English.

- ***Our Turn to Tell: A Tool for Us! Kenyan Girls Tell their Stories*** *(*AfriAfya and Street Kids International, 2008). This tool includes 12 real life stories written my Kenyan adolescent girls on the topics of HIV/AIDS and violence against women and girls. Reflection questions are found at the end of each story and a facilitator's guide is attached which includes interactive activities to accompany each story in the booklet. This tool can be used alone or as part of an educational programme. Stories and activities in English, Kiswahili and Luo are included. Available in English.

- ***Planning BCC Interventions: A Practical Handbook*** (Peter F. Chen for UNFPA CST Bangkok, 2006). The handbook, a resource for UNFPA staff and partners, aims to help practitioners plan and implement effective behaviour change communication (BCC) strategies in support of reproductive health, specifically around adolescent reproductive health (ARH) and HIV/AIDS prevention. The handbook provides an overview of the concepts of BCC, types of interventions, some theoretical frameworks behind BCC processes and detailed guidance for practitioners to plan design, execute, monitor and evaluate BCC activities. Though the handbook is not focused on violence against women, it provides guidance on

planning and implementing communication initiatives for behaviour change, advocacy, or social mobilisation that can be adapted. Available in English.

- ***The HIV/AIDS Emergency: Guidelines for Educators***. Pretoria, South Africa: Department of Education (Jewkes, R. 2000). Available in English.

- ***Beyond victims and villains: Addressing sexual violence in the education sector*** *(*Panos Institute. 2003)*.* Available in English.

3. Specific areas for integrating violence against women and girls programming into HIV programming

3a. Conduct a situational analysis

- A situational analysis is used to determine the needs and options of integration in a particular context and to adapt programming accordingly. It involves evaluating the following factors:

    - the epidemiology of both HIV/AIDS and violence against women and girls,
    - the related legal frameworks and other policies,
    - sectoral responses (health, justice, work, education etc),
    - existing and customary norms, gender roles, risk factors and vulnerabilities,
    - existing local resources (Luciano, 2009).

Illustrative Tools:

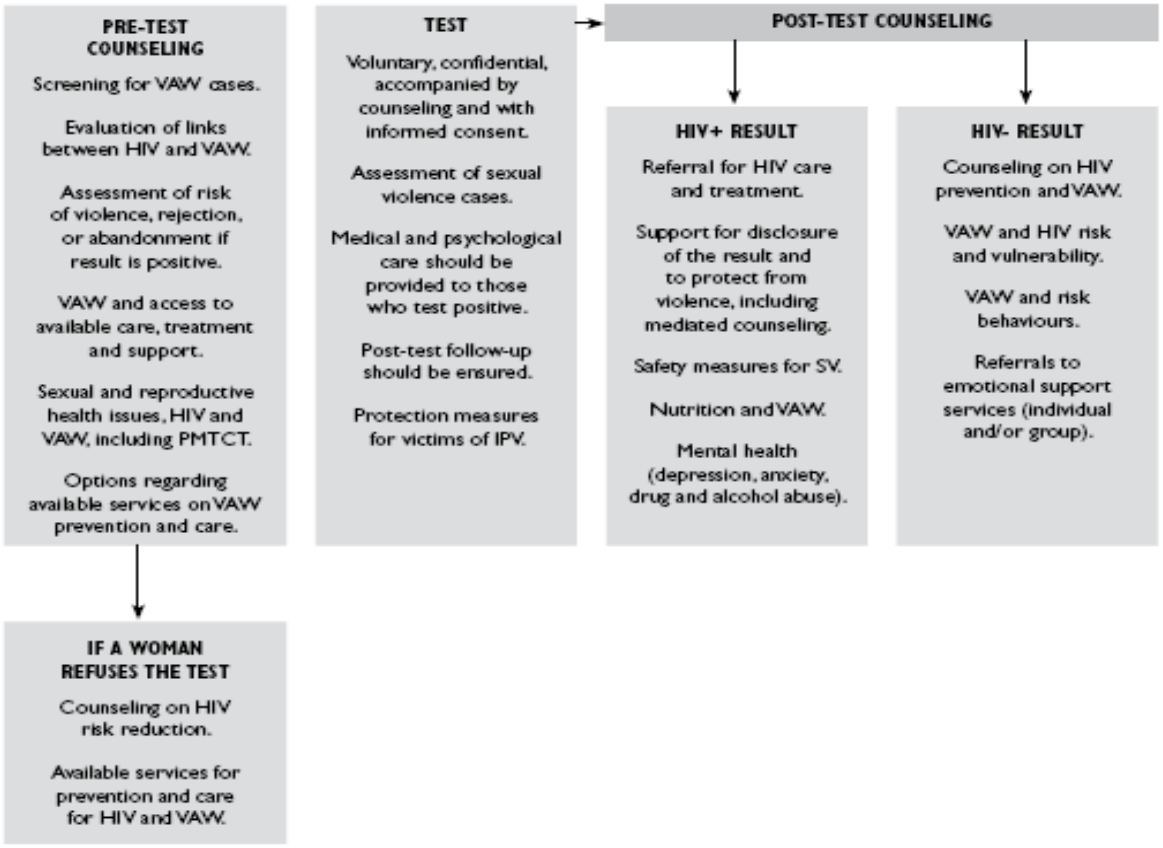
- **Situational Analysis of HIV and Violence against Women.** The following tool can be used as a guide when conducting a situational analysis of HIV and violence against women and girls at the Macro, Sectoral, Provincial, Institutional/Organizational, Community and Individual levels: **Luciano, D. 2009.** *Development Connections: A Manual for Integrating the Programmes and Services of HIV and Violence Against Women* (pgs. 47-50). Available in English and Spanish.

- **Stakeholder mapping for integrating HIV and Violence against Women programmes and services.** The following tool can be used as a guide when conducting Stakeholder mapping for integrating HIV and violence against women and girls programmes and services: **Luciano, D. 2009.** *Development Connections: A Manual for Integrating the Programmes and Services of HIV and Violence Against Women* (pg. 53). Available in English and Spanish.

3b. Voluntary counselling and testing for HIV

- The following provides a guide to integrating services of routine voluntary counselling and testing and violence against women and girls. This includes steps to take during pre-test counselling, testing, and post-test counselling.

Integrated services of routine VCT and VAW



Source: Luciano, 2009. *Development Connections: A Manual for Integrating the Programmes and Services of HIV and VAW*, pg. 41.

- Additional elements to consider when integrating violence against women and girls into voluntary counselling and testing services include:
    - **Screening:** Given the scale and the many different forms of violence against women and girls, screening for such experiences during voluntary counselling and testing can help to provide women with an entry point to support and services (Luciano, 2009). Routinely asking women and girls about violence within voluntary counselling and testing settings can have additional benefits such as**:**
        - Increasing the rates of disclosure
        - Creating opportunities to reduce barriers to prevention care and treatment of HIV associated with violence against women and girls
        - Changing service providers' attitudes toward violence against women and girls
        - Reducing stigma and discrimination related to HIV and violence against women and girls

    - **Pretest Information or counselling:** Providing pretest information and/or counselling gives health care providers an opportunity to share basic information about violence

against women and girls and HIV/AIDS. This step also provides women with the opportunity to "assess their risk, think about risk reduction, and prepare themselves for the test results" (WHO, 2009a, pg. 31).

- **Confidentiality**: Tests must always be voluntary and confidential. Testing positive for HIV, or simply getting tested, may increase a woman or girl's risk of violence. This is especially the case in situations where intimate partner violence is present. Therefore it is important to ensure that a partner will not find out about a woman's decision to get tested unless the woman provides clear consent.

- **Disclosure:** Disclosure can result in violence and discrimination from intimate partners, family members and the community. For this reason it is important to ensure policies are in place to make disclosure voluntary.

- When dealing with clients who experience intimate partner violence it is especially important to develop safe disclosure plans as part of the post-test counselling component of voluntary counselling and testing services. This should include:

    - Engaging in a discussion with clients about their fears of violence and abandonment as factors in their decision to disclose their status to their partner (WHO, 2009a).

    - Working with your client to develop the safe disclosure plan. When doing so it is important to recognize that where intimate partner violence is already present, disclosure can lead to increased violence.

    - If your client agrees, consider mediated disclosure with the help of counsellor (Maman et al., 2006; WHO, 2006). By having a counsellor present, mediated disclosure creates a safe environment for disclosure. When conducting a mediated disclosure avoid blame and tension by providing accurate information about transmission and prevention (Baty, 2008).

    - Encourage and support communication within couples about HIV/AIDS and voluntary counselling and testing. This can facilitate couples getting tested together and disclosing ones status (Maman et al., 2006; WHO, 2006). Meeting separately with men and women for pre-test and post-test counselling can help ease the process of couples voluntary counselling and testing, while helping avoid violence as well. After testing, give couples the option to come in together for serodisclosure, this option should be given with support clubs in place for sero-discordant couples (Maman et al., 2006).

Protocols to address violence in counselling on HIV status disclosure (118)

Example 1. Counselling protocol from Dar es Salaam, the United Republic of Tanzania

In a voluntary HIV counselling and testing clinic in Dar es Salaam, researchers piloted the following protocol to raise the issue of violence during counselling on HIV disclosure. Counsellors asked women the following questions:

1. Is your partner aware that you will be tested for HIV?
2. If you told your partner you tested positive for HIV, do you think he would react supportively?
3. Are you afraid of how your partner will react if you share your HIV test results with him?
4. Has your partner ever physically hurt you?
5. Do you think that your partner may physically hurt you if you tell him that you have tested for HIV and your HIV test results are positive?

Counsellors supported women's decision to disclose if they answered positively or negatively to question 1, positively to question 2 and negatively to questions 3–5. If women answered negatively to question 2, and positively to any of questions 3–5, then counsellors proceeded with caution and explored in more depth each woman's risk of disclosure-related violence. If the counsellors determined that the risk was high, they explored alternative options, including: opting not to disclose; deferring disclosure to a time when a woman's safety was ensured; or developing a plan for mediated disclosure in which women either brought the partner to the clinic to disclose, or identified a trusted family member or friend to be present when they shared their HIV test results with their partner. If women answered negatively to question 2 and positively to questions 3–5, regardless of how they answered question 1, then counsellors explored these alternative options for disclosure.

Example 2. Family Health International (FHI): Asia-Pacific region

In the region that FHI designates as the Asia-Pacific region, FHI staff have developed the following protocol for counsellors to use when counselling clients regarding disclosure.

1. Counsellor asks: "There are some routine questions that I ask all of my clients because some are in relationships where they are afraid that their partner may hurt them. What response would you anticipate from your partner if your results came back positive?"
2. If the client indicates that she or he is fearful or concerned, then the counsellor asks, "Have you ever felt afraid of your partner? Has your partner ever pushed, grabbed, slapped, choked or kicked you? Threatened to hurt you, your children or someone close to you? Stalked, followed or monitored your movements?"
3. If the client responds affirmatively to any of these points, the counsellor then adds, "Based on what you have told me, do you think telling your partner will result in a risk to you or your partner?"

The client is then encouraged to make a decision to disclose based on a realistic appraisal of the threat.

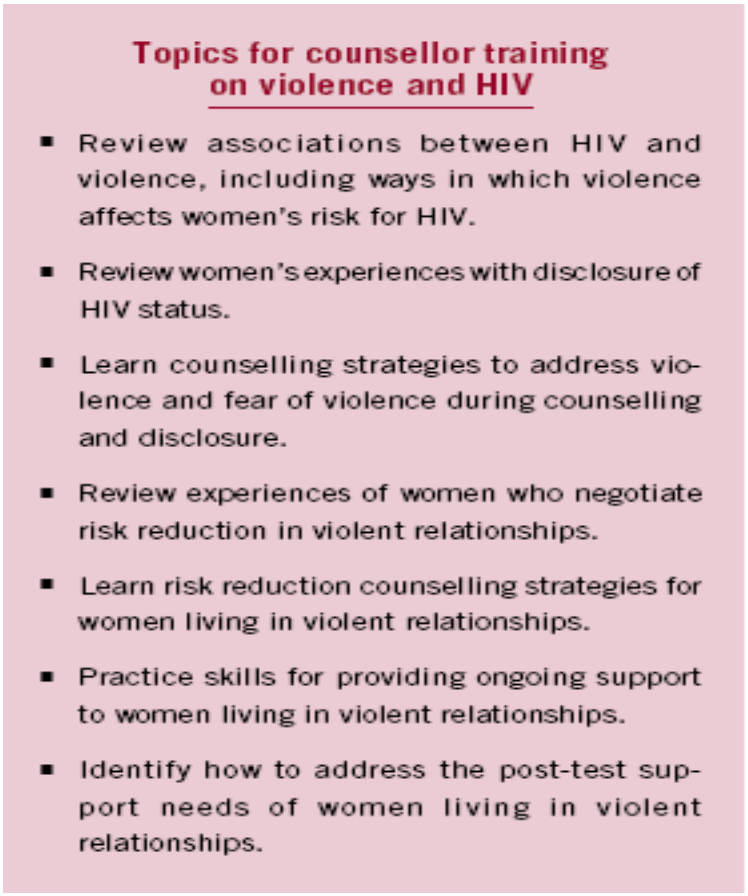
Source: WHO, 2009a. *Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs.* Geneva, Switzerland: WHO, Department of Gender, Women and Health, pg. 38.

- **<u>Routine Testing:</u>** Though there is a limited evidence-base on routine testing with varied opinions by practitioners and experts alike, routine testing can result in a violation of women and girls' human rights, if it is not based on individualized informed consent. This implies that unless safety, confidentiality and choice are ensured, the Opt-in model should be used instead of the Opt-out model.
    - **The Opt-out model:** This is when women are tested for HIV routinely, and have to clearly refuse testing if they do not want to be tested (World Health Organization and UNAIDS, 2007). Informed choice may be compromised when using this model because of lack of training of health providers and

other barriers between health care providers and women such as class or cultural differences.

- **The Opt-in model:** This is when there is individualized informed consent instead of routine testing (World Health Organization and UNAIDS, 2007). Using this model is more appropriate when working with highly vulnerable populations who are especially vulnerable to increased violence when disclosing their HIV test results.

- **Staff Training:** Sensitivity trainings should be provided to voluntary counselling and testing staff to raise awareness on gender, class, and ethnic differences which can create power inequalities between themselves and clients (WHO, 2009a).This includes training on how to use simple language to explain medical and technical terms that clients may not otherwise understand and trainings on how to avoid expressing judgmental attitudes and personal biases towards clients (WHO, 2009a).



Source: Maman, S., King, E., Amin, A., Garica-Moreno, C., Higgins, D. and Okero, A., 2006. *Addressing Violence against Women in HIV Testing and Counselling: A Meeting Report*. Geneva, Switzerland. WHO, pg. 23.

Example**:** **Vezimfihlo!** ("*To break the silence"*) is a training programme developed in South Africa that aims to equip counsellors who work in VCT settings to address gender-based violence. The programme explores why gender-based violence is a public health concern and how health workers can help abused patients; it also builds identification,

consultation, communication and response skills. The target audience includes lay counsellors and other service providers who give VCT. See the study.

BOX 1.9

Capacity-building for addressing gender-based violence through VCT (33)

Vezimfihlo! (*To break the silence*) is a training programme developed in South Africa that aims to equip counsellors who work in VCT settings to address gender-based violence. The programme explores why gender-based violence is a public health concern and how health workers can help abused patients; it also builds identification, consultation, communication and response skills. The target audience includes lay counsellors and other service providers who give VCT. Key topics in the manual include:

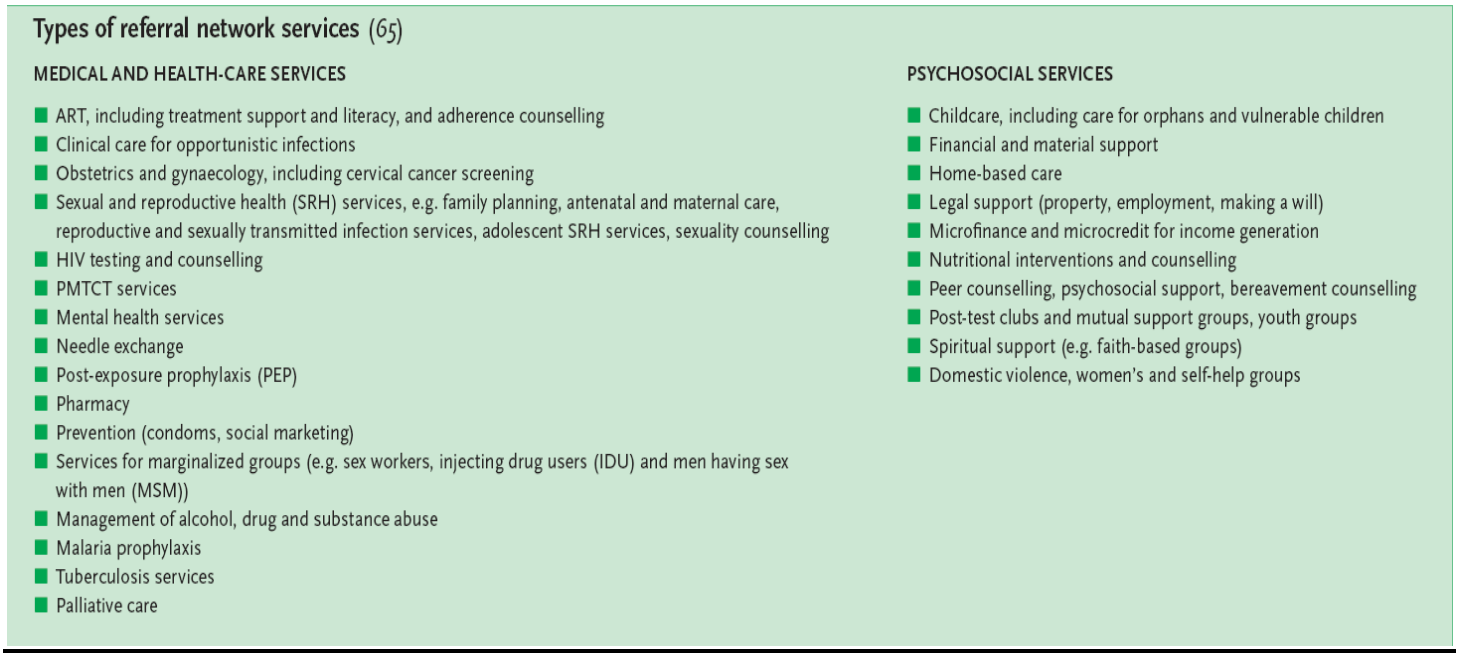
- the social construction of gender
- gender-based violence – a public health priority
- how the health sector can respond to gender-based violence
- attitudes to gender-based violence
- gender-based violence – causes and consequences
- experiences of gender-based violence
- identification of gender-based violence
- barriers to the identification and disclosure of violence
- the role of the health sector in ensuring safety
- asking about abuse and performing safety assessments
- consultation skills – how to improve communication
- options for abused women
- gender-based violence in VCT
- building support systems, including community resources.

Key messages for addressing violence against women in the health sector

- Gender-based violence is a health problem, so the question is not whether to engage with it but how to do so.
- Health workers in a VCT setting, and those supporting abused women, need to engage with factors that place women at risk and interfere with the ability of HIV-positive women to live healthy lives.
- The role of health workers in addressing gender-based violence is to:
  - — ask about it
  - — be empathetic and non-judgemental
  - — discuss how it can increase HIV risk
  - — discuss its effect on disclosure and living positively with HIV
  - — talk about safety and give information about options.

Source: excerpted from WHO, 2009a. I*ntegrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs.* Geneva, Switzerland: WHO, Department of Gender, Women and Health, pg. 10.

Referral services: The lack of available referral services for addressing violence makes it challenging for HIV programme staff to address violence against women and girls (WHO, 2009a). The following provides a comprehensive list of medical and health-care services as well as psychosocial services which should be included when building referral services for the integration of HIV/AIDS and violence against women and girls. In context were formal psychosocial support is weak, peer support programmes can be an important mechanism to support women through the HIV testing and counselling process(WHO, 2006).



Types of referral network services (65)

MEDICAL AND HEALTH-CARE SERVICES

- ART, including treatment support and literacy, and adherence counselling
- Clinical care for opportunistic infections
- Obstetrics and gynaecology, including cervical cancer screening
- Sexual and reproductive health (SRH) services, e.g. family planning, antenatal and maternal care, reproductive and sexually transmitted infection services, adolescent SRH services, sexuality counselling
- HIV testing and counselling
- PMTCT services
- Mental health services
- Needle exchange
- Post-exposure prophylaxis (PEP)
- Pharmacy
- Prevention (condoms, social marketing)
- Services for marginalized groups (e.g. sex workers, injecting drug users (IDU) and men having sex with men (MSM))
- Management of alcohol, drug and substance abuse
- Malaria prophylaxis
- Tuberculosis services
- Palliative care

PSYCHOSOCIAL SERVICES

- Childcare, including care for orphans and vulnerable children
- Financial and material support
- Home-based care
- Legal support (property, employment, making a will)
- Microfinance and microcredit for income generation
- Nutritional interventions and counselling
- Peer counselling, psychosocial support, bereavement counselling
- Post-test clubs and mutual support groups, youth groups
- Spiritual support (e.g. faith-based groups)
- Domestic violence, women's and self-help groups

Source: WHO, 2009a. *Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs.* Geneva, Switzerland: WHO, Department of Gender, Women and Health, pg. 47.

Illustrative Tools:

- **Integrating HIV Voluntary Counselling and Testing Services into Reproductive Health Settings: Stepwise Guidelines for Programme Planners, Managers and Service Providers** (IPPF South Asia Regional Office and UNFPA, 2004). Available in English.

- ***Disclosure Assessment***, by Suzanne Maman, is a 5-question tool to identify VAW victims and to assess their risk.

- ***Risk Reduction Counselling for Women at Risk for Violence***, by Elizabeth King, is a tool to raise the potential for violence in risk reduction counselling. The tool presents various role play scenarios that counsellors can use with clients to facilitate discussion about condom use and sexual coercion. It has 3 sections, as follows: 1) Younger couples and those in relationships, but not married; 2) Married couples; 3) Women involved in relationships (both permanent partnerships and married spouses).

- ***Guidelines for Integrating Domestic Violence Screening into HIV Counselling, Testing, Referral & Partner Notification***, by the New York State Department of Health, is a document outlining the New York State Department of Health's guidelines on addressing violence against women and girls within HIV services. It includes such subheadings as: *Domestic Violence Risk Assessment*

as a Standard of Care; Introducing a Discussion of Domestic Violence Within HIV Counselling and Testing; Referrals Should be Provided Whenever Domestic Violence or Risk of Domestic Violence is Identified; Discussion of Domestic Violence is Encouraged in Pretest Counselling; and *Domestic Violence Screening is Required During Post-test Counselling of HIV-Infected Individuals.* Available in English.

- ***Counselling Guidelines on Domestic Violence Southern African AIDS Training Programme*** (Southern African AIDS Training Programme, 2001). Available in English.

- **VCT Counsellor Interview Guide** (Raising Voices, 2008). As part of the SASA! Initiative, this tool was developed to provide practical guidance to voluntary counselling and testing counsellors about discussing violence with their clients. Available in English.

Additional Resources:

- ***The Intersection of HIV and Intimate Partner Violence: Considerations, Concerns, and Policy Implications*** *(*Baty, M.L., 2008). Family Violence Prevention & Health Practice. Available in English.

- ***Screening Persons Newly Diagnosed with HIV/AIDS for Risk of Intimate Partner Violence: Early Progress in Changing Practice*** (Klein, S.J., Tesoriero, J.M., Leung, S.Y., Heavner, K.K., Birkhead, G.S., 2008). Available in English.

- ***Addressing Violence against Women in HIV Testing and Counseling: A Meeting Report*** (Maman, S., King, E., Amin, A., Garcia-Moreno, C., Higgins, D. and Okero, A./WHO, 2006). Available in English.

3c. Prevention of Perinatal Transmission (also known as Prevention of Mother to Child Transmission)

- Across the world more than 90% of the 2.1 million children under the age of 15 years living with HIV have acquired the infection through their mothers. The prevention of perinatal transmission during pregnancy and delivery, and through breastfeeding is an area where there are feasible interventions in resource-limited settings. Nevertheless, the coverage of prevention of perinatal transmission interventions is low: in 2009 an estimated 26% of pregnant women received an HIV test, and an estimated 53% of pregnant women living with HIV received antiretrovirals for preventing transmission to their infants (WHO/UNAIDS/ UNICEF, 2010). Much like with voluntary counselling and testing, stigma, discrimination and the fear of violence deter women seeking out and adhering to prevention of perinatal transmission interventions. (Also see WHO, 2009a. **I***ntegrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs.* Geneva, Switzerland: WHO, Department of Gender, Women and Health).

- When integrating violence against women and girls into prevention of perinatal transmission interventions, key objectives should be to expand access to a comprehensive range of prevention of perinatal transmission interventions and to combat the stigma associated with HIV while encouraging and supporting disclosure (IGWG of USAID, 2009).

- Examples include:

    - Develop or strengthen linkages among HIV programmes and services, with sexual and reproductive health services (e.g. family planning, sexually transmitted infections, screening for cervical cancer).

    - Train family planning providers to routinely screen for violence during antenatal services and to offer voluntary counselling and testing for HIV.

    - Train family planning providers to see women living with HIV as part of their regular clientele, offering them a full range of contraceptive options, and referring them appropriately for other health needs.

    - Arrange for follow-up counselling for pregnant women who have tested positive for HIV. Health care providers can take this opportunity to provide women with information on prevention of perinatal transmission, the importance of taking ARV prophylaxis, and potential risks of disclosure (including partner violence). Using peer counsellors or community-based lay counsellors can be particularly effective as they may be able to share personal experiences and usually have more time available than clinic-based counsellors. For example, women living with HIV who have gone through prevention of perinatal transmission intervention scan act as peer counsellors and support to other women. Their role is especially important in that they can provide reassurance that prevention of perinatal transmission interventions can help to reduce the risk to unborn children. They can also act as role models for others, informing individual women, couples and communities through their own example that a programme is safe and effective (Excerpted from WHO, 2009a. *Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs.* Geneva, Switzerland: WHO, Department of Gender, Women and Health, pg. 35)

Example: The **MOTHERS-TO-MOTHERS (M2M)** programme in South Africa recruits HIV positive mothers who have recently given birth with a view to their educating, counselling and supporting HIV-positive pregnant women who attend antenatal clinics for prevention of mother to child transmission (PREVENTING MOTHER TO CHILD TRANSMISSION (PMTCT)). At every such visit, mentors engage pregnant women in conversation, share personal experiences, encourage adherence to anti-retroviral (ARV) prophylaxis, and help them during their hospital stay. The mentors also receive continued education and support, including a small stipend. The first M2M programme was started in a tertiary care hospital, with others scheduled to open over time in several primary care maternity

centres. The peer support mentorship programme fits seamlessly into routine antenatal care. The programme helps to educate pregnant women and mothers and thus empowers them in their families and communities. Empowerment contributes to the destigmatization of HIV infection and to improved community health. Postpartum women who had two or more contacts with the programme were significantly more likely than non-participants to have disclosed their HIV status to someone (97% versus 85%; $p<0.01$). Participants were significantly more likely to have received ARV prophylaxis (95% versus 86%; $p<0.05$) and to report an exclusive method of infant feeding (i.e. either exclusive breastfeeding or exclusive replacement feeding). Moreover, they reported a significantly greater sense of well-being than their counterparts, feeling that they could do things to help themselves, cope with caring for infants and live positively.

Source: excerpted from WHO, 2009a. *Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs.* Geneva, Switzerland: WHO, Department of Gender, Women and Health, p. 36).

Example: The **Twubakane Decentralization and Health Program** is a five-year program in Rwanda built on fostering strong decentralized local government that is responsive to local needs and promotes sustainable use of community health services. The Twubakane Program's overall goal is to increase access to and the quality and utilization of family health services in health facilities and communities by strengthening the capacity of local governments and communities to ensure improved health service delivery at decentralized levels. Between 2002 and 2004, IntraHealth tested an approach to assess the readiness of the health, policy and community systems to respond to gender-based violence in the context of two obstetrical-gynaecological services in Armenia.

In response to a request for assistance by USAID/Kigali, Twubakane conducted a similar qualitative and quantitative assessment to prepare for an initiative to integrate response to gender-based violence in antenatal care and prevention of mother-to-child transmission of HIV services. After consultation with a steering committee made up of the national partners involved in the prevention of both GBV and HIV transmission in Rwanda, and taking the lessons learned from Armenia, Twubakane adapted and tested their readiness assessment approach and tools in anticipation of preparing and implementing a multi-level, multisectoral intervention to integrate response to GBV in five sites in the districts of Nyarugenge, Kicukiro and Gasabo in Kigali Ville.

For additional information, see the Twubakane website.

Illustrative Tools:

- For ***guidelines*** and ***technical documents*** on preventing mother to child transmission of HIV, see dedicated section of the World Health Organization website in English.

- ***Twubakane Gender-based Violence/ Preventing Mother to Child Transmission Readiness Assessment Tools*** (IntraHealth International, 2008). Twubakane Project. The tools are all available in English and French and include:

- Clinic Record Review Form to Assess Providers' GBV Practice
- Interview Guide for Focus Group with antenatal care/ preventing mother to child transmission (PMTCT) Clients: Integrating Response to Violence in care/ preventing mother to child transmission (PMTCT) Services
- Interview Guide for Focus Group with Community Members
- Interview Guide for Focus Group with preventing mother to child transmission (PMTCT) Service Providers: Integrating Response to Violence in preventing mother to child transmission (PMTCT) Services
- Interviews Guide with Policy and Legal Stakeholders and Document Review Form
- Inventory to Assess Facility Readiness to Manage Gender-Based Violence
- Provider's Questionnaire on Knowledge and Beliefs Related to Gender-Based Violence
- GBV Resource Scanning Guide

➢ *I**ntegrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs*** (World Health Organization, 2009a). Available in English.

Additional Resources:

➢ ***Prevention of Mother-to-Child Transmission Services as a Gateway to Family-Based Human Immunodeficiency Virus Care and Treatment in Resource-Limited Settings: Rationale and International Experiences*** (Abrams, E.J., Myer, L., Rosenfield, A. and El-Sadr, W.M., 2007). *American Journal of Obstetrics and Gynecology*, Vol. 197, No. 3 Suppl., S101-S106. Journal available in English.

➢ ***Gender-based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa*** (Dunkle, K.L., Jewkes, R., Brown, G.E., McIntryre, J.A., Harlow, S.D., 2004). *The Lancet*, Vol. 363, No. 9419 (May), 1415-1421. Journal *a*vailable in English.

➢ ***Partner Notification in Pregnant Women with HIV: Findings from Three Inner-city Clinics*** (Forbes, K. M., Lomax, N., Cunningham, L., Hardie, J., Noble, H., Sarner, L. et al., 2008). *HIV Medicine*, Vol. 9, No. 6, 433-435. Journal available in English.

3d. Addressing violence against HIV positive women

- HIV positive women are at risk of experiencing the same forms of violence as other women in the population, in addition to new forms of direct and indirect violence, stigma and discrimination that arise because of their status. These include, but are not limited to:
    - Shunning

- eviction;
- property grabbing
- barring women from seeing their children
- maltreatment from family members and in-laws
- maltreatment by service providers
- forced sterilization and various forms of contraceptive control
- forced abortion
- police violence, abuse and extortion
- loss of livelihoods
- work-related abuses (e.g. unauthorized disclosure, testing without consent, dismissal or retraction of job offers)
- denial of medication
- use of discriminatory language
- legislation and policy which is developed without using the lenses of gender and HIV status
- clinical trials which do not adequately respect women's autonomy, humanity and rights
- the dominance of Western scientific understandings of 'evidence'
- institutional failure to understand the realities of HIV positive women's experiences and to create supportive environments (e.g. no recognition of marital rape, lack of property and inheritance rights, employment protection)

Source: extracted from Hale, F. and Vasquez, M./Development Connections, the International Community of Women Living with HIV/AIDS and UN Women. 2011. *Violence Against Women Living with HIV/AIDS: A Background Paper*. See paper for additional studies cited. Also available in Spanish.

- Women living with HIV are entitled to the same rights as any other man or woman. Addressing stigma, discrimination and violence against them requires a review of policies and laws to ensure they are aligned with international human rights and are understood through the lens of a positive woman; support to HIV positive women's networks to facilitate monitoring and implementation of the law; support for women's groups and other organizations that have been at the forefront of attending to the needs of HIV positive women and providing services; advocacy, awareness-raising and community mobilization to challenge negative social norms and behavioural practices among the population at large; and capacity development of health care workers, the police and justice sector personnel to respond appropriately.

Access recorded sessions to hear more from experts on violence against HIV positive women:

- Current definitions and data on types of violence, dimensions, social determinants and consequences of violence against women living with HIV (Fiona Hale, Salamander Trust)
- Projects and programmes addressing violence against women living with HIV (MariJo Vazquez, Salamander Trust)
- Strategic issues regarding violence against women living with HIV for advocacy, research, programming and policy development (Alice Welbourn, Salamander Trust)

Recordings available in Spanish.

Tools:

- ***The People Living with HIV Stigma Index*** (The Global Network of People Living with HIV/AIDS (GNP+); The International Community of Women Living with HIV/AIDS (ICW); The International Planned Parenthood Federation (IPPF); and The Joint United Nations Programme on HIV/AIDS (UNAIDS) with support from the UK Department for International Development). This tool by and for people living with HIV has been developed to measure stigma and benchmark progress in addressing it. The tool and accompanying guidelines are available in English.

- ***HIV & AIDS – Stigma and Violence Intervention Manual*** (Duvvury, N., Prasad, N. and Kishore, N./ICRW, 2006). Available in English.

- ***Understanding and Challenging HIV Stigma: Toolkit for Action*** *(revised edition)* (International HIV/AIDS Alliance and PACT, Tanzania, 2007). Available in English.

- ***Reducing HIV Stigma and Gender Based Violence Toolkit for Health Care Providers in India: Toolkit for Healthcare Providers in India***.(ICRW, 2007). Available in English.

- ***Understanding and Challenging HIV Stigma: Toolkit for Action*** (ICRW, 2003). Available in English.

- ***Facilitator's Guide for Training on HIV & AIDS Stigma and Discrimination Reduction*** (WACC/Christian Council of Ghana, 2010). Available in English.

- ***Can We Measure HIV/AIDS-related Stigma and Discrimination? Current Knowledge about Quantifying Stigma in Developing Countries (***Nyblade, L. and MacQuarrie, K./International Centre for Research on Women, 2006). Available in English.

- ***Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: Manual for Trainers and Programme Managers*** (EngenderHealth and International Community of Women Living with HIV/AIDS, 2006). Available in English, French, Spanish, Portuguese, and Russian; 239 pages.

- **Positive Women Monitoring Change: A Monitoring Tool on Access to Care, Treatment and Support, Sexual and Reproductive Health and Rights and Violence against Women Created by and for HIV Positive Women** (International Community of Women Living with HIV/AIDS, 2005). Available in English.

4. Develop specialized support services

In order to address some of the challenges of integrating survivor support programmes into the health care system, several models have been developed in countries around the world that provide specialized services for survivors. These programmes may be housed in health facilities, or they may exist in the community. Wherever they are situated, a defining feature of these programmes is that they specifically target the issue of violence against women and girls.

Lessons Learned: A review undertaken in the United Kingdom notes that even where specialist services for sexual assault exist, there are usually parts of the country with much less well organised service provision (End Violence against Women and Equality and Human Rights Commission, 2007). This reflects the reality that most countries are still in a phase of progressive realisation of the right to access to high quality sexual assault health services according to national resources and legislative frameworks on the issue.

In middle and lower income countries, sexual assault centres with dedicated trained health care providers represent the **gold standard** in terms of care, but they are likely to only be a realistic model in settings of higher (or the highest) population concentration. Elsewhere, having trained providers in facilities identified as providing post-sexual assault care or a sexual assault examiner programme is likely to be more realistic in terms of cost. Even if sexual assault centres are the preferred model, a decision must be made about whether the service will be exclusively medical, nurse-led or a combination of both. Although forensic nurse- led services often provide a particularly satisfactory combination of high-level skills and victim/survivor-centred care, there is no reason why these should not also be features of medically-led services if medical examiners have also been appropriately trained and the services are provided by staff and led by managers with a shared ethos. In practice the decision about who should provide care is usually influenced by historical practices in service provision, scope of nursing practice and the acceptability of nurses as sources of expert testimony in courts (excerpted from Jewkes, R., 2006. “Paper for Policy Guidance: Strengthening the Health Sector Response to Sexual Violence”).

Example: In **South Africa**, in-depth research was undertaken by the Medical Research Council to determine how quality services for sexual assault could be delivered feasibly without compromising the needs of survivors. See the power point presentation describing how research was used for policy development and implementation.

4a. Sexual assault nurse examiner programmes

- When receiving services in hospitals by non-specialized staff, rape survivors are at risk of receiving inadequate and unethical care. They may suffer long waiting periods in emergency rooms, and during treatment may not receive the full spectrum of treatment. Medical providers may not be sufficiently trained in collecting forensic evidence or in providing emotional support to the survivor.

- Sexual assault nurse examiner programs are those in which nurses are specifically trained to conduct sexual assault examinations and provide care. In general these programs are designed to emphasize quality of care for survivors. Nurses usually work from dedicated examining suites in hospitals, but some programmes cover several hospitals and thus the nurse travels and there may even be mobile examination facilities (Jewkes, 2006).

- Nurses are usually expected to provide both emergency medical care and facilitate access to on-going support services. They are specially trained through recognised and validated courses and are expected to provide comprehensive medical care. Some programmes have full-time staff and others operate with on-call systems (Jewkes, 2006).

- This model potentially has particular advantages for developing countries where doctors are often in short supply. Since the nurses give evidence in court it is essential that the legal system acknowledges the expertise of nurses and gives equal weight to this as it would to evidence of doctors (Jewkes, 2006).

Lesson Learned: Ensuring that trained nurses have the resources and support they need, especially in settings where the may have additional responsibilities beyond forensic nursing, is critical to the success of nurse examiner programs. Managers may not recognise that the needs of sexual violence health services should take precedence over those of other aspects of health care. This has been a particular problem in some settings outside North America.

Example: The Sexual Assault Nurse Examiner (SANE) forensics service has had positive results in the United States. A sexual assault nurse examiner is a registered nurse with an advanced education in the forensic examination of sexual assault survivors. Training in SANE, established by the International Association of Forensic Nurses, requires 40 hours of classroom learning and a clinical practicum of an additional 40 hours (Taylor, 2002).

Goals of SANE are to: protect the survivor from further harm; provide crises intervention; professional forensic collection, documentation and preservation of evidence; evaluate and treat sexually transmitted infections; evaluate pregnancy risk and offer prevention; assess, document and seek care for injuries; and appropriately refer survivors for immediate and follow-up medical care and follow-up counselling (Ledray, 1999). A SANE team may consist of a provider, police, and a rape advocate. Using the team approach, the survivor only has to tell the story once. Only the provider and counsellor should be present during the exam.

SANE patients in the United States experienced longer examinations and received higher quality of care as indicated by a greater percentage of completed physical exams and a greater percentage of completed evidence kits for prosecution (Derhammer et al., 2000, cited in Martin et al., 2007)

For comprehensive information on implementing a SANE program, see ***Sexual Assault Nurse Examiner (SANE) Development & Operations Guide*** (Ledray, L./Washington DC: Office for Victims of Crime, U.S. Department of Justice, 1999). Available in English.

4b. Intimate Partner Violence and/or Sexual Assault Centres (also referred to as One-Stop Centres)

- Intimate partner violence and/or sexual assault centres, also referred to as One-Stop Centres, provide multisectoral case management for survivors, including health, welfare, counselling, and legal services in one location (Colombini et al., 2008). These crisis centres are typically located in health facilities, including the emergency departments of hospitals, or as stand-alone facilities near a collaborating hospital (United Nations, 2006a). These centres can be staffed with specialists 24 hours or can maintain a core group of staff with specialists on call.

One-stop Centres

One of the best-known good practices in service provision involves bringing together services in one location, often called the “One-stop centre”, an interagency unit for victim/survivors of domestic or sexual violence. Such a service was first developed in the largest Government-run general hospital in **Malaysia**. The victim/survivor is first examined and treated by a doctor and is seen by a counsellor within 24 hours in a

separate examination room that protects privacy and confidentiality. If it appears that the victim will be in danger if she returns home, the doctor or counsellor arranges for her to go to an emergency shelter or admits her to the accident and emergency ward for 24 hours. If the patient chooses not to seek shelter, she is encouraged to return to see a social worker at the hospital at a later date. She is also encouraged to make a police report at the police unit based in the hospital. In a case involving severe injury, the police see the patient in the ward to record her statement and start investigations. This model is currently being replicated in many parts of the world.

Search the Secretary-General's Database to see which countries have established integrated service centres.

Source: adapted from the Secretary-General's in-depth study on violence against women, 2006.

- It has been shown that when comprehensive one-stop shops are adequately resourced, staffed and managed, reporting and demand for services increases. For example, following the introduction of comprehensive post-rape care services, the reporting of rape was ten times higher in the following three months at a district hospital in Kenya (Taegtmeyer et al., 2006).

- However, one-stop centres require the commitment of administrators in order to be effective, as well as training and support for all staff working within the centre. Key lessons learned from implementing a one-stop centre in Thailand include:

    - Hospital management must be involved in the establishment of one-stop crisis centres
    - Teamwork among various hospital personnel is crucial
    - Training for various hospital staff should focus not only on technical aspects of violence against women, but should also cover issues such as power, relationships, gender and sexuality.
    - Sensitization of police on the same issues is also important.
    - Visits to other crisis centres can be a useful starting point for designing services.
    - Initially, health care providers may identify only the most obvious cases of abuse, but sharing of experiences between personnel in various departments of the hospital can improve screening skills in general.
    - Adherence to a standard protocol for various health care workers is necessary. (Excerpted from WHO, 2007)

- The Council of Europe recommends the following minimum services for sexual assault centres located in health facilities, which can be used as a baseline to consider priorities for programme development:

Table 8.16: Service-specific standards

Sexual assault centres and specialist hospital services

Minimum standards	Aspirational standards	Human Rights	Support
Victims of sexual assault shall receive the same standard of care regardless of the circumstances of the sexual assault, their legal or social status.	• Health providers should ensure equitable access to quality medical care. • Services should develop age specific protocols and responses.	• Prohibition of discrimination, ECHR Art. 14 & Protocol 12, Art.1, CEDAW, *UDHR Art. 7 & EU Charter Art.21*	
Services should develop good working relationships with rape crisis centres, shelters and any other local service provider.		• Prohibition of inhuman treatment, ECHR Art. 3, ICCPR Art. 6 *& UDHR Art.1* • Respect for physical and moral or mental integrity, ECHR Art. 8, *EU Charter Art.3* • *Due diligence to prevent & investigate, DEVAW Art 4 (c), Beijing Platform para 124 (b) & CoE Rec(2002)5*	
Hospital emergency departments should have protocols for handling sexual violence and staff training.		• Right to adequate standards of health and medical treatment, Social Charter & Revised Social Charter Art.11, CEDAW Art. 12, ICESCR Art. 12, *EU Charter Art. 35* • *Due diligence to investigate DEVAW Art 4 (c), Beijing Platform para 124 (b) & CoE Rec(2002)5*	
The reception and treatment environment should be secure, clean and private.		• *Respect for dignity, EU Charter Art.1, UDHR Art.1, & Millennium Dec para 6*	
Hospital based sexual violence services should work from a victim-rights model (see core standards).		As above	
Forensic examiners should be female, unless the service user specifies otherwise. Services should: • increase capacity in female forensic examiners. • build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports.	• Service providers should consider developing forensic nursing to expand access. • Health services should be provided in the mother tongue of the service user, or in a language she or he understands. • Service users should have access to female interpreters experienced in dealing with trauma.	• *Respect for dignity, EU Charter Art.1, UDHR Art.1, & Millennium Dec para 6* • *Due diligence to investigate DEVAW Art 4 (c), Beijing Platform para 124 (b) & CoE Rec(2002)5* • Prohibition of discrimination, ECHR Art. 14 & Proto 12, Art.1, CEDAW, *UDHR Art. 7 & EU Charter Art.21* • *Respect for cultural, religious and linguistic diversity, EU Charter Art.22*	

Table 8.16: Service-specific standards

Sexual assault centres and specialist hospital services (continued)

Minimum standards	Aspirational standards	Human Rights	Support
Forensic examiners should develop organic informed consent processes throughout the entire process.	For minimum standards of treatment, forensic examination and documenting findings the WHO Guidelines should be followed.[1]	• Respect for free and informed consent in the field of medicine, EU Charter Art.3 • Respect for physical and moral or mental integrity, ECHR Art. 8 • Right to adequate standards of health and medical treatment, Social Charter & Revised Social Charter Art.11, CEDAW Art. 12, ICESCR Art. 12, *EU Charter Art. 35*	
All staff should be trained in confidentiality, including with respect to samples and medical records.		• Right to respect for private life and the protection of personal data, ECHR Art.8, CPIAPPD Art.8 *& EU Charter Art.8*	
During examination, treatment or counselling only the following people should be present: • People whose involvement is necessary; • People who the service user requests are present to support them.		• *Respect for dignity, EU Charter Art.1, UDHR Art.1, & Millennium Dec para 6* • Right to respect for private life, ECHR Art.8	
Services should provide on common physical and emotional responses.		• Right to adequate standards of health and medical treatment, Social Charter & Revised Social Charter Art.11, CEDAW Art. 12, ICESCR Art. 12, *EU Charter Art. 35*	
The full range of options should be presented to all service users, including post-control contraception and where relevant abortion.		• Right to adequate standards of health and medical treatment, Social Charter & Revised Social Charter Art.11, CEDAW Art. 12, ICESCR Art. 12, *EU Charter Art. 35* • *Respect for dignity, EU Charter Art.1, UDHR Art.1, & Millennium Dec para 6*	

Table 8.16: Service-specific standards

Sexual assault centres and specialist hospital services (continued)

Minimum standards	Aspirational standards	Human Rights	Support
Any medico-legal report or certificate should be provided free of charge and should not expire for legal purposes.		• Right to equal protection from the law, ICCPR Art 26, CEDAW Art. 2, *UDHR Art. 7, EU Charter Art.20* • *Governmental commitment to take measures to ensure the protection of women subjected to violence access to just and effective remedies, Beijing Platform para 124*	
Any medical evidence and medical certificates should only be collected and released to the authorities with the service user's consent.		• *Respect for free and informed consent in the field of medicine, EU Charter Art.3* • Right to respect for private life and the protection of personal data, ECHR Art.8, CPIAPPD Art.8 *& EU Charter Art.8* • *Respect for dignity, EU Charter Art.1, UDHR Art.1,* & *Millennium Dec para 6*	

[1] The Beijing Platform also provides at para. 128 Government, IGO and NGO action: "Encourage the dissemination and implementation of the UNHCR Guidelines on the Protection of Refugee Women and the UNHCR Guidelines on the Prevention of and Response to Sexual Violence against Refugees".

Source: Council of Europe, Kelly, L. 2008a. *Combating Violence against Women: Minimum Standards for Support Services. Strasbourg: Council of Europe*, pgs. 51-53.

Case Study: One-stop Centres for South Africa's Survivor's of Sexual Violence

South Africa has created the Thuthuzela Care Centres (TCC) that facilitate multisectoral collaboration between health, police, courts, and social services to provide quality, sensitive treatment for rape survivors. The goals of Thuthuzela Care Centres are to reduce secondary victimization, reduce waiting times and increase conviction rates. The ten centres spread throughout the country provide survivors with a range of services, including: emergency medical care; testing for pregnancy, sexually transmitted infections and HIV; post exposure prophylaxis, antiretrovirals, trauma counselling; court preparation, referrals and follow up support. Survivors are entitled to services even if they do not wish to prosecute the perpetrator (Vaz, 2008).

Successful implementation of Thuthuzela Care Centres is ongoing with growing public awareness of the centres. An analysis of 10 Thuthuzela Care Centres conducted in 2008 found the following challenges:

- staffing shortages;
- a need for increased training;
- inconsistencies in sexual assault management, including HIV testing and provision of post-exposure prophylaxis;
- limited access to psychosocial counseling; and
- inconsistent survivor follow-up systems.

Improvements to the centres include provision of equipment, such as **sterilizing machines**; increased **training** for survivors; creating **child-friendly spaces**; and making Thuthuzela Care Centres more **survivor-friendly** (Vaz, 2008).

See the brochure developed by the National Prosecuting Authority of South Africa.

Read more about the centres and see a list of locations by visiting the UNICEF South Africa website.

Example: The United Kingdom has created a system of Sexual Assault Referral Centers, safe locations where victims of sexual assault can receive immediate and longer-term medical care and counseling. The referral centers bring together all of the relevant legal and medical agencies and departments in a single center, which provides better assistance for the victim and aids criminal investigation. The system is modeled after the St. Mary's Sexual Assault Referral Centre in Manchester, which has been recognized as a model of good practice in providing immediate and "one-stop" services. The St. Mary's Center opened in 1986 and was the first such center in the United Kingdom to provide comprehensive and coordinated forensic, counseling and medical services to adults who had experienced rape or sexual assault. For victims the referral centers system reduces the stress of having to deal with multiple service providers and criminal investigators. Furthermore, practice has shown that victims who receive immediate care and counseling recover more steadily and are less likely to need long-term care. From the perspective of law enforcement, the centers assist the police by providing a centralized facility where they can meet with the victim and gather evidence.

See the UK Home Office website for more information.

Source: Excerpted from *Bringing Security Home: Combating Violence Against Women in the OSCE Region. A Compilation of Good Practices* (Organization for Security and Co-operation in Europe, 2009). OSCE Secretariat, Office of the Secretary General, Gender Selection, pg. 83.

Example: The President's Family Justice Center Initiative, a $20 million USD federal programme to create specialized "one stop shop" multi-disciplinary service centers in the US for victims of family violence and their children, was launched in 2003. The centers are modeled after the San Diego Family Justice Center, which is considered a good practice in the field of victim services. The San Diego Family Justice Center model reduces the number of institutions that a victim of domestic violence, sexual assault and/or elder abuse must go to in order to receive assistance. The family justice center model has several effective features. For example, all relevant partners to a multi-disciplinary approach are co-located at the center (law enforcement, prosecutors,

probation officers, victim advocates, attorneys, healthcare professionals as well as staff representing other community organizations and faith groups). The communities in which these centers are located have policies that emphasize arrest and prosecution of offenders– as well as a history of collaboration among law enforcement, government agencies and civil society. Victim safety, advocacy and confidentiality are the highest priorities under the family justice center model. The family justice centers are located in communities with well-developed specialized services for domestic violence victims and also receive local support from policymakers and the community at large.

See the Family Justice Center website for more information.

Source: excerpted from *Bringing Security Home: Combating Violence Against Women in the OSCE Region. A Compilation of Good Practices* (Organization for Security and Co-operation in Europe, 2009).. OSCE Secretariat, Office of the Secretary General, Gender Selection, pg. 83.

4c. Rape Crisis Centres

- The Council of Europe defines a rape crisis centre as "an NGO that provides some combination of helpline, counselling, advocacy and self-help in supporting women and girls who have been assaulted recently or in the past." One of the features that differentiates these centres from services that are integrated into the health care system is "a practice principle has always been that reporting to state agencies is women's choice." As a result, these centres tend to see a broader group of survivors than those accessing health facility-based services, including survivors who have chosen to not report to the police and who are seeking help for abuse that occurred in the distant past (Council of Europe, 2008a).

  The Council of Europe has identified the following minimum standards for these types of services, which can be used as a guide when considering priorities for programme development:

Table 8.15: Service-specific standards
Rape crisis centres

Minimum standards	Aspirational standards	Human Rights	Support
Services should include: • Anonymous telephone helpline; • One-to-one support and counselling; • Accompaniment to other services i.e. hospital, police, and court. • Group work; • Advocacy.	Should also include awareness-raising and engaging in advocacy in community for social change.	• *Respect for dignity, EU Charter Art.1, UDHR Art.1, & Millennium Dec para 6* • Right to adequate standards of health and medical treatment, Social Charter & Revised Social Charter Art.11, CEDAW Art. 12, ICESCR Art. 12, *EU Charter Art. 35*	
Training for volunteers and staff should be a minimum of 30 hours and include: • A gendered analysis of violence against women (including child sexual abuse); • Confidentiality; • Diversity; • The impacts and meanings of sexual violence, including trauma; • Active listening; • Assessing risk; • Empowerment.	Volunteers/staff should have access to training materials on assessment/intervention and a referral/resource list at all times. All volunteers should have a minimum number of hours (e.g. 8) of ongoing in-service training per year to retain volunteer status.	• *The commitment to gender mainstreaming and creation, improvement, developing or funding of training programmes, Beijing Platform para 124 – see Core Standards* • Right to respect for private life & protection of personal data, ECHR Art.8, CPIAAD Art.8 & *EU Charter Art.8* • *Respect for dignity, EU Charter Art.1, UDHR Art.1, & Millennium Dec para 6* • *Respect for cultural, religious and linguistic diversity, EU Charter Art.22*	
Centres should ensure safety of both service users and staff/volunteers.	• Protocols for suicide calls and crises. • Transportation should be arranged in emergency situations. • Should consider protocols for third-party anonymous reporting i.e. to provide police with information about the type of assault/perpetrator/location for intelligence gathering purpose.	• Prohibition of inhuman treatment, ECHR Art. 3, ICCPR Art. 6 & *UDHR Art.1* • Respect for physical and moral or mental integrity, ECHR Art. 8, *EU Charter Art.3* • *Due diligence to prevent, DEVAW Art 4 (c), Beijing Platform para 124 (b) & CoE Rec(2002)5*	
After hours information can be provided by answering machine and/or be diverted to a national crisis hotline.	Callers leaving messages on answer phones should receive a follow up response in 48 hours. Ideally calls should be answered by staff "live".	As above	
All services should be provided in comfortable private environments.		• Right to respect for private life & protection of personal data, ECHR Art.8, CPIAPPD Art.8 & *EU Charter Art.8* • *Respect for dignity, EU Charter Art.1, UDHR Art.1, & Millennium Dec para 6* • *Governmental commitment to ensuring safe and confidential reporting, Beijing Platform para 124[f]*	
Services should be holistic, and include • Legal advice/advocacy; • Practical support; • Information and referral; • Assistance with compensation.			

Source: Council of Europe, Kelly, L. 2008a. *Combating Violence against Women: Minimum Standards for Support Services. Strasbourg: Council of Europe*, pg. 50.

VI. What are some special considerations when working with specific populations?

A. Adolescents

- While there is no global standard for defining adolescence, it generally describes the *transitional period from chil*dhood t*o adulthood that begins at puberty, and is often characterized as the beginning and end of teenage years* (ages 13-19), but can also be considered to begin as young as 10 years of age.

- Girls are at risk of multiple forms of violence during these years, including:

Son Preference	In various cultures around the world, parents welcome the birth of sons, and are disappointed with the birth of daughters. At its most extreme, son preference can result in practices such as sex-selective abortion of female foetuses and female infanticide which, in some parts of South Asia, West Asia and China, have significantly altered usual female-to-male birth ratios (Plan International, 2007). In other cases, son preference is demonstrated in terms of gross neglect of girls, with sometimes fatal results (ECOSOC, 2002). Sometimes girl-child mortality is the outcome of discrimination against mothers. In settings where mothers do not receive adequate care and nutrition, their children, and especially their girl children, are at increased risk (Plan International, 2007). The most common manifestation of son preference, however, involves favouring the social, intellectual and physical development of a boy child over that of a girl child. **Examples relevant to adolescent girls** include requiring a daughter to quit school in order to take care of household chores, or preventing her from engaging in games and other activities with her peers so she can stay home and supervise younger siblings.
Female Genital Mutilation/ Cutting	Female genital mutilation/cutting, which involves the medically unwarranted excision of all or part of the external female genitalia, is primarily practiced in Africa, most prevalently in Djibouti, Egypt, Eritrea, Ethiopia, Guinea, Mali, Sierra Leone, Somalia and northern Sudan (Toubia, 1999; Carr, 1997). Females typically undergo the practice between the ages of four and 14 (WHO, 1998). The extensive health risks associated with FGM have historically not been sufficient to halt the practice in many settings where social norms are used to dictate women's sexuality. In many settings, FGM increases a girl's prospects for marriage and may, in fact, be a prerequisite. In some traditional Islamic cultures, and despite the increasing number of imams who are speaking out against the practice, FGM may be considered by men and women alike to be 'sunnah', or required practice (Carr, 1997). Across the wide range of cultural, ethnic and religious groups that perform FGM, a shared trait in the perpetuation of the practice is the conditioning of families to accept and defend it. Various myths, such as the one insisting that FGM promotes cleanliness and good health, are used to stigmatise girls who have not been cut. Against this backdrop of social pressure, FGM continues to thrive, even in many settings where governments have outlawed it.

Child Marriage	Early marriage is defined by the Inter-African Committee on Traditional Practices as "any marriage carried out below the age of 18 years, before the girl is physically, physiologically, and psychologically ready to shoulder the responsibilities for marriage and childbearing." (Inter-African Committee, 1993, in Somerset, 2000) This practice is most prevalent in developing countries. In South Asia and sub-Saharan Africa, for example, it has been estimated that on average one in every three girls between the ages of 15 and 19 is already married, and in specific countries the percentages are much higher (Otoo-Oyortey and Pobi, 2003). As with the practice of FGM, the desire to control women's sexuality may be one of the most significant reasons families choose to marry their daughters off at a young age. The practice may be promoted, for example, as a way of reducing a girl's risk of engaging in premarital sex, or as way of maximising her reproductive lifespan. Amongst some African communities, a girl's parents can obtain a higher bride price for a daughter who is a virgin, and therefore perceived to be free from HIV and other sexually transmitted infections. In Asian settings where dowry practices predominate, parents of a girl who is married off young may be able to pay less to the groom's family because younger girls are considered more desirable than their older counterparts. Whatever the material or other benefits to the family, the consequences of child marriage can be deadly for a girl. Complications from early pregnancy, for example, are a leading cause of death for 15- to 19-year-old girls worldwide (black, 2001). If not fatal, early childbearing significantly increases girls' risk for injuries, infections and disabilities, including obstetric fistula. Early childbearing can also pose risks to the girl's child: A baby's chance of dying in its first year of life is 60 percent higher if its mother is under, rather than over, the age of 18 (Black, 2001). Because of biological factors, young wives are also more physically vulnerable than mature women to contracting sexually transmitted diseases, including HIV, from an infected partner—a danger compounded by the fact that girls are even less likely to be able to negotiate safe sex with their partners than are older women.
Intimate Partner Violence	One important risk factor for intimate-partner violence may be the young age of the wife: Research suggests that girls who are married early are at greater risk of violence than those who marry late, especially when the age discrepancy between the girl and her husband is significant (Rubeihat, cited in Black, 2001). Girls who are forced into marriage—exemplified to the extreme in 'abduction marriages' customary in certain parts of Africa, Eastern Europe and Asia—also typically suffer the added trauma of forced sexual initiation. Girls are also more likely to be socially isolated by virtue of their age and lack of independent resources, and therefore less likely to be able to seek assistance for domestic violence. Girls may additionally be more likely to accept the abuse by their partner as part of the power differential in their marriage (Otoo-Oyortey and Pobi, 2003). Young women in many parts of the world also experience dating violence, including controlling behaviours by boyfriends, verbal and physical abuse, and date rape.
Incest	Incest refers to any sexual activity between a child and a closely related family member. Although most cultures around the world have legal and social sanctions prohibiting incest, the problem is nevertheless widespread. The WHO estimates that of 150 million girls and 73 million boys worldwide who have experienced forced sexual intercourse, up to 56 percent of girl victims were abused by family

	members, compared with up to 25 percent of boy victims (UN Study on Violence Against Children, 2006). The peak age of vulnerability to child sexual abuse—whether within the family or committed by someone outside the family—is estimated to be between seven and 13 years of age (Finkelhor, 1994). Cross-culturally, evidence suggests that from 40 percent to 60 percent of sexual abuse in families involves girls under the age of 15 (Kapoor, 2000).

Sexual Violence in Schools	While data on girls' exposure to sexual violence in schools is still limited, existing evidence paints a grim picture: In research undertaken in public schools in the United States, for example, 83 percent of girls surveyed in grades 8 through 11 reported exposure to some form of harassment (Newton, 2001). In many instances, the perpetrators are those who are entrusted with girls' care and protection. Studies from Botswana, Ghana, Malawi, Zimbabwe and Pakistan indicate that teachers as well as male students expose girls to sexually explicit language and/or sexual propositions (Dunne, Humphreys and Leach, 2003; UNICEF and Save the Children, 2005). And the threat to girls is not only limited to the school grounds: Research from Peru found that a girl's risk of sexual violence increases in relation to the distance she must travel to get to school (UN Study on Violence Against Children, 2006). This situation is exacerbated in school settings where there are few female teachers, especially in positions of authority. In many developing countries around the world, male teachers far outnumber female teachers. Such male-dominated contexts make it difficult for girls to challenge male authority and/or seek assistance. As such, girl students are likely to be exposed to violence both *because of* and as a *method for reinforcing* their lower status in relation to boys and to their male teachers. With regard to the former, boys can often bully, harass and even assault girls with relative impunity because girls have little recourse to protection in male-dominated school settings. With regard to the latter, boys may target girls who breach traditional norms of female subservience, such as those who are student leaders and/or are performing well in school, in order to 'put them in their place'.
Sexual Violence in the Community	Given vulnerabilities associated with their age, physicality and lack of negotiating power, it is likely that adolescent girls are among the highest of all risk groups for sexual violence perpetrated against them by members of their community. However, for many girls around the world, sexual aggression by boys and men is normative, and therefore not perceived by girls (or boys) as criminal unless it crosses the bounds into more conformist definitions of rape. Notably, 11 percent of adolescents responding to a survey conducted in South Africa reported being raped, but a further 72 percent reported being subject to forced sex. (Jewkes et al., 2000, in Bennett, Manderson and Ashbury, 2002). Average estimates of coerced first sex among adolescent girls around the world range from 10 percent to 30 percent, but in some settings, such as Korea, Cameroon and Peru, the number is closer to 40 percent. Research from the Caribbean suggests that forced first intercourse there is as high as 48 percent (Koenig et al., 2004, Jejeeboy and Bott, 2003, Ellsberg and Heise, 2006). Importantly, younger adolescent girls appear to be most at risk, as the likelihood of sexual initiation being coerced or forced decreases as girls get older. Multi-country research conducted by the WHO found that women who reported (retrospectively) that their first sexual experience was before the age of 15 were more likely to have been forced or coerced than those who reported initiation before the age of 17 years. Those who reported sexual initiation after 17 years of age were the least likely of all women surveyed to report that it was forced (UN Study on Violence Against Children, 2006).
Trafficking and Sexual Exploitation	According to UNICEF, the majority of the estimated one million children who are forced or coerced into the sex trade each year are girls (UNICEF, 2005). Many of these girls are victims of global trafficking networks. While the highest numbers

of Girls	of prostituted children—some as young as 10 years of age—are thought to be concentrated in Brazil, India, Thailand, China and the United States, experts agree that child prostitution is a worldwide phenomenon that is not only on the rise, but ensnares increasingly younger girls (Willis and Levy, 2000). Although much more difficult to measure, a significant amount of sexual exploitation of children occurs outside the context of commercial markets. Children may engage in 'survival' sex for subsistence money or goods, or be taken in by 'sugar daddies', or older men who offer them presents, school fees, etc. in exchange for sexual favours. Emerging data suggests that the growing number of AIDS orphans in sub-Saharan Africa are at special risk: 47 percent of surveyed children in Zambia who were selling sex for money had lost both their father and mother to AIDS, and 24 percent had lost one parent (UN Study on Violence Against Children, 2006). Whether in commercial or non-commercial markets, children who are poor, uneducated, homeless, or for other reasons exist in society's blind spot are those at greatest risk of being sexually exploited—and those least likely to receive assistance.

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

ADOLESCENTS	FAMILIES	PROVIDERS	FACILITIES
• Embarrassment	• Low position of girls in families	• Judgmental attitudes	• Non-availability
• Ignorance	• Lack of health knowledge	• Inability to talk/ listen to/treat adolescents	• Overcrowding • Long waiting times
• Fear	• Poverty • Low priority of sexual and reproductive health	• Legislative restrictions	• Low priority of sexual and reproductive health and insufficient supplies

Source: Excerpted from Temin, M. and Levin, R., 2009. *Start with a Girl: A New Agenda for Global Health*. Center for Global Development, p. 41.

- Some factors considered by young people to be most important in youth-friendly services include confidentiality, privacy, short waiting time, low cost, and friendliness to both young men and young women (Erulkar, A.S., Onoka, C.J. & Ohir, A., 2005, cited in Shaw, 2009; Mmari, K.N. & Magnani, R.J, 2003; Kipp et al., 2007). Other key considerations that all health programming should take into account when working with adolescents are:

WHO framework for youth-friendly health services

To be considered youth-friendly, services should be equitable—all adolescents, not just certain groups, are able to obtain the health services they need; accessible—adolescents are able to obtain the services that are provided; acceptable—services are provided in ways that meet the expectations of adolescent clients; appropriate—services that adolescents need are provided; and effective—the right services are provided in the right way and make a positive contribution to the health of adolescents.

Other specific characteristics make services youth-friendly. These include procedures to facilitate easy confidential registration, short waiting and referral times, and capacity to see patients without an appointment. Their providers are non-judgmental, technically competent in adolescent-specific areas and health promotion, and backed by compassionate support staff. The facilities should be convenient and allow for privacy. And importantly, they should be accompanied by community-based outreach and peer-to-peer dialogue to increase coverage and accessibility (B. J. Ferguson, pers. comm.; WHO 2003a).

Excerpted from Temin, M. and Levin, R., 2009. *Start with a Girl: A New Agenda for Global Health*. Center for Global Development, p. 45.

- As young girls are entering adolescence, the health sector may want to institute methods for assessing the particular vulnerabilities girls face in order to address their current needs and anticipate their future needs.

Excerpted from Temin, M. and Levin, R., 2009. *Start with a Girl: A New Agenda for Global Health*: Center for Global Development, pg. 46.

A modest proposal: the 12-year-old check-in

As a young girl enters early adolescence, she is at a critical point in time for protective health interventions. A 12-year-old check-in provides a scheduled and uniform way to ensure that girls most vulnerable to unhealthy outcomes receive the care they need and may have missed in childhood. This could be an important platform for girls themselves and for global health in general. Judith Bruce and colleagues at the Population Council have developed a promising idea in the spirit of "leaving no girl behind."

As with early childhood health schedules, donors and national health ministries can codify an age-benchmarked check-in wherein adolescent girls, in a rolling fashion across a district or country, are reliably contacted at this propitious moment. This social gateway can be used to find out where girls are on basic health indicators and the social conditions that underlie health outcomes (see table). Screening can be conducted for universal health concerns such as vision and hearing, but also for detection of country-specific health priorities such as malaria, sickle-cell anemia, and HIV. Gaps in immunization can be corrected; the HPV vaccine and other more sophisticated health technologies can also be made available, where appropriate.

Girls might be offered information about the core rights framing their health and development, such as minimum age for legal marriage, ages of consent for sexual relations, voting, working, and opening a savings account. This moment can also be used to inform parents and their children about their rights before child marriage, unsafe migration, FGC, and other gender-linked practices set in. An inventory of girls' status in terms of their living arrangements arrangements (e.g. with two parents, with one parent, with no parents, in a foster home, or as a domestic worker) and schooling level and plans can be conducted to connect them to appropriate services as needed. Ambitious programs might provide key assets, such as IDs and the opening of entry-level small savings accounts (possibly in partnership with the private sector). Additionally, it could provide a safe venue for adolescents to be confidentially queried about sensitive topics.

Check-in Wellness Components	
Health	**Social**
Physical exam	Counseling
Immunizations review and catch-up	Life-skills building
Nutrition/growth check-up	Educational assessment and support
Sexual and reproductive health information and services	Peer and social support screening and improvement
HPV vaccine (when available)	Drugs/alcohol/smoking screening and support for addictions prevention
HIV/AIDS prevention information	Family wellness and social support
Violence screening and support	Citizenship and social participation skill building and motivation
Mental health screening and support	
Injury screening and prevention	

Such a check-in lends itself to effective implementation through many avenues and features:

- Annual, community-based health campaigns
- Outreach and incentives promoting universal coverage
- Core campaign teams reaching the most vulnerable and excluded girls
- Private-public partnerships
- Social mobilization
- Household visits
- Central administration
- Recruitment and fielding of female community health workers to conduct screenings

The 12-year-old check-in provides an opportunity to find the often hidden information on adolescent girls apart from the aggregated numbers. Health and demographic data can be collected and tracked, and allow for a longitudinal assessment of women's health, pooling a subset of girls at critical ages.

This proposal originated in Judith Bruce, "The diverse universe of adolescents, and the girls and boys left behind: A note on research, program and policy priorities," background paper to *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals* (New York: UN Millennium Project, 2005). Additional applications with respect to Guatemala and sub-Saharan Africa were elaborated by Population Council colleagues Jennifer Catino and Martha Brady. This box is based on the background note "Poor Adolescent Girls—Still Lost Between Childhood and Adulthood—The Case for a 12-year-old Check-in" for the presentation entitled "Making Critical and Timely Investments in Adolescent Girls' Health: Why and How," prepared by Judith Bruce for the G-8 International Parliamentarians' Conference: Strategic Investments in Times of Crisis—The Rewards of Making Women's Health a Priority.

In addition, different types of health services should tailor their services according to the specific needs of their adolescent patients. **Sexual and reproductive health services** are particularly relevant. Many reproductive health initiatives for young people have assumed that sexual activity is voluntary and therefore have aimed to help young people manage their sexual activity responsibly. This approach ignores evidence that many girls and young women experience forced sex and/or cannot negotiate sex, condom use or other contraceptives without fear of physical violence (Jejeebhoy and Bott, 2003). Some methods for improving reproductive health services include:

- **Increased availability of contraception and other sexual health services for adolescent girls.** This not only requires that health providers are sensitized the adolescent sexuality and are comfortable discussing sexual issues with adolescents, but also that sexual and reproductive health services and commodities are located in geographic areas convenient to adolescents, but that also promote privacy and confidentiality.
- **Establishing linkages with the larger community.** Even when health services do improve their capacity to respond to the needs of adolescents, community attitudes may discourage adolescents from seeking care and treatment (Mmari and Magnani, 2003). It is therefore critical that providers work with the community in promoting understanding of the importance of adolescents seeking and receiving sexual and reproductive health services.
- **Universal screening for married adolescents.** All married female adolescents should be considered high-risk and screened accordingly for violence. Prenatal and MCH services are the main entry point to reach girls in child marriage, at time of first pregnancy. Pre-natal and MCH health personnel should be trained to educate and treat girls in child marriages with sensitivity to their risks, vulnerabilities, and needs, including pre-term labour, adequate nutrition, importance of emergency obstetric care, referral for voluntary counselling and testing, etc.
- **Establishing linkages with school-based services.** When screening in health services reveals that pregnancy or STI/HIV infection is due to school-based sexual harassment, the health sectors needs to collaborate with the educational system so that all are working in concert to protect girls from rape. In addition, close cooperation with the educational system would allow the establishment of school-based services, usually an office within the school and a nurse trained in adolescent-friendly sexual and reproductive health care and in screening and counselling.
- **Conducting prevention campaigns among youth on early marriage, teen relationship violence, sexual exploitation, etc.**

Example: In 2000 the Mexican NGO Fundacion para la Equidad (the Foundation for Equity), created a programme to prevent violence among youth aged 14 to 29 years in response to finding that girls and women, ages 16 to 24 years, were the most vulnerable to violence. The programme is designed to prevent violence particularly among “novios” i.e. girlfriend/boyfriend relationships and fiancés. Ongoing sessions in Mexico City in the Fundacion clinic are given to those who have suffered violence, either within a relationship or within their family. Sessions are conducted by women facilitators and are three hours long. These sessions cover issues such as: relationships, new gender norms,

sexuality, contraceptives, reproductive rights, violence against women and girls, types of violence, cycles of violence, legal issues, and how to construct non-violent relationships. Through these sessions the programme seeks to transform participants into advocates to combat violence against women and girls

Source: excerpted/adapted from: APIS Fundacion para la Equidad, Mexico: & Bustamente, N., 2007. *Modelo de Atencion y Prevencion de la Violencia Familiar y de Genero: Nosotras en la Violencia Familiar.* Mexico City, Mexico: APIS, Fundacion para la Equidad, A.C.

Example: In 2004, the Mexican NGO Instituto Mexicano de Investigacion de Familia y Poblacion (Mexican Institute of Family and Population Research) created a training programme for adolescents entitled, "Rostros y Mascaras de la Violencia" (Faces and Masks of Violence). This programme is directed at adolescents age 13 to 16 years and is provided in a low-income area of Mexico City thorough the government agency, "Desarollo Integral de la Familia" (Essential Family Development). The programme is 20 hours long (10 sessions of two hours each) and addresses the issue of violence in the context of friendships and relationships.

A survey conducted among 81 adolescents both before and after participating in this programme found that attitudes towards violence and relationships changed. This was demonstrated through an increase in correct answers to the following five survey questions (note correct answers to every issue listed is "false"): 1) Love means you can forgive anything (from 44% to 83%), 2) Jealousy is proof of love (from 28% to 77%), 3) Women who put up with violence do it for love (from 19% to 61%), 4) Men are violent by nature (74% to 83%), and 5) Only young and attractive women are raped (60 to 65%). The programme has developed a number of tools and set-up a YouTube channel that provides information on its programming as well as on IMIFAP campaigns against violence within "noviazgos" (dating relationships).

The tools are available in Spanish.
The videos are available in Spanish.

Source:Adapted from Instituto Mexicano de Investigacion de Familia y Poblacion

Case Example: Established in 1999, *Geração Biz* (Busy Generation) is a multisectoral adolescent reproductive health programme in Mozambique. Implemented by the Ministries of Health, Education, and Youth and Sports, with technical assistance from UNFPA and Pathfinder International, *Geração Biz* addresses the sexual and reproductive health needs of both in-school and out-of-school adolescents, giving attention to violence against women and girls. This is done through youth friendly clinical services, school-based interventions, community based outreach, peer education, and HIV/AIDS support. First implemented through two pilot sites in Maputo and in Zambézia Provinces, Geração Biz has since been extended to 62 districts in 10 of the country's 11 provinces and

involves 26 local organizations in programme implementation. At the request of UNFPA, an external evaluation of *Geração Biz* was conducted in 2004. The evaluation found evidence that *Geração Biz* had had a significant impact on young people's knowledge, attitudes and behaviour. Heightened community awareness and sharply increased reporting of violence against women and girls were positive outcomes, but the evaluation showed that providers needed to incorporate more discussion on violence against women and girls within the context of youth friend service visits, even if the clients did not request it.

Source: adapted from: Hainsworth, G. and Zilhão, I., 2009. *From Inception to Large Scale: The Geração Biz Programme in Mozambique*. Geneva: World Health Organization, Pathfinder International.

Additional Resources:

- ***The Family Health International Youth Net*** is a global programme committed to improving the reproductive health and HIV/AIDS prevention behaviours of youth 10-24 years of age. Family Health International publishes training materials that assist programme planners and those working in clinical settings to meet and understand the specific needs of youth. The materials are available in English.

- ***The Coalition for Adolescent Girls*** is committed to creating lasting change for communities in the developing world by driving investments in adolescent girls. The idea behind this initiative is that when girls are educated, healthy and financially literate, they will play a key role in ending generations of poverty. For more information, see the website.

- ***Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents - Chapter 7: Counseling Victims of Sexual Violence*** (Family Care International, 2006). This guide is for health service providers. The chapter highlights the problem of forced sex for many adolescents and outlines key questions for health providers to ask during counseling sessions to identify young people who are survivors of or at risk for violence. Available in English and Spanish.

- ***Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*** (United Nations Population Fund and Save the Children USA, 2009). This Toolkit provides user-friendly tools for assessing the impact of a crisis on adolescents, implementing an adolescent-friendly *Minimum Initial Service Package*, and ensuring that adolescents can participate in the development and implementation of humanitarian programmes. Other tools are specifically designed for healthcare providers to help them be more effective in providing and tracking services for adolescents at the clinic and community levels. Available in English, French and Spanish.

B. Disabilities

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

- In general, however (and regardless of the disability), health care providers should at minimum understand that women and girls with disabilities may be at the same or higher risk for violence than those without disabilities due to issues of power and control. In order to assist women and girls with disabilities, health programs should develop specific policies for working with disabled and health care providers should receive specific training. Health facilities should also consider the following strategies:

    - **Conduct community outreach:** Women and girls with disabilities may face challenges accessing treatment because they may be isolated in their homes, or in institutions, and in some instances may have limited knowledge about their bodies and sexual and reproductive health and therefore not understand the importance of receiving care. The health system needs to devise strategies to reach out to women and girls with different types of disabilities, and ensure they have access to services.

    - **Improve facility infrastructure to meet the needs of women and girls with disabilities:** This may include providing wheelchairs and wheelchair access, interpreters for the deaf, special examination equipment that prioritizes comfort for those with physical impairments, etc. Health facilities can engage local organizations working specifically with disabled people to determine what other accommodations should be made.

    - **Recognize and address the specific vulnerabilities to violence that women with disabilities may face.**

        - Develop screening protocols that recognize some of the particular tactics associated with abuse of disabled women and girls, including manipulation of medication; financial exploitation; destruction of or withholding of assistive devices; neglect or refusal to help with personal care (such as toileting); emotional abuse that is specifically focused on a victim's disability (Hoog, 2003).

        - Ensure that screening for violence against women and girls is done in an initial private interview, if possible without the caretakers' presence. Some women and girls with disabilities have caretakers who may be the perpetrators of violence, whether they are family members, staff in institutions, or paid caretakers. Women and girls with disabilities often depend on their caretakers for survival and daily living, which makes it very difficult for them to leave abusive situations (Hoog, 2003).

Screening for Domestic Violence among Women with Disabilities

Key points to remember:

- Develop screening questions that help an advocate determine what barriers the victim has experienced or fears she may have about using domestic violence services.
- Develop screening questions that identify the victim's strengths and her expertise in understanding how her disability affects her abuse experience. Develop screening questions that recognize the ways a victim's disability may have affected her abuse experience and her daily life activities.
- Develop screening questions that identify the physical environment of the abusive situation and the relationship of the abuser. For example, is the person living in a group home institution or private home? Is the perpetrator a personal care attendant or possibly a guardian of the victim?
- Develop screening questions that assist an advocate in determining what resources are available to the victim because of her disability, and if the victim has any concerns about that support system's possible alignment with the abuser or inability to maintain confidentiality.

Sample screening questions:

- Is there anything I need to know about you to be able to provide the best services possible?
- Does anyone control your communication with others or change what you are trying to say?
- Has anyone taken or broken something that you need to be independent? For example, your cane, walker, wheelchair, respirator or TTY?
- Does anyone have legal control over your money or your decisions? What happens if you disagree with them about their decisions?
- Does anyone prevent you from using resources and support you need to be independent? For example, resources such as vocational services, personal care attendants, disability agency support person, specialized support personnel for Deaf-Blind, readers or interpreters?
- Has anyone refused to give you your medication, kept you from taking your medication or given you too much or too little medication?
- Do you have any health issues that can become dangerous if neglected, such as diabetes, epilepsy, skin sores, cancer or heart disease?
- If you depend on caregivers, does your caregiver use your need for assistance to keep control over you? Do you have emergency back-up caregivers?

Excerpted from Hoog, C., 2003. "Model Protocol on Screening Practices for Domestic Violence Victims with Disabilities", pg. 7, with information from *Curry*, M.A et al., 2002. *Development of An Abuse Screening Tool for Women with Disabilities.*

Example: **Sada Action Strategy – New South Wales**. The Sexual Assault in Disability and Aged Care Residential Settings (SADA) action strategy, auspiced by People With Disability Australia Incorporated, aims to identify best practice in preventing and responding to sexual assault. It was initiated in 2005 by the Northern Sydney Sexual Assault Service in response to the number of people with disability and older people

approaching their service as victims of sexual assault (People with Disability, 2007). In 2006, the project received 2-year funding from the Office for Women to continue its work. The SADA action strategy has involved a number of consultations with stakeholders including across disability, aged care, police and sexual assault sectors in order to identify strategies for action to enable a better response to sexual assault of people living in disability and aged care residential settings. Findings from these consultations have emphasized the importance of recognizing both the sexuality of people with disability as well as their vulnerability to sexual assault (People with Disability, 2007). The project has a website where they are collating existing tools and resources for disability and aged care services to guide prevention and responses to sexual assault. The next phase of the project is to pilot a training package for staff in the disability and aged care sectors on recognising and responding appropriately to sexual assault.

For more information visit the website.

Source: excerpted from Murray, S. & Powell, A., 2008. "Sexual assault and adults with a disability: Enabling recognition, disclosure and a just response" Australian Centre for the Study of Sexual Assault, p.11.

Example: **Family Planning Australia**. Family Planning in most states and territories offer education and professional training as well as access to resources and information regarding sexuality and relationships for people with disabilities, their parents/carers and professionals working in the disability field. This includes formally accredited training for professionals in the disability sector, as well as consultation and seminars on developing sexuality education programs for people with a disability. Most states also have a disability resource library with materials that can be loaned or purchased, including sexuality and relationshipeducation services for people with disabilities, their parents/ carers and professionals working in the disability field. Family Planning services also offer direct, specialist individual sexuality education for people with a disability. For example, Family Planning Victoria (FPV) run a "Sexuality Education and Intervention Service" which provides education and intervention services to people whose behaviour is placing them at significant risk of sexually offending or being sexually exploited due to lack of knowledge. FPV has developed a "Sexual Assault and Intellectual Disability Resource Kit" for working with victim/survivors of sexual assault who have an intellectual disability. Family Planning New South Wales, with funding from the New South Wales Department of Ageing, Disability and Home Care, provide education and training for professionals in the disability sector to better identify and respond to inappropriate and abusive sexual behaviours.

For more information, see the website.

Source: excerpted from Murray, S. & Powell, A., 2008. "Sexual Assault and Adults with a Disability: Enabling Recognition, Disclosure and a Just Response" Australian Centre for the Study of Sexual Assault, pgs.11 & 13.

Illustrative Resources:

- ***Model Protocol on Screening Practices for Domestic Violence Victims with Disabilities*** (Hoog, C., 2003). Available in English.

- ***The Women with Disabilities Australia*** website has a sexual and reproductive rights section, including a number of resources that address violence. Available in English.

- ***Violence against Women with Disabilities (USA) –*** This website provides numerous resources on addressing violence against women with disabilities. Available in English.

- Center for Research on Women with Disabilities at Baylor College of Medicine includes an overview of domestic violence among women with disabilities, as well as educational and other resource materials, including: Gynecological Considerations in Treating Women with Physical Disabilities (ppt) and Improving the Health and Wellness of Women with Physical Disabilities--Clinical Perspectives (ppt)

- ***Sexual and Reproductive Health of Persons with Disabilities: Emerging UNFPA Issues*** *(*UNFPA, 2007). Available in English.

C. Sex Workers

- Because sex work is illegal and/or stigmatized in many settings around the world, sex workers are often marginalized. Their marginalization puts them at risk of violence in multiple ways: they may work alone, in unfamiliar areas, and without the protection of the police; they may be unable to develop supportive networks that could help them avoid dangerous clients or dangerous settings; and they may seek out the protection of gangs or others operating outside the law, leading to further risk of exploitation and abuse. Sex workers may also not be aware of their rights and may be less likely to consider an act violence if it does not necessitate hospitalization, decreasing their likelihood of reporting violence which in turn limits their ability to prevent future violence (International HIV/AIDS Alliance, 2008; WHO, 2005b).

- Even when sex workers do seek out assistance, they may be met with further abuse. Within the health sector, for example, when health professionals are not adequately trained, they may reflect the stigma in the surrounding culture through judgmental or abusive treatment. Health services may subject sex workers to disapproval, refusal to treat their health problems, mandatory HIV testing, exposure of their HIV status and threats to report them to the authorities. Sex workers who have been raped or beaten may be blamed, or have their concerns dismissed (Montgomery, R., 1999 & Amin, A., 2004, cited in World Health Organization, 2005b).

- The minimum standard to which any health service should be held is to do no harm. Therefore, it is essential for health services to train staff to treat sex workers with the same respect and compassion that they would treat any other person, and to not report them to authorities. However, their vulnerability to sexual violence means that it is essential to go beyond that minimum standard, to provide sex workers with supportive and rights-based counselling, voluntary testing for HIV, and referrals to

legal assistance if available. In addition to providing the full array of violence-related services described in Build institutional capacity to address violence against women and girls in hospitals, health clinics, and other primary and secondary health facilities, health facilities should also be prepared to:

- Provide sex workers with information on their rights and that violence is a violation of rights.
- Provide sex workers with information on where they can safely go for help on violence issues.
- Provide safe places to disclose violence with ensured confidentiality and privacy.
- Provide health services near sex workers' places of work, such as clinic within the hotels frequented by sex workers.
- Promote sex worker organizations that can advocate for quality of care medical treatment for sex workers.
- Train service providers by sex workers on how to provide care in a non-stigmatizing way

Sources: WHO and Global Coalition on Women and AIDS, UNAIDS, 2005b; UNAIDS, 2009.

- Violence against sex workers is one of the factors driving the HIV epidemic in many countries, because violence against women and girls is linked to their inability to insist on use of condoms, thus consequent inability to protect themselves as well as their clients. HIV programs have an important role to play in addressing violence. The International HIV/AIDS Alliance has documented some ways in which HIV/AIDS services can help to address violence against sex workers by enlisting the participation of sex workers in the training of providers and development of protocols:

    - HIV/AIDS projects can assist sex workers to conduct training for health service providers, in order to show them how they should **address and treat sex workers in a non-abusive and non-stigmatising way**. Sex workers can work with health services to develop guidelines that promote safety, confidentiality, and non-discriminatory care and support (International HIV/AIDS Alliance, 2008).

Example: In 2003, the Bill & Melinda Gates Foundation launched Avahan, an initiative to reduce the spread of AIDS in India. Avahan specifically supports programs that serve groups that are most vulnerable to HIV infection, including sex workers and their clients and partners. Through their interventions for work sex workers, Avahan has aimed to reduce the incidence of HIV among sex workers and their partners, reaching 59,000 sex workers since 2004. These interventions have included instituting a system whereby health workers are sensitized to provide appropriate health care to sex workers and sex worker peer educators are oriented to help each other and contact providers and police when subjected to violence or coercion. Within 12 months of introducing this system, the project responded to all reported crises within 20 minutes, benefitting 6,507 sex workers, leading to improved condom negotiation. Prior to this project, the previous response time

was 8 hours and a response rate of only 80% of reported cases (Gaikwad and Kumar, 2008).

Example: Médecins sans Frontières (MSF) faced a particular challenge in its work with migrant sex workers in Svay Pak, Cambodia. From MSF's perspective, providing only clinical services was not enough to ensure the effectiveness of their efforts to combat HIV/AIDS. It was important to find ways of addressing some of the broader issues affecting sex workers' vulnerability and risk, in a way that did not threaten the brothel owners or other powerful groups such as the police. However, they were working in an area where sex workers faced serious restrictions, with their movements being controlled by brothel owners and the police. The owners of the brothels were generally suspicious of the activities of any organizations that tried to work with the sex workers, although they were keen to allow sex workers to attend clinical services. MSF therefore worked with sex workers to set up a drop-in centre just above the clinic. The centre provided an informal safe space which sex workers could attend at the same time as they made visits to the clinic. In time, the centre began to organize regular group activities including structured discussions about well-being, about common needs of the community and ways of acting upon them. Gradually, it became possible to organize discussions on sensitive issues such as violence and how to avoid it, although facilitators were very careful to allow these discussions to emerge in their own time, rather than forcing the issue. (Busza, J., Hom-Em, X., Ly, S., Un, S., 2001. "Petals and thorns: the dilemmas of PLA and debt bondage", PLA Notes, 40.

Source: excerpted from International HIV/AIDS Alliance, 2008. "Sex Work, Violence and HIV", pg. 20.

Additional Resources:

- ***Sex Work, Violence and HIV. A Guide for Programmes with Sex Workers*** (International HIV/AIDS Alliance. 2008). Available in English. Also see AIDS Alliance website.

- ***UNAIDS Guidance Note on HIV and Sex Work*** (Joint United Nations Programme on HIV/AIDS, 2009). Available in English and French.

- ***The Global Network of Sex Work Projects (NSWP).*** See the website and see "Violence, Repression and Other Health Threats," (Wolffers, I. 2001) in Issue 4: Risk and Violence of *Research for Sex Work*. Available in English.

D. Migrants

- There are both internal migrants -- generally rural to urban within the same country – and transnational migrants, or those who migrate from one country to another. Most often, migration is driven by poverty and lack of opportunity at home, and the perception of better employment opportunities in the destination city or country.

- A large proportion of women and girl migrants end up working low-paying, unstable jobs in the service industry (e.g., waitressing), or in the informal sector (domestic work, farm work, and sex work) (UNFPA, 2006a). Female migrants of all ages are at risk for violence and sexual harassment because of issues such as isolation, exploitation, lack of legal protection, and limited access to protective services. An IOM study in South Africa of male and female migrant farm workers determined that the female workers were particularly vulnerable to HIV infection, with the risk greatly heightened among young women (International Organization for Migration, 2009).

- Many migrants do not have access to adequate sexual and reproductive health care or any other health services due to lack of legal immigration status, lack of health insurance, cultural or linguistic barriers, lack of information about available services, and poverty. Female migrants who have been sexually abused or forced into sex work and live with HIV/AIDS often do not seek medical attention out of shame or fear (Global Migration Group, 2008).

- An important first step in ensuring access to health services for migrants is addressing the need for protective laws and policies that ensure non-discrimination against migrants, and educate providers to recognize the high risk of violence among women and girls who are migrants**.** Laws and policies should be developed not only for migrants working in foreign countries, but also for internal migrants, and those who are repatriating to their home settings.

- In addition, health facilities may need to conduct community outreach in order to identify and assist migrant workers. As with any specialized population, health care providers should involve migrant workers and migrant-focused organizations in the design and delivery of community outreach. Health facilities should make information available that is culturally sensitive, and have strategies for addressing language barriers and literacy levels of the targeted group, such as having interpreters available to assist in conducting intake interviews and in clarifying treatment processes**.**

Example: The Government of Jordan, in collaboration with UNIFEM, developed a labour contract for non-Jordanian domestic workers that guarantees the rights of migrant women to life insurance, medical care and rest days, and is considered a requirement for obtaining residency, a work permit and a visa to enter Jordan (United Nations Secretary General, 2009).

Example: The Overseas Workers Welfare Administration (OWWA) in the Philippines offers returning migrant workers health services, counselling, and voluntary HIV testing and counselling, along with many other services to assist with repatriation (UNAIDS, ILO, and IOM 2008).

Example: In partnership with the Institute of Sociology of the Chinese Academy of Social Sciences (CASS), UNESCO started the “Together with Migrants” project in 2002 that seeks to promote the integration of women migrant workers in the urban social and

economic fabric through training in life and basic skills, vocational training, career counselling, family planning, health and rights. In recent years, the project has broaden its partnerships to include contemporary Chinese artists in order to encourage, through contemporary art, non-discriminatory public perceptions of migrant women workers (Excerpted from UNESCO, 2010).

Resources:

- ***An Action Oriented Training Manual on Gender, Migration and HIV*** (International Organization for Migration, 2009a). Available in English.

- The Secretary-General regularly produces a report on the issue of violence against women that includes updates on member states' activities to address the protection needs of migrants. The 2009 report is available in English.

- The Secretary-General's database on violence against women includes a search item on migrant women that provides access to brief summaries of policies and programs focusing on migrants. Available in English.

E. Trafficked Women and Girls

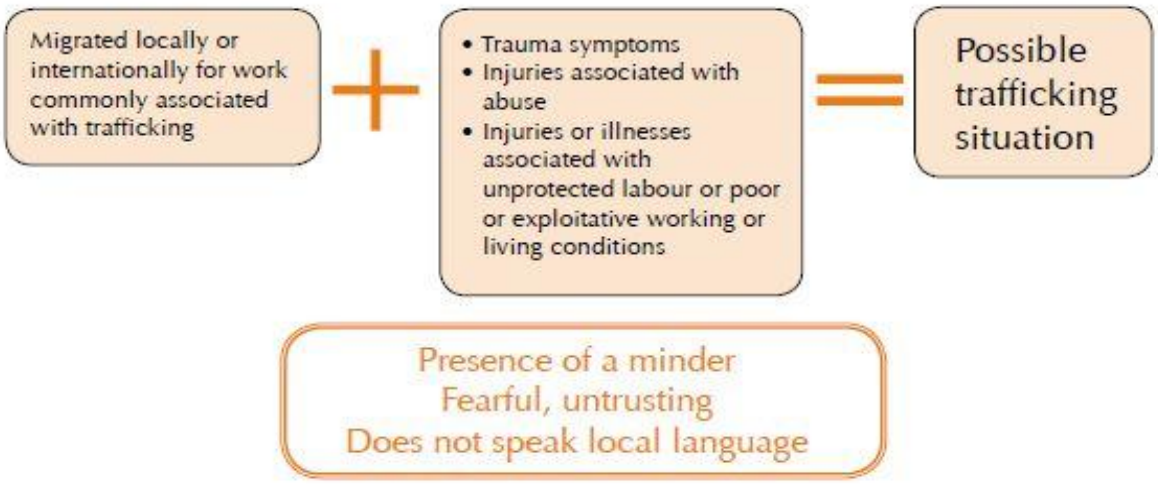
- According to the Palermo Protocol, trafficking means: "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs" (United Nations 2000, Art. 3).

- Involuntary servitude is the essential feature of trafficking. In 2010 over 12 million people around the world are estimated to be trafficked. (US Dept of State, 2010). The most common form of human trafficking is sexual exploitation, and the majority of victims of sexual exploitation are women and girls (UNODC, 2009).

- As each trafficking incident unfolds, the victim experiences threats to her physical and metal health. From the pre-departure stage, to the travel, transit and destination stages, through to detention, deportation and integration or return and reintegration, women and girls may experience repeated physical, sexual and psychological abuse or torture.

- **Policies and protocols should assume health risks for trafficked women**. Although trafficked women and girls could present at any type of service, including emergency rooms, the high health risks that they face mean that it is essential to provide information, counselling, and services.

- As increased attention to ending trafficking and supporting victims of trafficking occurs through government and NGO programs, health providers will come into increased contact with trafficked women and girls. Health care providers should know the clues for identifying whether a person has been trafficked:



Source: excerpted from UN.GIFT (United Nations Global Initiative to Fight Trafficking), IOM (International Organization for Migration) and the London School for Hygiene and Tropical Medicine. 2009. *Caring for Trafficked Persons: Guidance for Health Providers.*

- Many trafficked women and girls are under such tight controls that they have no access to health care, despite the serious health risks they are subject to. When health personnel do come into contact with them, trafficked women and girls may be reluctant to disclose their situation for fear of prosecution (where sex work is illegal) or of deportation, since they are often in the receiving country illegally (Amnesty International, 2006). Health care providers should be especially aware of security risks that trafficked women face, and should attempt to interview women privately in a secure, soundproof room. Even if the provider does not speak the language of the client, translation should not be conducted by any person(s) accompanying the client.

- In all cases, the health providers' main task to provide all required care and counselling according to the same guidelines and procedures as for all women affected by violence, but with special attention to safety assessment and safety planning, as well strict confidentiality.

- Health care providers should also abide by the following principles when engaging with trafficked women:

1. Adhere to existing recommendations in the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women (*Available in Armenian, Bosnian, Croatian, English, Japanese, Romanian, Russian, Spanish and Serbian)

2. Treat all contact with trafficked persons as a potential step towards improving their health. Each encounter with a trafficked person can have positive or negative effects on their health and well-being.

3. Prioritize the safety of trafficked persons, self and staff by assessing risks and making consultative and well-informed decisions. Be aware of the safety concerns of trafficked persons and potential dangers to them or their family members.

4. Provide respectful, equitable care that does not discriminate based on gender, age, social class, religion, race or ethnicity. Health care should respect the rights and dignity of those who are vulnerable, particularly women, children, the poor and minorities.

5. Be prepared with referral information and contact details for trusted support persons for a range of assistance, including shelter, social services, counseling, legal advocacy and law enforcement. If providing information to persons who are suspected or known victims who may still be in contact with traffickers, this must be done discretely, e.g., with small pieces of paper that can be hidden.

6. Collaborate with other support services to implement prevention activities and response strategies that are cooperative and appropriate to the differing needs of trafficked persons.

7. Ensure the confidentiality and privacy of trafficked persons and their families. Put measures into place to make sure all communications with and about trafficked persons are dealt with confidentially and that each trafficked person is assured that his or her privacy will be respected.

8. Provide information in a way that each trafficked person can understand. Communicate care plans, purposes and procedures with linguistically and age-appropriate descriptions, taking the time necessary to be sure that each individual understands what is being said and has the opportunity to ask questions. This is an essential step prior to requesting informed consent.

9. Obtain voluntary, informed consent. Before sharing or transferring information about patients, and before beginning procedures to diagnose, treat or make referrals, it is necessary to obtain the patient's voluntary informed consent. If an individual agrees that information about them or others may be shared, provide only that which is necessary to assist the individual (e.g., when making a referral to another service) or to assist others (e.g., other trafficked persons).

10. Respect the rights, choices, and dignity of each individual by

• Conducting interviews in private settings.

• Offering the patient the option of interacting with male or female staff or interpreters. For interviews and clinical examinations of trafficked women and girls, it is of particular importance to make certain female staff and interpreters are available.

• Maintaining a non-judgmental and sympathetic manner and showing respect for and acceptance of each individual and his or her culture and situation.

• Showing patience. Do not press for information if individuals do not appear ready or willing to speak about their situation or experience.

• Asking only relevant questions that are necessary for the assistance being provided. Do not ask questions out of simple curiosity, e.g., about the person's virginity, money paid or earned, etc.

• Avoiding repeated requests for the same information through multiple interviews. When possible, ask for the individual's consent to transfer necessary information to other key service providers.

• Do not offer access to media, journalists or others seeking interviews with trafficked persons without their express permission. Do not coerce individuals to participate. Individuals in 'fragile' health conditions or risky circumstances should be warned against participating.

11. Avoid calling authorities, such as police or immigration services, unless given the consent of the trafficked person. Trafficked persons may have well-founded reasons to avoid authorities. Attempts should be made to discuss viable options and gain consent for actions.14

12. Maintain all information about trafficked persons in secure facilities. Data and case files on trafficked persons should be coded whenever possible and kept in locked files. Electronic information should be protected by passwords.

Source: **IOM (International Organization for Migration). 2006.** *Breaking the Cycle of Vulnerability: Responding to the Health Needs of Trafficked Women in East and Southern Africa.*

Illustrative Tools:

- The **UN.GIFT (United Nations Global Initiative to Fight Human Trafficking)** website has a full array of basic references, manuals and tools, and news about past and upcoming meetings on trafficking. The link relating to "best practices" is particularly useful as guidance.

- ***Caring for Trafficked Persons: Guidance for Health Providers*** (United Nations Global Initiative to Fight Trafficking), IOM (International Organization for Migration) and the London School for Hygiene and Tropical Medicine, 2009). Provides practical, non-clinical advice to help health providers understand trafficking, recognize associated health problems, and consider safe and appropriate approaches to providing healthcare for trafficked persons. The guidance is also useful for meeting the health needs of women migrant workers who are victims of abuse. The "action sheets" include: sexual and reproductive health, special considerations when examining children and adolescents, trauma-informed care, safe referral, mental health care, disabilities, and medico-legal considerations. Available in English.

- ***WHO Ethical and Safety Recommendations for Interviewing Trafficked Women*** (Zimmerman, C. and Watts, C. 2003). Available in Armenian, Bosnian, Croatian, English, Japanese, Romanian, Russian, Spanish and Serbian)

- ***Handbook on Direct Assistance for Victims of Trafficking*** (International Organization for Migration, 2007). Available in English.

- ***Breaking the Cycle of Vulnerability: Responding to the Health Needs of Trafficked Women in East and Southern Africa*** (International Organization for Migration, 2006). Available in English.

- ***Manual for Medical Officers Dealing with Child Victims of Trafficking and Commercial Sexual Exploitation*** *(Manual for Medical Officers Dealing with Medico-Legal Cases of Victims of Trafficking for Commercial Sexual Exploitation and Child Sexual Abuse* (United Nations Children's Fund and the Department of Women and Child Development, Government of India, New Delhi, 2005). Available in English.

- ***National Referral Mechanisms: Joining Efforts to Protect the Rights of Trafficked Persons: A Practical Handbook*** (Organization for Security and Co-operation in Europe, 2004). Available in Albanian, English, French, Russian, Spanish, and Turkish.

- For additional resources on trafficking, search the tools database by clicking on "subject", then sexual exploitation and trafficking.

VII. How is the health sector response to violence against women and girls monitored and evaluated?

Overview of the importance of monitoring and evaluation of health sector initiatives

- The evidence base around the effectiveness of different strategies and interventions in the health sector, while growing, is still weak in many areas. This poses challenges on a number of levels. Where thorough assessments are not available, decisions regarding how resources should be spent and what programmes should be supported may be made on the basis of incomplete information or findings from evaluations that are inappropriate for the specific contexts. In the worst cases, without proper evaluation programmes may also be doing more harm than good for survivors.

- Evaluations provide a framework for identifying promising interventions, targeting specific aspects of those interventions that contribute to their success, and drawbacks and gaps with each strategy. Without this information, critical resources might be wasted on programmes that will not lead to desired outcomes or may even worsen the situation for women.

- Ideally, a health programme should be able to measure progress toward its objectives and evaluate whether an intervention has been beneficial or has created additional

risks. However, many health programmes carry out activities without clarifying what results they are trying to achieve or determining whether or not they did in fact achieve those results. (Guedes 2004, Bott, Guedes and Claramunt 2004)

- Health programmes that address violence have a particularly great responsibility to invest in monitoring and evaluation given the possibility that a poorly-planned intervention can put women at additional risk or inflict unintended harm. For example, a training session may fail to change misperceptions and prejudices that can harm victims of violence, or may even reinforce them. Or a routine screening policy may be implemented in ways that actually increase women's risk of violence or emotional harm.

- Monitoring and evaluation offer invaluable information about the best way for health programmes to protect the health, rights and safety of women who experience violence.

- Health services provide a unique window of opportunity to address the needs of abused women and are essential in the prevention and response to violence against women and girls, since most women come into contact with the health system at some point in their lives. The health sector is frequently the first point of contact with any formal system for women experiencing abuse, whether they disclose or not. Every clinic visit presents an opportunity to ameliorate the effects of violence as well as help prevent future incidents. Monitoring and evaluating these service in the health sector is crucial to the broader response to violence against women and girls. (Heise, Ellsberg and Gottomoeller, 1999)

- Monitoring and evaluation should look at all elements of the system-wide approach to health, including the policies, protocols, infrastructure, supplies, staff capacity to deliver quality medical and psychosocial support, staff training and other professional development opportunities, case documentation and data systems, the functioning of referral networks, safety and danger assessments, among other items that are relevant to specific contexts and programmes. (See Heise, Ellsberg and Gottomoeller, 1999, Velzeboer et al 2003, Bott, Guedes and Claramunt 2004)

Conducting an evaluation of health sector interventions

Keep in mind that evaluations should be based on operational and theoretical frameworks and that they should be incorporated in a programme's planning stages. Baseline and situation analyses are critical to monitoring and evaluation efforts, but rarely conducted. Please refer to the introductory section for additional information on developing an appropriate framework and collecting baseline data.
(Bott, Guedes and Claramunt, 2004)

- **Define a clear programmatic goal for the intervention**
  A goal reflects the basic, very broad, conceptual aim of the project and the desired long-term outcome. Examples of possible goals include:

    - To improve the quality of care that survivors of gender-based violence receive in health care settings.
    - To strengthen the ability of the health care sector to prevent gender-based violence.

- **Keeping this overall goal in mind, identify clear objectives and expected results**.

- **Remember to keep in mind the difference between proposed activities, outputs and outcomes**, between what will be undertaken, what will be produced and what is expected will happen as a result. For example:
    - Activities might include conducting training for health service providers or developing standardized protocols for responding to cases of sexual violence.
    - Outputs might include the number or percentage of health service providers in a target area who have been trained or the number of health care facilities that have adopted standardized protocols for responding to cases of sexual violence.
    - Outcomes might include strengthened capacity on the part of health service providers to respond to violence against women in a meaningful, appropriate manner or an integrated response on the part of the health care facility following standardized protocols.

- **Develop indicators for measuring each of the objectives**

- **Remember to distinguish between process and results indicators**. Health programmes usually collect data on processes rather than on results or outcomes and may not focus on whether their activities were beneficial or effective. This does not mean however, that monitoring and evaluation frameworks should exclude process indicators.
    - **Process Indicators** are used to monitor the number and types of activities carried out, such as the number and types of services provided, number of people trained, number of materials produced and disseminated or number and percentage of clients screened.

    - **Results Indicators** are used to evaluate whether or not the activity achieved the intended objectives. Examples include indicators of providers' or community level knowledge, attitudes and practices as measured by a survey, women's perceptions about the quality and benefits of services provided by an organization or institution as measured by individual interviews, women's experiences with health care, and the appropriateness or readiness of health unit capacity and infrastructure. (Bott, Guedes and Claramunt, 2004)

Examples of strategies, objectives and indicators for monitoring and evaluation of health sector initiatives

Strategy/ intervention	Examples of possible objectives	Example indicators
1) Dissemination of materials/ information	• Raising health care providers' awareness and understanding of gender-based violence, in particular: a) GBV as a critical human rights and public health issue b) barriers women living with violence or survivors of violence face when accessing services c) links between GBV and HIV and AIDS d) laws addressing GBV and providers' responsibilities	• proportion of providers who identify GBV as a critical human rights and public health issue • proportion of providers who can identify and discuss (# of) barriers women face • proportion of providers who are able to identify (# of) links between GBV and HIV/AIDS • proportion of providers who correctly outline legal obligations with regard to gender-based violence
2) Training of service providers	• Strengthening health care providers' ability to respond to cases of gender-based violence [in particular…] a) following appropriate routine screening protocols b) responding to cases of rape and sexual violence c) addressing GBV and HIV/AIDS links holistically d) establishing and using community-based referral networks of care providers and social services e) improving medico-legal documentation of cases f) changing stigmatizing norms and attitudes g) providing emergency and crisis care • Strengthening health care providers' ability to prevent possible gender-based violence through: a) changing stigmatizing norms and attitudes b) strengthening capacity to screen for possible violence, provide appropriate care and referrals	• proportion of providers who understand and use appropriate screening protocols • proportion of providers who can provide appropriate care for survivors of rape and sexual violence • proportion of providers who address links between GBV and HIV in care • proportion of providers who are trained to identify, refer and care for survivors • proportion of providers who have made referrals for survivors • proportion of providers who feel comfortable asking about violence • proportion of providers who demonstrate appropriate practices and attitudes with respect to gender-based violence • proportion of women accessing services who indicate they received appropriate, comprehensive care

	as necessary	• proportion of rape/ sexual violence survivors who indicate they received appropriate, comprehensive care • proportion of rape/ sexual violence survivors who indicate they received appropriate, comprehensive care • proportion of GBV survivors who indicate they received appropriate, comprehensive care
3) Development of protocols and norms for managing GBV cases	• Establishing system-wide protocols and norms • Improving implementation of system wide protocols, policies and norms for managing GBV cases • Improving clinic infrastructure to provide safe, confidential spaces for consultations • Strengthening multisectoral collaboration with other community-based services as part of routine protocols	• proportion of health units that have documented and adopted a protocol for the clinical management of GBV • proportion of health units that have done a readiness assessment for the delivery of GBV services • proportion of health units that have commodities for the clinical management of VAW • proportion of health units with at least one provider trained to care for and refer GBV cases
4) Routine screening	• Increasing levels of screening, detection and referrals • Making it easier for women who have experienced or live with violence to share their experiences • Strengthening the ability of health care providers to accurately diagnose and care for their patients • Improving and ensuring quality of care during screening	• proportion of women who report physical and/or sexual violence • proportion of women who were asked about physical and/or sexual violence during a visit to a health unit • proportion of women screened and referred in accordance with clinic policies • percentage of women who report that the screening was done in private – not during the clinical exam – and in a sensitive and respectful

		manner • proportion of providers who are able to demonstrate the ability to screen and respond to disclosure adequately during a role play • percentage of women who would feel comfortable disclosing and discussing violence in their lives with the provider
5) Campaigns to empower women	• Increasing women's knowledge about possible sources of help for gender-based violence • Increase women's sense of empowerment with respect to receiving appropriate care for gender-based violence	• percentage of women who could identify organizations and resources for care and assistance for gender-based violence • percentage of women who articulate that gender-based violence is a health and human rights issue that health care providers should be addressing

Source: PATH, 2010.

Examples of different approaches to monitoring and evaluation for health sector

Approach	Examples of methods used
Formal evaluations by external consultants at baseline, midterm and follow-up	Surveys using structured questionnaires Discussion groups with providers and clients Random record reviews Clinic observations In-depth interviews with key informants
Small-scale case studies to evaluate new policies or tools	Routine service statistics Focus groups with staff Focus groups with clients
Information systems to collect systematic service data	Routine service statistics on key indicators
Regular meetings with staff to discuss new policies and tools	Informal discussions and dialogue among frontline staff and managers
Individual efforts of managers to track the progress of needed reforms in the organization	Checklists Strategic plans Personal observation
Individual efforts of managers to monitor the morale and performance of staff	Routine service statistics Informal reviews of medical records Informal discussions with staff members
Pre- and post-tests of providers' knowledge and skills before and after training	Questionnaires Role-plays Informal group discussions

Source: Bott, Guedes and Claramunt, 2004.

Case Study: **International Planned Parenthood Western Hemisphere Region Evaluation to Improve the Health Sector Response to Gender-Based Violence**

The evaluation included **four main components**:

1. A **baseline evaluation** study including:

a. A knowledge, attitudes and practices survey of providers using face to face interviews. IPPF/WHR designed a survey questionnaire to gather information on health care providers' knowledge, attitudes, and practices related to gender-based violence. The questionnaire contains approximately 80 questions. Although the questionnaire includes a few open-ended questions, most of the questions are closed-ended so that the results can be tabulated and analyzed more easily. The questionnaire covers a range of topics, including: whether, how often and when providers have discussed violence

with clients; what providers think are the barriers to screening; what providers do when they discover that a client has experienced violence; attitudes toward women who experience violence; knowledge about the consequences of gender-based violence; and what types of training providers have received in the past. This questionnaire can also be adapted to evaluate a single training. One possibility is to use all or part of the questionnaire before the workshop begins and use only part of the questionnaire after the workshop is over. If the questionnaire is used immediately "before and after" a single training, the organization may be able to measure changes in knowledge, but changes in attitudes and practices usually take time.

b. A clinic observation/ interview guide The Clinic Observation/Interview Guide gathers information on the human, physical, and written resources available in a clinic. The first half of the guide consists of an interview with a small group of staff members (for example, the clinic director, a doctor, and a counselor). This section includes questions about the clinic's human resources; written protocols related to gender-based violence screening, care, and referral systems; and other resources, such as whether or not the clinic offers emergency contraception. Whenever possible, the guide instructs the interviewer to ask to see a copy or example of the item in order to confirm that the material exists and is available at the clinic. The second part of this guide involves an observation of the physical infrastructure and operations of the clinic, including privacy in consultation areas (for example, whether clients can be seen or heard from outside), as well as the availability of informational materials on issues related to gender-based violence.

2. **Service statistics** on detection rates and services provided using standardized screening questions and indicators

Sample tables for gathering screening data. To ensure that all three participating associations could collect comparable screening data, IPPF/WHR developed a series of model tables, which each association completed every six months. These tables may or may not be useful for other health programmes, as this depends on whether or not the health programme decides to implement routine screening, what kind of policy it adopts, what kind of questions it asks, and what kind of information system it has. Nevertheless, these tables illustrate the types of data that can be collected and analyzed on a routine basis.

3. A midterm, primarily qualitative, evaluation including:

a. **Focus group discussions and in-depth interviews** with providers, survivors and external stakeholders/key informants: A summary protocol for collecting qualitative data describes these methods, including in-depth interviews and group discussions; and also provides an idea of what types of providers, clients and other stakeholders were asked to participate.

b. **Client satisfaction surveys:** The Client Exit Survey Questionnaire is a standard survey instrument for gathering information about clients' opinions of the services they have received. This survey is primarily designed for health services that have implemented a routine screening policy. It is important to note that exit surveys tend to have a significant limitation: many clients do not want to share negative views of the services, especially when the interview is conducted at the health center. IPPF/WHR was not able to interview clients offsite, but it did arrange for all the interviewers to be from outside the organization, so that they could reassure the women who participated that they were not going to breach their confidentiality. This questionnaire contains mostly closed-ended questions about the services. It asks women whether they were asked about gender-based violence and about how they felt answering those questions; however, the questionnaire does not ask women to disclose whether or not they have experienced violence themselves.

c. **Case studies** of pilot strategies to address various aspects of gender-based violence.

4. A **final evaluation** serving as a follow up to the baseline including:

a. KAP survey of providers using face to face interviews
b. A clinic observation/ interview guide
c. Random records reviews and development of a protocol:

Throughout the course of the IPPF/WHR regional initiative, the participating associations gathered routine service statistics about clients, including the numbers and percentages of clients who said yes to screening questions. However, the quality of these service statistics depends on the reliability of the information systems and the willingness of health care providers to comply with clinic policies—both of which may vary from clinic to clinic. IPPF/WHR therefore designed a protocol to measure screening levels and documentation using a random record review approach. This manual contains a brief description of the protocol as well as a tabulation sheet.

Download the main publications related to this initiative:

Basta! The Health Sector Addresses Gender-Based Violence. Available in English and Spanish.

Improving the Health Sector Response to Gender-Based Violence. . Available in English and Spanish.

Source: Bott, Guedes and Claramunt 2004)

Indicators

MEASURE Evaluation, at the request of The United States Agency for International Development and in collaboration with the Inter-agency Gender Working Group, compiled a set of indicators for the health sector. The indicators have been designed to measure programme performance and achievement at the community, regional and national levels using quantitative methods. Note, that while many of the indicators have been used in the field, they have not necessarily been tested in multiple settings. To review the indicators comprehensively, including their definitions; the tool that should be used and instructions on how to go about it, see the publication **Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators.**

The compiled indicators for the health sector are:

- **Proportion of health units that have documented & adopted a protocol for the clinical management of women/girls (VAW/G) survivors of violence**
  What It Measures: This indicator to measures whether or not a health unit has a standard protocol to guide the identification, service provision and referral mechanism for VAW/G survivors. The protocol should describe the elements of care that should be provided, and the way in which it should take place. The protocol should be displayed or be otherwise accessible to health facility staff.

- **Proportion of health units that have done a readiness assessment for the delivery of VAW/G services**
  What It Measures: This measures a health unit's efforts to provide a basic level of service that can be expected to be delivered to VAW/G survivors. If there is a low proportion of facilities who have done such an assessment, it would indicate that the services being provided may be of variable quality. Once a readiness assessment is completed, health units will be in a position to look at their strengths and rectify the gaps in VAW/G service provision.

- **Proportion of health units that have commodities for the clinical management of VAW/G**
  What It Measures: This is a measure of readiness for health units to provide VAW/G services. If the necessary commodities are not present in the health unit, presumably, VAW/G services cannot be provided at an acceptable level. The indicator does not measure the service quality with which these commodities are delivered.

- **Proportion of health units with at least one service provider trained to care for and refer VAW/G survivors**

What It Measures: This is an indicator of readiness for health units to provide VAW/G services. If staff have undergone no specific training, the provision of such services could be done in an inappropriate or detrimental manner. This indicator reflects training, but not the quality of the training, or how well the staff member integrated what they learned into practice.

- **Number of service providers trained to identify, refer, and care for VAW/G survivors**
  What It Measures: This indicator is an output measure for a program designed to provide training to health service providers in VAW/G service provision. This will provide a measure of coverage of trained personnel per geographic area of interest, and will help monitor whether or not a program is attaining its target number of providers trained.

- **Number of health providers trained in FGC/M management and counseling**
  What It Measures: This indicator is an output measure for a program designed to provide training to health service providers in the management of complications, both physical and psychosocial, resulting from FGC/M procedures. This will provide a measure of coverage of trained personnel per geographic area of interest, and will help monitor whether or not a program is attaining its target number of providers trained.

- **Proportion of women who were asked about physical and sexual violence during a visit to a health unit**
  What It Measures: The number of women presenting for any type of care at health units who are asked about experiencing any physical or sexual violence that may have occurred, ever. The count can be determined per health unit, or per area of interest.

- **Proportion of women who reported physical and/or sexual violence**
  What It Measures: This output indicator provides a measure of service utilization by VAW/G survivors who disclose their experience to health providers.

- **Proportion of VAW/G survivors who received appropriate care**
  *What It Measures***:** This output indicator provides a measure of adequate service delivery to VAW/G survivors who disclose their experience to health providers. This does not assess the quality of service delivery.

- **Proportion of rape survivors who received comprehensive care**
  What It Measures: This output indicator provides a measure of adequate service delivery to rape survivors who present at health units. This does not assess the quality of service delivered.

Baseline (and endline) assessment methods

Four general areas for baseline data include:

- Assessing providers knowledge, attitudes and practices
- Assessing appropriateness and readiness of health unit infrastructure and capacity
- Assessing women's experiences with health care
- Assessing compliance with policies and protocols

Assessing providers' level of knowledge, attitudes and practices (KAP) related to violence against women and girls

Information on providers' knowledge, attitudes and practices can help managers understand what their staff knows and believes about violence, what issues need to be addressed during training, and what resources are lacking in the clinics or health centers. Moreover, this information can be used to document a baseline so that health programmes can measure changes in providers' knowledge, attitudes, and practices over time.

A couple of ways to collect information on providers' knowledge, attitudes, and practices, include surveys and gathering qualitative data through group discussions or other participatory methods with providers. Qualitative data can provide an in-depth understanding of providers' perspectives. Quantitative data makes it easier to measure change over time.

Knowledge attitude and practices surveys of health care providers are useful because they:

- offer information about whether, how often and when providers have discussed violence with clients; what providers think are the barriers to screening; what providers do when they discover that a client has experienced violence; providers' discriminatory or stigmatizing attitudes; attitudes toward women who experience violence; knowledge about the consequences of gender-based violence; and what types of training providers have received in the past; and
- can be used as a convenient pre and post intervention measure.

It is best to use or adapt already designed and validated instruments and questions, including the:

- **World Health Organization Multi-country Study on Women's Health and Domestic Violence against Women** (WHO). The survey includes questions to gauge attitudes towards violence against women. Available in English.

- **Gender-Equitable Men (GEM) Scale** (Horizons and Promundo). The scale measures attitudes toward "gender-equitable" norms, provide information about prevailing norms in a community and the effectiveness of programmes hoping to influence them. Available in English, Spanish and Portuguese on the Virtual Knowledge Centre site.

- **National Community Attitudes towards Violence against Women Survey 2009** (The Victorian Health Promotion Foundation) has subsections focusing on attitudes towards domestic violence and sexual violence using a scale of agreement or disagreement. Available in English.

- **The Attitudes Towards Rape Victims Scale** (The Arizona Rape Prevention and Education Project). These scales are self administered instruments designed to assess individuals' attitudes towards rape victims rather than towards rape in general. Available in English

- **The Sexual Violence Research Initiative** compiled a comprehensive package of programme evaluation tools and methods for assessing service delivery, knowledge, attitudes, practices and behaviours in sexual violence projects and services. By making such materials available to service providers, managers, researchers, policy makers and activists, among others, the hope was that evaluation could be more easily incorporated into project and programme plans. The assessment instruments are drawn from articles in peer-reviewed journals that report findings from evaluations of health care-based services and interventions for women victims/survivors of sexual violence, written in English or Spanish, published between January 1990 and June 2005. The instruments are available from the evaluation section of sexual violence research initiative website.

Semi-structured interviews with health care providers are useful because they**:**

- offer insight into providers' knowledge, attitudes and practices; and
- offer the potential for digging deeper into any challenges, barriers, concerns that may affect ability to provide care.

- **International Planned Parenthood Federation, Western Hemisphere Region's (IPPF/WHR's) Survey of Provider Knowledge, Attitudes and Practices** (KAP): This face-to-face interview is designed for administration to women's health care providers. It focuses on providers' knowledge, attitudes and practices concerning violence in the lives of their

patients. There are approximately 80 questions (most close-ended), that cover a range of topics, including: whether, how often and when providers have discussed violence with clients; what providers perceive of as barriers to screening; what providers do when they identify a client who has experienced violence; attitudes toward women who experience violence; knowledge about the consequences of gender-based violence; and the types of training providers have received in the past. Available in English and Spanish.

Forensic and Medical Care Following Sexual Assault Service Education Programme Evaluation Questionnaire: This questionnaire is designed to assess medical personnel's knowledge and satisfaction concerning their abilities to treat sexual assault patients, and includes questions such as "How would you rate your ability in forensic evidence collection?". It can be self-administered or used as an interview guide.

Qualitative, participatory methods with clinic/ health unit staff including focus group discussions, open-ended stories, mapping, role plays, Venn diagrams and others can be useful, because they:

- offer insight into provider's knowledge, attitudes and practices; and
- offer insight into institutional practices and norms, as well as group dynamics and work flow.

See the section on qualitative methods for ideas and examples of what can be used.

Assessing appropriateness of clinic/ health unit infrastructure and capacity

Improving the health sector response to gender-based violence has implications for many aspects of the way a clinic functions. For example, ensuring adequate care for women who experience violence may require private consultation spaces, written policies and protocols for handling cases of violence, client flow that facilitates meaningful care, access to emergency contraception, and a directory of resources in the community. One way to assess what resources exist in a clinic is to have an independent observer visit the clinic and assess the situation through firsthand observation. Another way to do this is for a group of staff to complete a checklist or self administered questionnaire that includes resources that are important for providing quality care to survivors of violence.

Methods that can be used include:

- **Clinic observations**
- **Confidential interviews** with clinic staff are an excellent source of information about the infrastructure, protocols and capacity of the health

care facility. However, they require time and confidentiality assurances, and staff may not want to get involved in critical evaluations of the facility that employs them.

- **Questionnaires/ management checklist** are an easy, resource friendly monitoring mechanism. A management checklist can be used for monitoring what measures an institution has taken to ensure an adequate response for women experiencing gender-based violence.
- **Review of protocols *a*nd policies**

Example Monitoring Checklist of Minimum Key Elements of Quality Health Care for Women Victims/Survivors of Gender-Based Violence

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

1. **Institutional values and commitment:** Has the institution made a commitment to addressing violence against women, incorporating a "system's approach"? Are senior managers aware of gender-based violence against women as a public health problem and a human rights violation, and have they voiced their support for efforts to improve the health service response to violence?
2. **Alliances and referral networks:** Has the institution developed a referral network of services in the community, including to women's groups and other supports? Is this information accessible to all health care providers?
3. **Privacy and confidentiality:** Does the institution have a separate, private, safe space for women to meet with health care providers? Are there protocols for safeguarding women's privacy, confidentiality and safety, including confidentiality of records? Do providers and all who come into contact with the women or have access to records understand the protocols?
4. **Understanding of and compliance with local and national legislation:** Are all providers familiar with local and national laws about gender-based violence, including what constitutes a crime, how to preserve forensic evidence, what rights women have with regard to bringing charges against a perpetrator and protecting themselves from future violence, and what steps women need to take in order to separate from a violent spouse? Do health care providers understand their obligations under the law, including legal reporting requirements (for example, in cases of sexual abuse) as well as regulations governing who has access to medical records (for example, whether parents have the right to access the medical records of adolescents)? Does the institution facilitate and support full compliance with obligations?
5. **Ongoing provider sensitization and training:** Does the institution provide or collaborate with organizations to provide ongoing training for staff around gender-based violence, harmful norms and practices, legal obligations and proper medical management of cases?
6. **Protocols for caring for cases of gender-based violence:** Does the institution have clear, readily available protocols for screening, care and referral of cases of gender-based violence? Were these protocols developed in a participatory manner, incorporating feedback from staff at all levels as well as clients? Are all staff aware of and able to implement the protocols?
7. **Post-exposure prophylaxis, Emergency contraception and other supplies:** Does the institution have supplies readily available, and arestaff properly trained on their dissemination and use?
8. **Informational and educational materials:** Is information about violence against women visible and available, including on women's rights and local services women can turn to for help?
9. **Medical records and information systems:** Are systems in place for documenting information about violence against women as well as collating standardized data and service statistics on the number of victims of violence? Are records kept in a safe, secure manner?
10. **Monitoring and evaluation:** Does the institution integrate mechanisms for ongoing monitoring and evaluation of their work, including receiving feedback from all staff as well as from women seeking services? Are there regular opportunities for providers and managers to exchange feedback? Is there a mechanism for clients to provide feedback regarding care?

Source: adapted from Bott, Guedes and Claramunt 2004

Illustrative tools:

- **How to Conduct a Situation Analysis of Health Services for Survivors of Sexual Assault** (South African Gender-based Violence and Health Initiative and Medical Research Council of South Africa). This guide provides tools and outlines steps for conducting a situation analysis of the quality of health services for victims/survivors of sexual assault. It includes a *facilities checklist* for collecting information on the infrastructure of the facilities where survivors are managed and where medico-legal/forensic examinations take place, including medication, equipment and tests available at the facility. It also includes a *standardized health care provider questionnaire* designed to be used in face to face interviews with health care providers who manage the care of survivors. Note that, the tool does not address stigma and discrimination, the time a patient waits to be seen by a provider, or what happens after the provider has completed the examination. Available in English.

- **Clinic Interview and Observation Guide (**International Planned Parenthood Federation/Western Hemisphere Region). This assessment tool gathers information on the human, physical, and written resources available in a clinic. The first half of the guide consists of an interview with a small group of staff members (for example, the clinic director, a doctor, and a counselor). This section includes mostly closed-ended questions about services, including: the clinic's human resources; written protocols related to gender-based violence screening, care, and referral systems; and other resources, such as whether or not the clinic offers emergency contraception. The second part of the guide involves an observation of the physical infrastructure and operations of the clinic, such as privacy in consultation areas, as well as the availability of informational materials on sexual violence. Available in English and Spanish.

- **STI/HIV Self-Assessment Module** (International Planned Parenthood Federation/Western Hemisphere Region). This self-assessment module contains a questionnaire designed to assess whether an organization has the necessary capacity, including management systems, to ensure high quality sexual and reproductive health services. The questionnaire allows staff from different levels of an organization to assess the extent to which their organization has addressed a multitude of issues relevant to gender-based violence, including sexual violence. Available in English and Spanish.

- **Management of Rape Victims Questionnaire** (Azikiwe, Wright, Cheng & D'Angelo). This self-administered questionnaire was designed for programme directors of pediatric and adult hospital emergency departments to report on their department's management of care for rape survivors. The 22 questions gather information concerning the

department's volume of rape cases, screening for STDs, emergency contraception policies, medications offered or prescribed for emergency contraception, non-occupational HIV postexposure prophylaxis policies, medications offered or prescribed for HIV postexposure prophylaxis, and patient follow-up. Available for purchase in English from Elsevier.

- **Standardized Interview Questionnaires and Facilities Checklist** (Christofides, Jewkes, Webster, Penn-Kekana, Abrahams & Martin). This face-to-face interview questionnaire was designed to gather information from health care providers who care for rape survivors. The questionnaire contains 5 sections that collect information on: the demographic characteristics of providers; the types of services available for rape survivors; whether care protocols for rape survivors are available at the facility; whether the practitioner had undergone training in how to care for rape survivors; and practitioner's attitudes towards rape and women who have been raped. Responses to particular items are used to develop a scale that measures the quality of clinical care. In addition, the assessment tool includes a checklist that the fieldworkers complete at each health care center noting the presence or absence of equipment and medicines and the structural quality of the facilities. Available in English.

- **Quality of Care Composite Score (**Christofides, Jewkes, Webster, Penn-Kekana, Abrahams & Martin). The Quality of Care Composite Score is a self-reported measure used at the individual practitioner level to assess the clinical care provided by doctors and nurses who care for rape victims in terms of indicators of preventive strategies for sexually transmitted infections and prevention of pregnancy, counseling, and the quality of forensic examinations. It consists of 11 items such as treatment of sexually transmitted infections and clothing or underpants ever sent for forensic testing. Available in English.

Assessing women's experiences with health care

Strengthening the response of the health sector to gender-based violence requires an understanding of women's experiences accessing or attempting to access health services. This includes measures taken to understand and address the barriers and challenges women experiencing violence face when seeking care. This is most feasible through interviews with women as they are leaving the health care institution. It may be difficult for women to feel comfortable saying something critical about the services they have received while they are on the premises. If possible, additional interviews and focus group discussions with women identified through other social services outside of the health care setting might be used to assess access to health service and quality of care.

Methods that can be used include:

- Qualitative, participatory methods with women accessing or attempting to access health services including focus group discussions, role plays, open-ended stories, mapping, Venn diagrams [link to descriptions of these methods]
- Client exit interviews; and
- Interviews with women unable to access health services to determine the barriers these women face and to provide a non-health care setting for women to speak more freely about their experience

Illustrative tools:

- **In Her Shoes methodology** (Washington Coalition on Domestic Violence). This methodology was developed by and adapted for Latin America to train and sensitize service providers on the barriers women living with violence face. It has also been adapted for Latin America in Spanish by the InterCambios Alliance.

- **Client Exit Survey Questionnaire** (International Planned Parenthood Federation/ Western Hemisphere Region). This is a standard survey instrument for gathering information about clients' opinions of the services they have received and is primarily designed for health services that have implemented a routine screening policy. This questionnaire contains mostly closed-ended questions about the services. It asks women whether they were asked about gender-based violence and about how they felt answering those questions; it does not ask women to disclose whether or not they have experienced violence. Available in English and Spanish.

- **Using Mystery Clients: A Guide to Using Mystery Clients for Evaluation Input** (Pathfinder, 2006). Available in English.

- **Positive Women Monitoring Change: A Monitoring Tool on Access to Care, Treatment and Support, Sexual and Reproductive Health and Rights and Violence against Women Created by and for HIV Positive Women** (International Community of Women Living with HIV/AIDS, 2005). Available in English.

Assessing compliance with policies and protocols

Routine service statistics about clients, including the numbers and percentages of clients who said yes to screening questions, are an important way to gauge an institution's response to gender-based violence.

However, the quality of these service statistics depends on the reliability of the information systems and the willingness of health care providers to comply with clinic policies—both of which may vary from clinic to clinic. The availability and

quality of statistics also depend on whether or not the health programme decides to implement routine screening, what kind of policy it adopts, what kind of questions it asks, what kind of information system it has, and the capacity of staff to collect data.

Random record reviews are a way to evaluate the completeness of record keeping with regard to screening for gender-based violence and how well providers understand and use screening policies and protocols.

Methods that can be used include:

- **Review of screening data**
- **Review of routine service statistics**
- **Review of protocols and procedures** by:
  -Asking for documentation of all available protocols and procedures, including screening protocols
  -Determining whether there are protocols and procedures for the management of gender-based violence, including sexual violence
  -Determining whether the protocols are clear, unambiguous and easily accessible to all staff.

Illustrative tools:

- **Sample tables for gathering screening data** (International Planned Parenthood Federation/ Western Hemisphere Region)**.** This series of model tables were developed to collect comparable screening data across facilities. These tables illustrate the types of data that can be collected and analyzed on a routine basis. Their use of these tables depends on whether or not the health programme decides to implement routine screening, what kind of policy it adopts, what kind of questions it asks, and what kind of information system it has. Available in English and Spanish.

- **Random record review protocol** (International Planned Parenthood Federation/ Western Hemisphere Region)**.** The quality of routine service statistics such as the numbers and percentages of clients who said yes to screening questions depends on the reliability of the information systems and the willingness of health care providers to comply with clinic policies—both of which may vary from clinic to clinic. Available in English and Spanish.

Steps after Evaluation

These recommendations are extracted from International Planned Parenthood's publication, *Improving the Health Sector Response to Gender-based Violence*.

- Use the findings from the baseline study during sensitization and training of staff. Findings from the provider survey can be used to identify which specific topics need to be addressed during provider sensitizations and trainings. For example, the provider survey can point to the types of knowledge and attitudes that could be discussed at a sensitization workshop.
- Hold a participatory workshop to share the results, identify areas that need work, and develop an action plan. After collecting baseline data, health programmes may find it valuable to hold a workshop with a broad group of staff members to discuss the results
- Plan to collect follow-up data using the same instruments to determine how much progress your organization has made over time. Once an organization has baseline data on providers' knowledge, attitudes, and practices, as well as clinic resources, then it can repeat the survey or clinic observation at a later point and thereby measure change over time.

Illustrative health sector monitoring and evaluation reports:

- **Pan American Health Organization Violence against Women: The Health Sector Responds** [La violencia contra las mujeres: responde el sector salud] (Velzeboer, Ellsberg, Arcas, García-Moreno/Pan-American Health Organization, 2003). Available in English and Spanish.

- **Evaluating an Intervention of Post Rape Care Services in Public Health Settings** (Kilonzo, Liverpool VCT, 2007). Power Point available in English.

- **Review of PAHO's Project Towards an Integrated Model of Care for Family Violence in Central America. Final Report** (Arcas and Ellsberg, 2001). Available in English.

Additional Tools and Resources:

- ***Ver y Atender, Guía práctica para conocer cómo funcionan los servicios de salud para mujeres víctimas y sobrevivientes de violencia sexual*** [Getting It Right! A Practical Guide to Evaluating and Improving Health Services for Women Victims and Survivors of Sexual Violence] (Troncoso, Billings, Ortiz, Suárez/Ipas 2006). Available in English and Spanish.

- ***Improving the Health Sector Response to Gender-Based Violence*** (Bott, Guedes, Claramunt and Guezmes, International Planned Parenthood Federation/ Western Hemisphere, 2004). Available in English and Spanish.

- ***Preventing intimate partner and sexual violence against women: taking action and generating evidence*** (World Health Organization/London School of Hygiene and Tropical Medicine, 2010). Available in English.

- ***Sexual Violence Research Initiative Website***, Evaluation Section. Available in English.

- ***Positive Women Monitoring Change: A Monitoring Tool on Access to Care, Treatment and Support, Sexual and Reproductive Health and Rights and Violence against Women Created by and for HIV Positive Women*** (International Community of Women Living with HIV/AIDS, 2008). Available in English.

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