



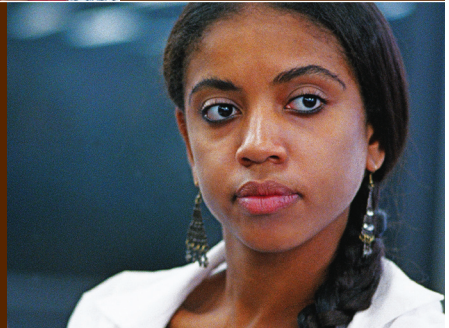
Improving the Health Sector Response to Gender Based Violence

A Resource Manual for Health Care Professionals in Developing Countries



Authors:

Sarah Bott
Alessandra Guedes
María Cecilia Claramunt
Ana Guezmes



ABOUT IPPF/WHR

The vision of IPPF/WHR is to build upon a network of local and global partnerships to advance the sexual and reproductive health and rights of women, men and young people. IPPF/WHR is one of six Regional Offices of the International Planned Parenthood Federation and is a secretariat to 40 Member Associations in the Western Hemisphere. For our partners, IPPF/WHR offers technical assistance and training in a variety of capacity-building and programmatic areas, including proposal writing and evaluation. To find out more, visit our Web site at www.ippfwhr.org or contact us at info@ippfwhr.org.

PREFACE

The recent publication of the IPPF Declaration of Sexual Rights laid the groundwork for an approach to gender based violence (GBV) predicated on the individual rights to bodily integrity and freedom from discrimination and violence. The International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) currently provides many of its 40 Member Associations throughout the region with support to integrate GBV services into pre-existing clinical services. In 2008, over 149,000 GBV related services were offered. IPPF/WHR encourages those using this manual to ground successful service delivery to survivors of gender based violence in the inalienable sexual rights outlined in the Declaration.

Since its first publication in 2004, IPPF/WHR's *Improving the Health Sector Response to Gender Based Violence* has served as a valuable tool for health providers in Latin American and Caribbean. The objective of the manual is to provide health care managers with a practical guide to improving the health care response to violence against women in developing country settings.

Our 2010-2015 Strategic Plan continues our efforts to establish effective responses to GBV in the region. The plan calls for improvement in service delivery, heightening of community awareness, improvement of policy, and generation of experiences that may be shared within the public health sector and the region. We very much welcome this collaboration with PAHO because public-private partnerships are crucial for the eradication of GBV in our region.

Sincerely,

Carmen Barroso
IPPF/WHR
Regional Director

Violence against women is both a violation of women's human rights and a major public health problem. While both men and women experience violence, the patterns and consequences are different. Women are more likely than men to be injured by someone close to them, and girls and women comprise the overwhelming majority of survivors of sexual violence. World Health Organization research in ten countries around the world indicates that between 15% and 71% of women have experienced physical or sexual violence by an intimate partner. Worldwide, violence against women is a significant cause of injury and death, as well as a risk factor for many physical and psychological health problems; it also has serious negative economic and social costs, both for individual women and for society as a whole.

Given the serious consequences of violence against women, the United Nations has called on governments, international organizations and civil society to prevent and respond to violence against women through multi-sectoral efforts, based on a human rights framework. The Pan American Health Organization (PAHO) has a long history of working to address violence against women, as documented in publications such as *Violence against Women: The Health Sector Responds*. It is only fitting, therefore, that PAHO now joins efforts with the International Planned Parenthood Federation/Western Hemisphere Region to print the second edition of this publication. By reprinting this second edition, PAHO and IPPF/WHR hope to expand access to this important resource and thereby improve the health and wellbeing of women throughout the region.

Sincerely,

Dr. Mirta Roses Periago,
Director of the Pan American Health Organization (PAHO)

What is the campaign **Unite to End Violence Against Women**?

In 2008, the Secretary-General of the United Nations, Ban Ki-moon, launched the global multi-year campaign for 2008-2015: “**UNITE to End Violence against Women**”, where violence against women was identified as one of the most prevalent violations of human rights and as an obstacle to the achievement of the Millennium Development Goals.

The campaign is a call to action for governments, civil society, the private sector, the media, citizens and the United Nations System to work together towards the elimination of all forms of violence against women. It maintains that to build an egalitarian and non-violent society, each person needs to take responsibility.

The Campaign emphasizes the need to end impunity by promoting actions that increase survivors access to services in the fields of: (a) justice, by promoting the deep knowledge of their rights and increasing the availability of effective resources to address their needs; (b) strengthening access to and quality of health services that address the health needs resulting from different types of violence (physical, psychological and sexual) and providing secondary prevention, and (c) promoting education and training for the pertinent actors, including the personnel in education, health and justice sectors.

Click here to **Say No to Violence against Women**

INTRODUCTION

In 1999, the Regional Office of the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) began collaborating with three IPPF Member Associations—PROFAMILIA (the Dominican Republic), INPPARES (Peru), and PLAFAM (Venezuela)—to improve the capacity of those organizations to respond to gender based violence.

The four objectives of the IPPF/WHR regional initiative were:

- 1 To improve the capacity of sexual and reproductive health services to respond to the needs of women who experience gender based violence;
- 2 To raise community awareness of gender based violence as a public health problem and a violation of human rights;
- 3 To contribute to improvements in laws about gender based violence and the application of those laws; and
- 4 To increase knowledge about effective and feasible ways that the health sector can help women who experience gender based violence.

When IPPF/WHR and the Member Associations launched this initiative, they found many articles, manuals, tools and research studies on the health sector response to violence against women; however, much of this material was based on experience and research from developed countries such as the United States. To compensate for the gaps in the research and program literature, IPPF/WHR developed, field-tested, and evaluated tools and strategies that were specifically designed for sexual and reproductive health programs in the Dominican Republic, Peru and Venezuela. This manual compiles many of these materials into a single publication in the hopes that IPPF/WHR can fill some gaps in the published literature.

Specifically, this manual aims to:

- Document and disseminate the lessons learned from the IPPF/WHR regional initiative.
- Provide managers in developing countries with tools to improve the health care response to violence against women; and
- Identify the ongoing challenges and debates about how the health sector should address the problem of gender based violence in developing country settings.

This manual is intended to be most useful for the following audience:

- **Health care managers.** This manual is designed to help entire organizations or clinics improve their response to gender based violence. It focuses on information that managers might need to develop feasible and appropriate strategies, policies and evaluation plans. This manual does not contain guidelines or training materials that would prepare individual health care professionals to care for women who have experienced violence.
- **Private and nongovernmental organizations.** We hope that this manual will be helpful for health care professionals working in both the public and private sectors. However, we recognize that the recommendations in this manual primarily reflect the experiences of private, nongovernmental organizations.
- **Those working in developing countries.** The tools and lessons learned in this manual are based on experiences from Latin America and the Caribbean. However, health programs in other developing regions such as Africa and Asia may face similar challenges. Therefore, this manual is intended to be a resource for health organizations in developing countries that face a number of common challenges, such as low awareness of gender based violence as a public health problem, weak legal systems, and limited referral services for survivors.

- **Health programs devoted to the health of adolescent and adult women.** This manual is designed for the specific needs of programs devoted to women's sexual and reproductive health services, including family planning, STI/HIV services and prenatal care. Health professionals working in other settings, such as emergency rooms, general primary care settings or pediatric health care may need additional resources that are not addressed here.
- **Health professionals seeking practical tools.** This manual is designed to provide practical recommendations and tools for health care organizations, rather than a comprehensive overview of gender based violence. Readers who need detailed background information on gender based violence are advised to explore the extensive literature about violence against women as a public health problem and a human rights violation.

Structure and content of this manual

This manual is divided into six chapters, not including the Annexes. The materials have been organized in chronological order so that the chapters toward the beginning address the challenges facing organizations that have just begun to address gender based violence, whereas the chapters toward the end of the manual contain information and tools that are more relevant for organizations with more experience. In general, tools related to program design have been incorporated into the main body of the text, while evaluation tools (such as surveys and data collection protocols) are located in the Annexes. Briefly, the chapters are organized as follows:

Chapter 1: Introduction

This chapter provides a brief introduction to the issue of gender based violence, the reasons why the health sector should address this issue, the history of IPPF/WHO's work in this area, and suggestions for using this manual.

Both women and men experience violence, but the risk factors, patterns and consequences of violence for women are not the same as those for men.¹ In 1993, the United Nations adopted the first international definition of violence against women. That declaration highlighted the need to understand violence against women within the context of women's and girl's subordinate status in society. As Heise et al. point out, in many settings, "beliefs, norms and social institutions ... legitimize and therefore perpetuate violence against women."²

This manual will argue that health care organizations—particularly those working in the field of sexual and reproductive health—can improve the quality of women's health care by addressing the needs and safety of women who experience violence. Health care providers who ignore violence against women not only miss the opportunity to address an important public health problem, but can inadvertently put women at additional risk. In 1996, the World Health Assembly called on governments and health care organizations to address violence against women as a pervasive public health problem through the world.³ Unfortunately, the links between gender based violence and women's health are often overlooked by the health sector. Many health care professionals continue to consider violence against women to be a social rather than a public health problem. Others recognize violence as a health issue, but do not know how to address the issue as health professionals.

Specifically, the chapter includes the following subsections:

- What is Gender Based Violence?
- Why Should the Health Sector Address Gender Based Violence?
- IPPF/WHR's Work on Gender Based Violence
- How to Use this Manual

Chapter 2: The Planning and Preparatory Phase

This chapter explores key elements of the planning and preparation stage for organizations that are just beginning to address the issue of gender based violence.

The IPPF Member Associations that participated in the IPPF/WHR regional initiative spent many months educating themselves, establishing links with other organizations, evaluating the needs of their institutions, and understanding the situation in each community where they planned to work. This period of preparation proved to be invaluable for designing an effective approach to gender based violence.

This chapter explores the ways in which an organization can lay the groundwork for improving the health care response to violence by ensuring that it is based on a human rights and public health perspective. The chapter discusses both the importance and the challenges of educating health care providers about human rights, gender and the links between physical, emotional and social wellbeing. It also provides recommendations for developing objectives, strategies, and monitoring and evaluation plans, as well as collecting baseline data.

Specifically, this chapter includes the following subsections:

- Overview
- Gender Based Violence as a Public Health Problem
- Adopting a Human Rights Framework
- Conducting Rapid Diagnosis of the Situation
 - ➔ Tool: [Rapid situation diagnosis tool](#)
- Identifying Goals, Objectives and Key Strategies
 - ➔ Tool: [Suggested steps for developing goals, objectives and strategies](#)
- Developing a Monitoring and Evaluation Plan
 - ➔ Tool: [Sample monitoring and evaluation matrix](#)
- Gathering Baseline Data
 - ➔ Tool: [Suggested steps for gathering baseline data and developing an action plan](#)

Chapter 3: Improving the Health Service Response

This chapter presents recommendations and tools that any women's health care organization can use to evaluate and improve the quality of care it provides to women in general and to survivors of gender based violence in particular.

Researchers and advocates⁴ have argued that the best way to improve the health sector response to gender based violence is to take a “systems approach”—one that involves changes at all levels of the organization to protect women's health, safety and wellbeing. This approach recognizes that gender based violence has implications for almost every aspect of health services, including the physical infrastructure of the clinic, written policies and protocols, patient flow, referral networks, data collection systems and of course, training providers to respond to disclosures of violence in a compassionate and informed manner.

Given the prevalence of violence against women throughout the world, providers of women's health services will almost certainly care for survivors of gender based violence at some point in their practice. And women may disclose experiences of violence to their health care providers whether or not they are asked a direct question. A provider's response can have an enormous impact on women's safety, health and wellbeing. Providers who hold negative attitudes about survivors or who lack the resources to provide emergency services or referrals can harm their patients.

In recent years, a debate has emerged about whether and when health care providers should routinely ask women about gender based violence. Routine screening was an important component of the IPPF/ WHR regional initiative, but before launching routine screening policies, the Member Associations spent up to a year strengthening the physical, written and human resources throughout their institutions. Their experience highlights the need to make improvements throughout the organization before providers begin to screen.

This chapter is designed to outline the key elements that should be considered by *all* organizations that provide health services to adolescent and adult women, whether or not they have a routine screening policy.

Specifically, this chapter includes the following sub-sections:

- Overview
 - ➔ Tool: Management Checklist
- Aiming for Integration
- Ensuring Privacy
- Strengthening Confidentiality
- Developing Referral Networks
 - ➔ Tool: Suggested steps for developing a referral directory
- Understanding the Legal Issues
 - ➔ Tool: Legal Guide for service providers
- Sensitizing Staff
- Training Health Care Providers
 - ➔ Tool: Key elements of training on gender based violence for health care providers
- Developing Key Policies and Protocols
- Improving Danger Assessment
- Providing Safety Planning
- Providing Emergency Services to Survivors of Sexual Violence
 - ➔ Tool: Key elements of comprehensive emergency care for survivors of sexual violence
- Developing Educational and Informational Materials
- Monitoring and Evaluating Quality of Care

Chapter 4: Implementing a Routine Screening Policy

This chapter presents recommendations and tools for health programs that have already strengthened the resources available in the institution, as outlined in the previous chapter, and are ready to implement a routine screening policy.

A growing number of researchers and professional organizations, including the American College of Obstetrics and Gynecologists, and the British Medical Association, have called upon health providers to routinely screen women for gender based violence.^{5, 6, 7} On the other hand, some researchers^{8, 9} have questioned whether the benefits of routine screening outweigh the risks in settings that lack adequate legal systems, referral services, or respect for women's rights more generally.

In the course of the regional initiative, IPPF/WHO found reasons to agree with both sides of this debate. On the one hand, the evaluation found that routine screening helped transform health services in participating clinics and benefited many women who had experienced violence. Standardized, written questions encouraged large numbers of women to disclose their experiences of violence to providers. Both providers and survivors reported that routine screening was an important way to identify women at risk, to offer more appropriate medical care to women, and to help survivors understand their rights, the risks that they face, and any services that may be available in the community. On the other hand, the IPPF/WHO experience highlighted the complexity of implementing a feasible screening policy that minimized the risk to women's safety and wellbeing.

This chapter explores the many lessons learned from the IPPF/WHO initiative about how to set up a routine screening policy. Those lessons include, for example, the importance of adapting tools to the local setting, allowing providers to participate in developing a sustainable clinic-wide policy, and monitoring and evaluating the results and process of screening.

Specifically, this chapter includes the following subsections:

- Overview
- When to Implement Routine Screening
- How to Implement a Routine Screening Policy
- Developing Operational Definitions
 - Tool: Steps for developing operational definitions
- Developing Screening Questions
 - Tool: Guidelines for adapting screening questions to the local setting
- Documenting the Results of Screening
 - Tool: Sample stamp for recording answers to screening questions
- Writing a Routine Screening Protocol
 - Tool: Guidelines for writing a routine screening protocol
- Addressing Providers' Concerns About Screening
- Offering Emotional Support to Health Care Providers
- Gathering Screening Statistics
- Monitoring and Evaluating Routine Screening

Chapter 5: Providing Specialized Services

This chapter contains recommendations for providing in-house specialized services, such as counseling, legal services, and support groups, to women who have experienced violence.

Health programs in developing countries often face serious challenges in their effort to assist survivors of gender based violence, namely, weak legal systems and the lack of adequate referral services in the community, such as shelters and affordable legal advice. This situation raises important questions such as: what are the most important services that survivors need? And, given limited resources, what services

should receive most priority when a health program considers setting up some specialized services within its organization?

From the beginning, the planners of the IPPF/WHR initiative struggled to understand how their health care organizations could help survivors get the services they needed in resource-poor settings. The Member Associations found diverse ways to address survivors' needs. Where services existed, they reached out to other organizations and established formal or informal alliances. When such services did not exist, they established in-house legal and counseling services, an approach that allowed them to test and evaluate various strategies. Finally, all three organizations established "mutual support groups" for women and found that this offered a relatively low cost strategy to help survivors of violence, in a way that recognized the potential for women to help each other.

Specifically, this chapter includes the following subsections:

- Overview
- Counseling, Emotional Support, and Psychological Services
- Legal Services
 - ➔ Tool: Strategies for increasing women's access to legal services
- Women's Support Groups
 - ➔ Tool: Guidelines for forming a women's support group
- Monitoring and Evaluating Specialized Services

Chapter 6: Beyond the Clinic: Building Networks, Legal Advocacy, and Community Education

This chapter provides a brief discussion of ways that health care organizations can reach beyond the clinic to address gender based violence through legal advocacy and community education.

Although resource constraints often make it difficult for health care organizations to reach out beyond their clinic walls, such efforts are important for a number of reasons. First, survivors of gender based violence often need services beyond health care, such as legal advice, police protection, housing, economic support and other social services. Helping women access these services may be essential for women's health and safety. Another reason for health organizations to reach out beyond the clinic walls is to contribute to the broader policy debate about gender based violence. Health professionals often have the ability to change attitudes toward women's rights by reframing the discussion about violence as a public health problem.

Through legal advocacy and community education efforts at the community, regional and national levels, health organizations have an important role to play in challenging the social norms that perpetuate violence against women.

The participants in the IPPF/WHO initiative experimented with different strategies to strengthen referral networks, build alliances with other sectors, conduct legal advocacy, and carry out community education efforts. This chapter presents some of the lessons learned from those experiences.

Specifically, this chapter includes the following subsections:

- Overview
- Building Alliances With Other Organizations
- Legal Advocacy and Community Education

Chapter 7: Bibliography and References

This chapter includes a one-page annotated bibliography and a longer list of references for materials cited in this manual.

Chapter 8: Annexes: Monitoring and Evaluation Tools

- ➔ Tool: Sample Logical Framework
- ➔ Tool: Provider Knowledge, Attitudes and Practices Survey Questionnaire
- ➔ Tool: Clinic Observation Guide
- ➔ Tool: Client Exit Survey Questionnaire
- ➔ Tool: Sample Protocol for Qualitative Evaluation
- ➔ Tool: Random Record Review Protocol

- ¹ Krug et al. eds. *World report on violence and health*. Geneva: World Health Organization, 2002.
- ² Heise L, Ellsberg M, Gottemoeller M. "Ending Violence Against Women." *Population Reports*, Volume XXVII, Number 4, Series L, Number 11, 1999.
- ³ *Resolution WHA49.25 of the Forty-ninth World Health Assembly*. Geneva: World Health Organization, 1996.
- ⁴ Heise et al, 1999.
- ⁵ "Violence against women: relevance for medical practitioners." *Journal of the American Medical Association*, 267: 3184-95, 1992.
- ⁶ *Domestic Violence. American College of Obstetrics and Gynecologists Technical Bulletin*, Number 209. Washington: American College of Obstetrics and Gynecologists, 1993.
- ⁷ *Domestic violence: a health care issue*. London: British Medical Association, 1998.
- ⁸ García-Moreno C. "Dilemmas and opportunities for an appropriate health-service response to violence against women." *Lancet* 359: 1509-14, 2002.
- ⁹ Ramsay J, Richardson J, Carter Y, Davidson L, Feder G. "Should health professionals screen women for domestic violence? Systematic Review." *British Medical Journal* 325 (7359):314, 2002.



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IPPF/WHR

120 Wall Street, 9th Floor • New York, NY 10005-3902

Tel: 212-248-6400 • Fax: 212-248-4221

Email: info@ippfwhr.org • Web: www.ippfwhr.org

With support from



Improving the Health Sector Response to Gender Based Violence

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Authors:

Sarah Bott

Alessandra Guedes

María Cecilia Claramunt

Ana Guezmes

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i. Preface

In 1999, three IPPF member associations and the Regional Office of the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) began collaborating on a joint initiative to improve the health care response to gender-based violence at these three associations, namely:

PROFAMILIA, the IPPF member association in the Dominican Republic

INPPARES, the IPPF member association in Peru

PLAFAM, the IPPF member association in Venezuela

with limited participation by **BEMFAM**, the IPPF member association in Brazil

The Regional Office and the member associations confronted many challenges in the process of designing, planning and implementing this initiative. Although they found a large number of excellent articles, manuals, tools and research studies on the health sector response to violence against women, these resources tended to have some limitations. For example:

- Much available material was based on research and program experiences from **developed countries**, such as the United States and Britain, rather than **developing countries**, where health programs may face greater challenges such as weak legal systems and a lack of referral services in the community.
- While there was a lot of material available for **individual health care providers** on how to care for women who experience violence, less information was available for **health care managers** who might want to adapt systems, protocols and tools for an entire institution.
- Much of the existing literature provided an **overview** of how to approach the issue of violence in a health care setting, rather than **detailed, practical** recommendations and tools that health managers could use to design effective and feasible policies.

- Finally, the literature seemed to focus more on **emergency rooms and primary care settings** rather than the issues that were particularly relevant to **sexual and reproductive health services**.

To address the gaps in the research and program literature, IPPF/WHR invested heavily in adapting tools for sexual and reproductive health programs in Brazil, the Dominican Republic, Peru and Venezuela. IPPF/WHR also devoted substantial resources to monitoring, evaluating and documenting the results of the regional initiative and to exchanging lessons learned with other organizations in Latin America. Earlier versions of some tools and recommendations in this collection were previously published in newsletters,¹ journal articles^{2, 3} and presentations, or were made available on the Internet.

In March 2003 IPPF/WHR organized a regional conference in Antigua, Guatemala that brought together individuals and organizations working on the intersection of violence against women and health in Latin America. That Conference brought together 43 participants from 13 countries, representing 23 different organizations working on issues related to health and violence. Conference participants shared their work, identified key recommendations, and discussed remaining challenges and knowledge gaps about the health sector response to violence.

This manual is an attempt to compile all of these materials into a single publication in the hope that IPPF/WHR can fill some gaps in the published literature and thereby help other health programs to avoid having to reinvent the wheel.

ii. Acknowledgements

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I. Introduction

a. What Is Gender-Based Violence?

*“Violence against women” means any act of **gender-based violence** that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life. Violence against women shall be understood to encompass, but not be limited to, the following: Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.*

— 1993 UNITED NATIONS DECLARATION
ON THE ELIMINATION OF VIOLENCE
AGAINST WOMEN⁴

In 1993, the United Nations adopted the first international definition of violence against women. By referring to violence against women as “gender-based,” the United Nations highlighted the need to understand violence against women within the context of women’s and girl’s subordinate status in society. While both women and men experience violence, evidence suggests that the risk factors, patterns and consequences of violence against women are different than violence against men.⁵ As argued by Heise et al., “many cultures have beliefs, norms and social institutions that legitimize and therefore perpetuate violence against women.”⁶ Violence against women, therefore, cannot be understood in isolation from the norms, social structures and gender roles that influence women’s vulnerability to violence.

Gender-based violence is a pervasive public health and human rights problem throughout the world, but the patterns and prevalence of violence vary from place to place. For example, dowry-related violence is a serious problem in South Asia, but is rare in Latin America. Partly as a result, researchers and health programs have defined specific types of gender-based violence in different ways. By identifying the types and patterns of gender-based violence in the local community, health programs can develop operational definitions of violence to guide their work in ways that are most appropriate for their own setting.

This manual will use the terms “gender-based violence” and “violence against women” interchangeably to refer to the broad United Nations definition cited above. However, the recommendations in this manual are largely based on a four-year IPPF/WHR regional initiative in Latin America, which used the specific working definitions of gender-based violence described on the following page.

In Practice

IPPF/WHR working definitions of gender-based violence against adolescent and adult women

The three associations involved in the IPPF/WHR regional initiative developed working definitions that reflected the types of violence most common among their client population. Because the vast majority of their clients are adolescent and adult women, these definitions did not include violence against children. Detailed descriptions of these definitions are discussed later in this manual, but briefly they were as follows:

Violence within the family*

DEFINITION: Physical, psychological and/or economic abuse of a woman by her partner, ex-partner(s) or by another person within the home or family.

Sexual abuse/rape

DEFINITION: A broad concept that includes all forms of sexual coercion (emotional, physical and economic) against an adolescent or adult woman. It may or may not include rape (for example, imposing certain sexual practices such as fondling, exhibitionism, pornography etc.). Rape means the use of physical and/or emotional coercion, or threats to use it, in order to penetrate an adolescent or adult woman vaginally, orally or anally against her wishes.

History of sexual abuse in childhood

DEFINITION: Sexual abuse in childhood means utilizing a minor 12 years old or younger for sexual pleasure. Sexual abuse in childhood may involve physical contact, masturbation, sexual intercourse (inclusive of penetration) and/or oral and anal contact. It can also include exhibitionism, voyeurism, pornography and/or child prostitution. Having a history of sexual abuse in childhood means that an adolescent or adult woman had such an experience in the past.

**Sexual violence often accompanies other kinds of family violence, but to facilitate the classification of data, IPPF/WHR grouped all sexual violence into one category regardless of who perpetrated the abuse.*

b. Why Should The Health Sector Address Gender-Based Violence?

In addition to being more humane, now I see the patient as a whole. Before, I saw problems that did not fit into what I had learned. Now I am more efficient. I have a new approach, and I know that many pathologies for which I did not find an explanation have to do with violence.

— GYNCOLOGIST FROM PROFAMILIA, THE DOMINICAN REPUBLIC

In 1996, the World Health Assembly declared violence against women to be a major public health problem that urgently needed to be addressed by governments and health organizations.⁷ However, despite evidence that it is a pervasive public health problem throughout the world, gender-based violence is often ignored by the health sector. Health care professionals often fail to recognize the impact of gender-based violence on women's health, and many continue to consider it a social or cultural issue that is not relevant to their work.

This manual will argue that health care organizations—particularly those working in the field of sexual and reproductive health—cannot provide adequate quality health care to women unless they make a commitment to the needs and safety of women who experience violence. Health care providers who ignore violence against women not only miss the opportunity to address an important public health problem, but can inadvertently harm women or put women at additional risk of violence.

Reasons why health organizations should address gender-based violence:

- **Gender-based violence is a major cause of disability and death among women.** A growing body of epidemiological evidence indicates that intimate partner violence alone is a major cause of disability and death among women of reproductive age throughout the world.⁸ Gender-based violence has profound, negative consequences for women's physical and emotional health, ranging from emotional distress, physical injury and chronic pain to deadly outcomes such as suicide and homicide. It
- **Gender-based violence has adverse consequences for women's sexual and reproductive health.** Physical and sexual violence can limit a woman's ability to negotiate the use of condoms or other contraception,⁹ putting them at a higher risk for unintended pregnancies¹⁰ and sexually transmitted infections (STIs), including HIV. Childhood sexual abuse has been associated with risky behaviors such as drug and alcohol use, more sexual partners and lower contraceptive use.¹¹ The experience of gender-based violence has also been linked to increased risk of gynecological disorders,¹² unsafe abortion, pregnancy complications,¹³ miscarriage, low birth weight¹⁴ and pelvic inflammatory disease.
- **If they do not ask about violence, providers may misdiagnose victims or offer inappropriate care.** Many conditions, such as chronic pain or reoccurring sexually-transmitted infections, can be difficult to diagnose or treat without knowing about a woman's history of violence. Providers who fail to consider the possibility that women are living in situations of violence may not be able to provide effective or appropriate counseling related to family planning, STI prevention or HIV/AIDS. Finally, providers who ignore victims' broader needs may miss the opportunity to help women avoid a potentially life-threatening situation.
- **Health care providers are strategically placed to identify women at risk.** Health programs—particularly those that provide sexual and reproductive health services—are often among the few institutions that have routine contact with most adult women in developing countries. Health professionals are thus strategically placed to identify women who experience gender-based violence. However, many women do not disclose experiences of violence to health care providers unless they are asked. Health programs can contribute to this effort by equipping staff to discuss violence with clients and to respond appropriately to a disclosure. Health providers are also well-placed to help women living

with violence to become aware of the risks that they face, and survivors sometimes cite this experience as the first step on the road to seeking help.

- **Health professionals are in a unique position to change societal attitudes about violence against women.** Health professionals have an important role to play in the effort to change attitudes about violence because they can reframe violence as a health problem rather than merely a social custom. Conservative elements of society that tolerate or justify violence against women sometimes change their views when health professionals demonstrate the negative consequences of gender-based violence for women's and children's health.
- **Responding to gender-based violence can improve the overall quality of health care.** IPPF/WHR found that improving the health service response to violence produced unexpected improvements in quality of care throughout the participating clinics. For example, providers told evaluators that the regional initiative helped strengthen privacy and confidentiality, increased respect for women's rights more generally, and encouraged a more integrated and holistic vision of women's health.
- **Health professionals may inadvertently put women at risk if they are uninformed or unprepared.** Given the prevalence of violence against women in most settings of the world, most providers who care for adult women have probably cared for survivors of violence, whether or not they know it. Health professionals who breach patient confidentiality, who respond poorly to a disclosure of violence, who blame victims, or who fail to offer crisis intervention can put women's safety, wellbeing and even their lives at risk. For example, providers can unwittingly cause harm by:
 - Expressing negative attitudes to clients about women who are beaten or raped.
 - Discussing a woman's injuries in a consultation room that can be overheard by a potentially violent spouse standing outside.
 - Breaching confidentiality by sharing information about pregnancy, abortion, STIs, HIV or sexual abuse with another family member without the woman's consent.

- Providing inappropriate medical care by misunderstanding the reasons behind a recurrent sexually transmitted infection.
- Ignoring warning signs that a woman is in danger of suicide or homicide.

When health care organizations fail to address the issue of gender-based violence, such neglect can cause harm to women.

In Practice

A health care manager's perspective on the importance of addressing gender-based violence

Violence has spent much time sitting in our waiting room; it has likely been on the verge of entering a clinic. It is one more issue that we need to heal. It is known that violence is a topic that receives little discussion, since it is seen as a private matter of interest only to those involved. The association, then, must become involved when it takes on the task of working with those whose health has been affected by violence. In order to help lay our own doubts and anxieties to rest, it was important to:

- Recognize the effort to address gender-based violence as an essential part of our mission to improve the quality of women's lives and as a cornerstone of sexual and reproductive health.
- Create spaces for participation and sensitization of all personnel—not just the health providers, but also the managers, administrative personnel, Board of Directors, executive management, and volunteers.
- Recognize gender-based violence as a real and fundamental aspect of the current workings of our society, no matter how undesirable this might be. This being the case, the issue of gender-based violence is demystified from something distant and of interest only to those who are directly involved, allowing us to identify ourselves as persons just as vulnerable to a life threatened by violence.

— SUSANA MEDINA, GENDER-BASED VIOLENCE COORDINATOR, PLAFAM (VENEZUELA)

c. IPPF/WHO's Work on Gender-Based Violence

The International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHO) was founded in 1954 with the goal of improving the health of women throughout the Americas. IPPF/WHO works through a network of 46 member associations in the United States, Canada, Latin America and the Caribbean. These associations provide twelve million services each year at more than 40,000 service delivery points. Each member is a private, autonomous organization, established to supply family planning and other health services according to local needs, customs and laws. IPPF/WHO is one of six regions that comprise the International Planned Parenthood Federation (IPPF). The Regional Office of IPPF/WHO, which is based in New York, provides technical assistance and financial support to its member organizations and other reproductive health organizations, helps facilitate information sharing among its members, and advocates for sexual and reproductive rights on a regional and international level.

The 1994 International Conference on Population and Development in Cairo called for a broader, more integrated and holistic approach to sexual and reproductive health, recognizing individual rights, especially women's rights.¹⁵ The Cairo agenda acknowledged the impact of gender inequalities on health outcomes and encouraged health programs to raise awareness among their staff about women's rights. Following Cairo, IPPF/WHO took steps to help its member associations incorporate this vision and improve the quality of services by incorporating a gender perspective.¹⁶ IPPF/WHO carried out trainings and evaluations focused on gender to raise consciousness among associations' staff.¹⁷ During this process, clients and providers repeatedly mentioned violence against women, including sexual coercion, as an issue that merited attention.

The IPPF/WHO Regional Office and its member associations responded by developing a number of initiatives. Most importantly, in 1999, IPPF/WHO and three member associations launched a coordinated effort to integrate gender-based violence screening, referral and services into existing sexual and reproductive health services. Those associations were: PROFAMILIA (the Dominican Republic), INPPARES (Peru) and PLAFAM (Venezuela).

Their efforts were part of a multi-country initiative funded by the European Commission and the Bill and Melinda Gates Foundation. In addition, the IPPF member association in Brazil, BEMFAM, participated in several regional planning meetings and implemented efforts in its own clinics to improve the response to gender-based violence. Throughout the course of the initiative, the Regional Office in New York played a coordinating role, providing technical assistance, promoting south-to-south collaboration, and helping to disseminate lessons learned.

The four objectives of the IPPF/WHO regional initiative were:

- 1 To improve the capacity of sexual and reproductive health services to respond to the needs of women who experience gender-based violence;
- 2 To raise community awareness of gender-based violence as a public health problem and a violation of human rights;
- 3 To contribute to improvements in laws about gender-based violence and the application of those laws; and
- 4 To increase knowledge about effective and feasible ways that the health sector can help women who experience gender-based violence.

The regional initiative had several distinguishing features:

- Because sexual violence has particular relevance within the context of sexual and reproductive health services, IPPF/WHO and its member associations chose to address sexual violence by any perpetrator, not simply intimate partner violence (physical, sexual, emotional). This decision contrasts with initiatives that focus exclusively on either “domestic violence” or on “sexual assault.”
- The IPPF/WHO initiative was designed to produce lessons learned that could be relevant for Latin America and the Caribbean more generally. To achieve this, participants designed the interventions and evaluation to ensure cross-country comparability. Participants collaborated on the development of common definitions, tools, evaluation mechanisms, standard approaches to integrating screening and other services, and common strategies for conducting IEC (information, education and communication) campaigns and influencing changes in legislation. They held regional meetings to share results and plan new approaches.
- The associations took what Heise et al. call a “systems approach”.¹⁸ This approach emphasizes transforming the whole organization, not just training individual providers. To implement routine screening, referrals, and services, the associations reviewed all aspects of their health programs, including patient flow, clinic infrastructure, staff training, treatment protocols, clinical history forms, data systems, and agreements with referral organizations.
- Although some challenges remain, the evaluation suggested that the IPPF/WHO regional initiative produced organization-wide changes that encouraged staff to recognize screening for violence and service provision as an integral part of sexual and reproductive health services, improved overall quality of care, and benefited survivors of violence.

d. How to Use This Manual

The purpose of this manual is to document and disseminate the lessons learned from the IPPF/WHR regional initiative; to provide managers in developing countries with tools to improve the health care response to violence against women; and to identify the ongoing challenges and debates about how the health sector should address the problem of gender-based violence.

We expect that this manual will be most useful for the following audiences:

- Health care managers.** This manual is designed to help managers improve the way that whole organizations or clinics respond to gender-based violence. It is not a training curriculum or a guide for how individual health care professionals should care for women who have experienced violence.
- Private and nongovernmental organizations.** We hope that this manual will be helpful for health care managers working in both the public and private sectors. However, we recognize that the recommendations in this manual primarily reflect the experiences and perspectives of private, nongovernmental organizations devoted to sexual and reproductive health. As a result, this manual may not address all of the challenges facing those working in public sector health programs, including those belonging to ministries of health.
- Those working in developing country settings.** The tools and lessons learned in this manual were largely based on experiences from Latin America and the Caribbean. Conversations with health professionals from Asia and Africa suggest that health programs in other resource-poor settings face similar challenges, most notably a lack of referral services in the community and weak legal systems. However, while health programs in developed countries may find some of the material in this guide useful, other resources may be more suited to their needs. For example the Family Violence Prevention Fund has produced a guide that is specifically designed for the United States context.¹⁹
- Health programs devoted to the health of adolescent and adult women.** Gender-based violence affects women throughout their life cycle. However, the tools and strategies for addressing violence against children are often different than those needed to address violence against adolescent and adult women—the focus of the IPPF/WHR initiative. Therefore, health programs that want to address violence against the girl child may have to find other resources to help them in that effort.

Structure of this manual

This manual is divided into six chapters, not counting the Annexes. The materials are organized in chronological order so that the chapters at the beginning address the challenges facing organizations that have just begun to address gender-based violence, while the chapters toward the end of the manual contain information and tools for organizations with more experience. In general, tools related to program design have been incorporated into the main body of the text, while evaluation tools (such as surveys and data collection protocols) are generally located in the Annexes. Briefly, the chapters are organized as follows:

- Chapter 1: Introduction**
Provides a brief introduction to the issue of gender-based violence and the reasons why the health sector should address this issue.
- Chapter 2: The Planning and Preparatory Phase**
Provides information for health programs that are planning to address the issue of violence and that want information about how to prepare.
- Chapter 3: Improving the Health Service Response**
Presents recommendations and tools that may be helpful for **any** health service organization that wants to ensure quality health care for adolescent and adult women.
- Chapter 4: Implementing a Routine Screening Policy**
Presents recommendations and tools for health programs that have already strengthened the health service response to victims of violence and are considering asking their staff to screen women for gender-based violence on a routine basis.

- Chapter 5: Providing Specialized Services**
Contains recommendations for providing specialized services, such as counseling, psychological or legal services, and support groups, to women who have experienced violence.
- Chapter 6: Beyond the Clinic: Building Networks, Legal Advocacy, and Community Education**
Provides a brief discussion of strategies that the health sector can undertake beyond the clinic in the area of legal advocacy and community education.
- Chapter 7: Bibliography and References**
Includes a one-page annotated bibliography and a longer list of references for materials cited in this manual.

To adapt the information in this manual to other settings, readers should keep in mind that these instruments were originally developed in Spanish for the Latin American and Caribbean context, and the English language versions have not been field-tested. In addition, all of these instruments need to be adapted to suit the local language, cultural norms, institutional environment and objectives of each organization. And finally, there is still much to learn about how to reduce violence and care for women who experience gender-based violence. These tools should be considered working documents. There is always room for improvement, and all suggestions are welcome.

II. The Planning and Preparatory Phase

a. Overview

Health programs that want to address violence against women face a number of challenges. For example, they may need to educate their providers about difficult issues such as human rights, gender and the links between physical, emotional and social wellbeing. Although international agreements have repeatedly called on the health sector to promote gender equity, respect for human rights, and a more holistic approach to health care, these ideals have not been easy to put into practice in the field.

A second challenge is that health programs must ensure that their efforts do not harm women or put them at greater risk of additional violence or trauma. Caring for survivors of violence is complex. There is much to be learned about how health programs can care for women in effective and ethical ways. Health programs that launch a poorly-planned routine screening policy, for example, may do more harm than good.

Moreover, to address gender-based violence effectively, health programs must build links with the legal system and other sectors working on these issues. Intersectoral alliances do not always come easily to the health sector, especially when resources are limited and staff members are overworked.

To overcome these challenges, participants in the IPPF/WHO regional initiative spent many months educating themselves, establishing links with other organizations, understanding the situation in each community where they planned to work, and evaluating the needs of their institutions. This period of preparation helped them design approaches that were informed and carefully planned.

Recommendations and Lessons Learned

During the planning and preparation stage, health program managers may find it helpful to take a number of

key steps before launching an effort to help a health care organization address gender-based violence, each of which will be discussed in more detail later in this chapter. For example:

Inform yourself about gender issues, human rights and the epidemiology of gender-based violence. The more informed you are, the more able you will be to help your organization develop an ethical and effective strategy for addressing violence against women.

Learn as much as you can about the legal framework and the resources available in the local area. It is essential for managers to understand the local context of violence in their own community before they begin working in this area. This includes understanding the laws about violence against women and identifying which other organizations in the area offer services that might be helpful for women who experience violence. In addition, health programs can greatly benefit from identifying local, national and regional sources of advice and training.

Consider which goals, objectives and strategies your organization is prepared to address. For example, health programs can focus on improving the service response to violence, educating the broader community about violence as a public health problem, and/or participating in advocacy campaigns to improve legal protections for women.

Develop a monitoring and evaluation plan. Once your organization has selected an approach, monitoring and evaluation plans should be built into the effort to address gender-based violence from the beginning. Evaluation should not be seen as a separate activity, but as an integral part of any intervention or reform.

Carry out a baseline assessment of your organization. Conducting a baseline study is essential for assessing the needs of your organization and for gathering baseline data that can be used to measure key indicators of change over time.

b. Gender-Based Violence As A Public Health Problem

A growing body of epidemiological evidence demonstrates that gender-based violence can cause or contribute to a host of health problems among women, as outlined in the below chart produced by the Center for Health and Gender Equity (CHANGE).

Health Outcomes of Violence Against Women

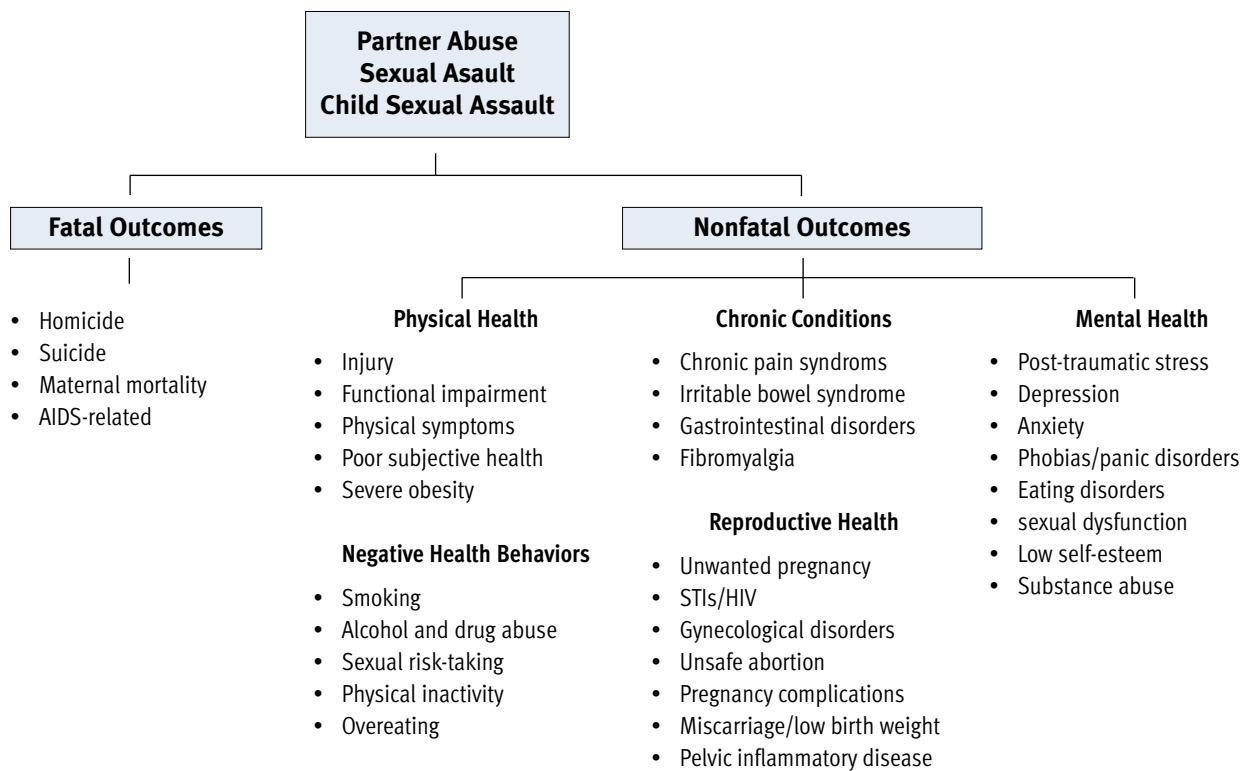
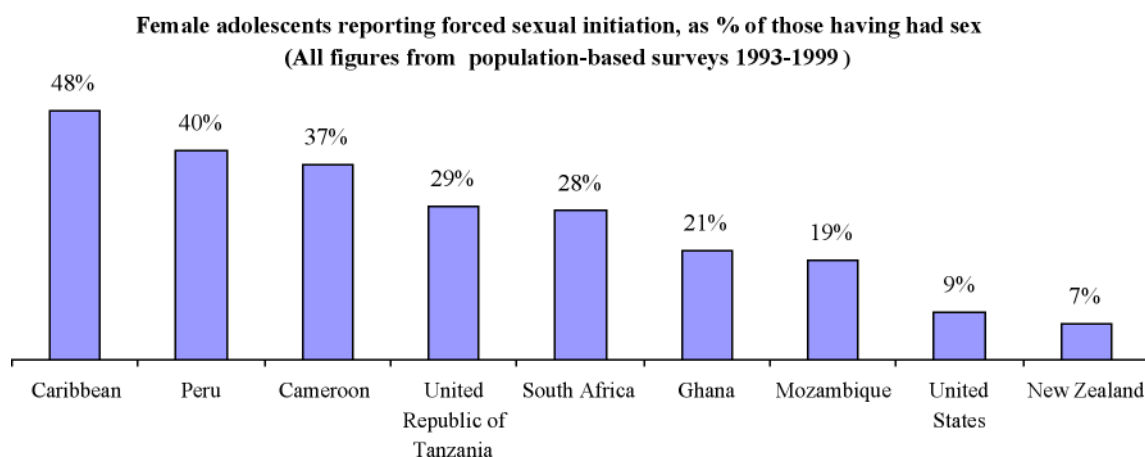
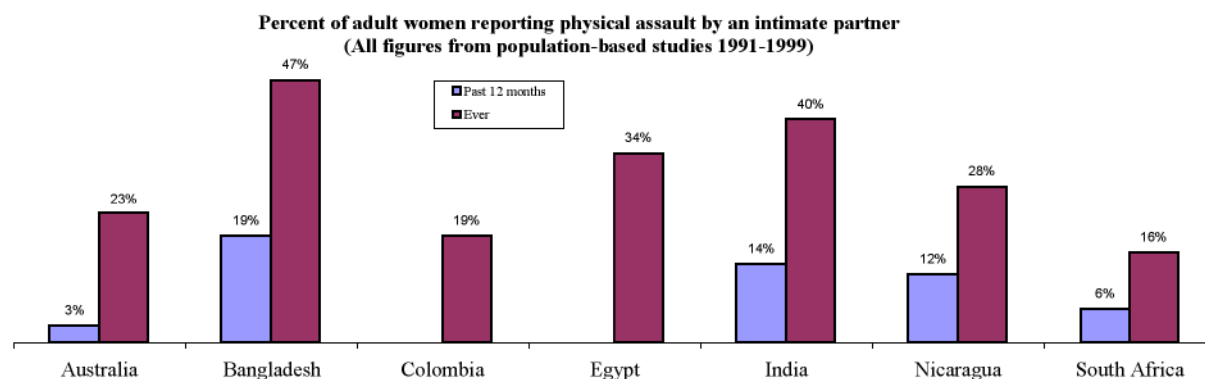


Figure reprinted with permission from the Center for Health and Gender Equity (CHANGE), as published in Heise L, Ellsberg M, Gottemoeller M (1999) Ending Violence Against Women. *Population Reports*, Volume XXVII, Number 4, Series L, Number 11.

While the prevalence of different kinds of gender-based violence varies from setting to setting, epidemiological evidence demonstrates that physical and sexual violence against women is a public health problem in virtually every part of the world. For example, the tables below present data cited in the World Health Organization (WHO) publication *World Report on Violence and Health*.²⁰



Despite this evidence, many health professionals do not recognize the links between violence and women's health, often because violence against women remains a "silent epidemic", under-recognized by society and rarely included in the professional training of medical staff. Too often, health care professionals believe that violence against women is a social problem that is not relevant to their daily practice, and may fail to recognize violence as

the cause of or contributing factor behind injury, infection, and chronic conditions. They may underestimate the risk of future injury and even death. They may miss the opportunity to provide adequate medical care and reduce risk. Even more serious, they may compound women's suffering by minimizing the problem, expressing negative attitudes toward victims, or by taking actions that put women's safety at risk.

There is a common tendency among health workers—particularly physicians—to believe that gender-based violence is not a health issue at all, but is something that should only concern psychologists or social workers.

How can a health organization approach violence against women as a public health problem?

- Educate all health personnel in the organization about the epidemiology of physical, sexual and psychological violence against women, including the magnitude of the problem, patterns of violence in the surrounding community, and the impact of violence on women's health.
- Ensure that the organization's policies and protocols incorporate the issue of gender-based violence.
- Ensure that health personnel are trained to recognize the direct and indirect consequences of gender-based violence and to recognize key signs and symptoms.
- Ensure that health personnel understand the potential dangers and risks faced by women living with violence, as well as ways to increase women's safety.
- Ensure that staff members understand the seriousness of breaching patient confidentiality to partners and family members, especially about issues such as pregnancy, contraception, abortion, STIs and HIV.
- Reassure providers that discussing violence is a legitimate use of time during a consultation.
- Communicate to providers that information about violence is important medical information that should be included in medical records (unless the clinic decides that this would put women's safety at risk).
- Encourage providers to embrace the World Health Organization's definition of health as: "a state of complete physical, mental and social wellbeing", not just the absence of disease.²¹
- Review the clinic policies, infrastructure, human resources and written materials to ensure that victims of violence have access to basic services in case of emergency or situations of risk.
- Incorporate messages about violence prevention and human rights into public health campaigns and community-based education efforts.
- Create a work environment with zero tolerance for violence and sexual harassment.
- Use the resources of the organization to raise awareness among the broader society about gender-based violence as a public health problem and a violation of human rights.

c. Adopting a Human Rights Framework

Most governments around the world have signed international agreements recognizing violence against women as a violation of human rights. However, there is still much work to be done to ensure that these international agreements are put into practice. The unfortunate reality is that many societies have cultural traditions and norms that tolerate or justify violence against women and that blame or stigmatize the victims. For example, in some

settings, many men and women believe that men have the right to discipline their wives or that women and girls who experience sexual violence must have done something to provoke or deserve the abuse.

Examples of negative attitudes about gender-based violence

Norms, attitudes and beliefs	Examples
<i>Husbands have the right to use physical violence against their wives</i>	<p><i>If it is a great mistake, then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings. (Husband, India)²²</i></p> <p><i>Wife beating is an accepted custom . . . we are wasting our time debating the issue. (Parliamentarian, Papua New Guinea)²³</i></p>
<i>Women like to be treated with violence</i>	<p><i>Some women don't feel loved if they are not beaten at home. (Nurse, rural South Africa)²⁴</i></p>
<i>Sexual violence by men against women is 'normal' and harmless</i>	<p><i>Gang rape shows the people who do it are still vigorous, and that is o.k. I think that might make them close to normal. (Senior lawmaker and former Cabinet Minister, Japan)²⁵</i></p> <p><i>If you are not a virgin, why do you complain? This is normal. (Assistant public prosecutor to a victim of sexual assault, Peru)²⁶</i></p> <p><i>The boys never meant any harm to the girls. They just wanted to rape. (Deputy principal of a boarding school, Kenya)²⁷</i></p>
<i>Victims of violence are to blame for their own suffering</i>	<p><i>There are women who look like they are saying, 'Do it to me.' . . . Those who have that kind of appearance are at fault, because men are black panthers (Chief Cabinet Secretary, Japan)²⁸</i></p> <p><i>The child was sexually aggressive. (Judge in British Columbia, Canada speaking about the sexual assault of a three-year old girl)²⁹</i></p>

Unfortunately, many health professionals share the norms, beliefs and attitudes of the broader society in which they live. Negative attitudes toward women in general and toward victims of violence in particular can inflict additional harm upon victims and may prevent health professionals from providing adequate medical care. Improving provider attitudes and beliefs about gender-based violence should therefore be considered a responsibility of every health organization; however, this is a challenging task that requires a long-term approach. This manual will argue that a human rights framework is an essential tool for changing the way that health professionals understand violence, view women's roles, treat their clients, and advocate for human dignity.

Issues such as gender and human rights can easily be misunderstood. The concepts of gender equity and human rights often remain poorly understood or accepted among health care providers in developing countries, despite many official agreements and declarations signed by governments at the international level. Even when professionals have attended workshops on gender awareness, they may resist a gender perspective or misinterpret the concept. In some cases, IPPF/WHR found that health personnel believed that a gender perspective simply meant that men and women should be treated the same. Others believed that a gender perspective was a superficial concept that could be put into practice simply by replacing masculine pronouns with gender-neutral language ("he/she" instead of "he"), even while they continued to express attitudes that ignored or justified social, political and economic discrimination against women in society.

Approaching violence against women as a violation of human rights is a challenging but essential part of any effort to transform the health sector's response to gender-based violence.

Recommendations and Lessons Learned

IPPF/WHR and other organizations in the Latin American region recommend that health managers who want to ensure that their approach to gender-based violence is based on principles of public health and human rights consider the following lessons learned:

Training in gender and human rights is essential preparation for improving the health sector response to violence. IPPF/WHR found that members associations that had already sensitized their staff about issues related to gender and human rights were better prepared to address the issue of violence against women. Associations whose staff had not been exposed to human rights concepts, or whose staff resisted a "gender perspective", found it more difficult to address gender-based violence.

Misunderstandings about gender and rights can lead to emotional debates unless managers approach these issues in a thoughtful way. Health providers often have deeply held beliefs about gender issues and women's rights. Asking health professionals to embrace a "gender perspective" may challenge their fundamental beliefs and provoke a powerful negative reaction unless managers approach these issues in ways that take into account staff members' personal experiences and values. Later sections of this manual will present suggestions about how to do this in the context of training.

A human rights perspective is just as important as a gender perspective. While a gender perspective is important for understanding attitudes about violence against women, a human rights perspective is an essential way to change those attitudes. IPPF/WHR found that some health professionals' hostility to the concept of gender could be resolved through a better understanding of the human rights framework. Human rights has always been an integral part of theoretical writing about gender; however, IPPF/WHR found that these ideas sometimes get overlooked in field trainings about gender among health workers. Unfortunately, in settings where disrespect for human dignity is common, treating women and men equally can mean treating them with equal disrespect. What ultimately brought IPPF/WHR initiative participants to a consensus on contentious issues about "gender" was an emphasis on human rights. *All people, women and men, have a right to live free of violence. Women should not have to give up this right in order to live with a husband or ensure economic support for their children.*

It is especially challenging to address women's rights when an organization is extremely hierarchical or when the society tolerates disrespect for human rights more generally. Encouraging respect for human rights may be particularly challenging when hierarchies by profession, social status, class, gender or ethnicity foster an environment in which subordinates are treated with disrespect. In medical settings, there are often large power differences between physicians and other health workers, due to differences in class, gender, ethnicity, sex and profession. Furthermore, in developing countries, doctors often have a higher social status than their female clients. In such settings, it is particularly important for health care organizations to insist that staff treat each other and their clients with respect.

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

- Collecting, reading and distributing educational material about gender and human rights.
- Encouraging staff in the institution to attend workshops on gender and human rights.
- Building alliances with local organizations and individuals working on issues of health, gender and human rights.
- Evaluating whether the organization incorporates a gender and human rights perspective into its work.
- Identifying ways to strengthen the institution's commitment to gender equity and human rights.
- Considering carrying out an organization-wide exercise such as "Evaluating Quality of Care From a Gender Perspective", a methodology developed by IPPF/WHR.³⁰
- Ensuring that anyone hired to educate or train staff about violence against women has a grasp of gender and human rights issues.
- Ensuring that your organization's approach to violence is based on a gender and human rights framework.
- Developing or strengthening policies that acknowledge patient rights and prohibit sexual harassment.

In Practice

Disagreements over the concept of “gender”

Most staff involved in the IPPF/WHR initiative had participated in workshops on gender issues by the time the regional initiative began. Nonetheless, a number of heated disagreements occurred during the planning phase about what it meant to see things from a gender perspective. For example, one debate dealt with whether or not the interventions should target men either as victims or aggressors.

The initiative had been specifically designed to meet the needs of women who experience violence. Both the patterns and consequences of violence against women are different from those associated with violence against men. For example, sexual violence (of any kind) and physical violence within the family disproportionately affect women³¹ and are closely linked to women’s subordinate social and economic status.³² However, a few participants in the IPPF/WHR regional initiative argued that it was “sexist” and “gender insensitive” to devote resources to violence against women without devoting the same kinds of resources to male victims of violence.

To build a consensus among participants, IPPF/WHR found it helpful to emphasize the implications of unequal power relationships between men and women, as highlighted by researchers such as Ann Blanc,^{33, 34} and to explore the cultural and social norms used to justify, excuse or ignore men’s use of violence against women, as explored by Heise et al.³⁵ Ultimately, however, what brought the regional initiative participants together was an emphasis on human rights as inalienable and indivisible, which led to the belief that women have a right to live free of violence under all circumstances, and that they should not have to give up this right in order to live with a husband or ensure economic support for their children. This experience suggests that the concept of “gender” can be easily misunderstood, and that field trainings on “gender” may not always devote enough attention to human rights.

d. Conducting a Rapid Diagnosis of the Situation

Before developing a plan to help your organization respond to violence against women, managers need to have at least a preliminary understanding of the legal, social and epidemiological situation in the country, region or local community. For example, it is helpful to gather the following kinds of information:

- Any available evidence about the epidemiology of violence against women in the surrounding area, including data on prevalence, patterns and consequences of violence against women.
- Existing services—either public or private—for women who experience violence in the local coverage area. These can include medical, legal, psychological or social services for women.
- The legal framework at the national and local levels, including legislation related to gender-based violence, the procedures for enforcing the laws, and the reality of how those laws are applied or could be applied in practice.
- Local and national policies related to gender-based violence, including, for example, the policies and programs of governmental agencies such as ministries of health.
- The organization’s own experiences working on the issue of gender-based violence (if any), for example, any lessons learned from providing services to victims of violence, previous efforts to train staff in gender issues and human rights, known barriers and challenges, accomplishments, or experiences collaborating with networks or other organizations.

Recommendations and Lessons Learned

Preparing an organization to address the issue of gender-based violence can be a long process. However, a rapid situation analysis can be a first step in the process of educating managers about the legal issues, the existing resources and experiences of an institution, and the broader social and service context in the community. For this purpose, IPPF/WHO developed a **“Rapid Situation Analysis Tool”** (see the following pages), which is simply a two-page list of questions for gathering a preliminary understanding about the legal, administrative and institutional context. Eventually, health managers may need to gather more detailed, structured information on these issues in the country and local region. Other sections of this manual provide more in-depth tools for gathering information on the same set of issues, but the rapid situation analysis offers a way to begin the process.

Other lessons learned from the IPPF/WHR initiative include:

- ***Prevalence data on violence in the country or local community can help build support for the effort to improve the health service response.*** Although there is a growing amount of data on the prevalence of gender-based violence gathered by international researchers, it is often helpful for health programs to identify what data exist at the local or national levels, and whether or not this data has been published. This kind of local information can often be more compelling to health care providers than information from international sources. Data collected among providers' own clients can be the most powerful of all.
- ***Identifying which other organizations work in the area of gender-based violence is an essential step in the effort to improve the health sector response to violence.*** Researching and establishing alliances with other organizations in the area is important for a number of reasons. For one, it allows health programs to learn more about the issue of gender-based violence in general and about the situation in their particular setting. Such collaboration is essential for increasing women's access to the services that they need, given that women who experience violence often have needs that go far beyond medical care or psychological services.
- ***Many organizations have some experience working on the issue of gender-based violence, even if it has not been part of a comprehensive effort.*** Health care organizations that consider themselves in the beginning stages of addressing the issue of gender-based violence may find that their institution has more resources than they might think. For example, perhaps some individual staff members have sought out training on the topic of gender-based violence or have begun to screen women on their own initiative. It is important for health organizations not to overlook these resources within their own institution.

RAPID SITUATION ANALYSIS TOOL

What is the general context of the problem?

- 1 In general, what is known about the problem of gender-based violence in your health program's coverage area? Have any studies on the prevalence or patterns of gender-based violence been carried out in your region? Country? State/province? Community? Institution?
- 2 Does your country's government have a national plan to address the issue of gender-based violence? At the national level, are there any health sector policies, plans or programs to address the problem of gender-based violence? What are these policies and how are they applied in your community?
- 3 In the surrounding community, what types of services related to gender-based violence are available to women and/or perpetrators? For example, are there any organizations that offer support groups for women? Are there government-funded programs to protect minors? Are there any emergency hostels or shelters? Are there any non-governmental organizations that offer legal, psychological or social services for women who experience gender-based violence?
- 4 In your coverage area, what are the primary points of detection and care for adult women experiencing gender-based violence (for example, nongovernmental organizations, centers for reporting violence, hospitals, etc.)?
- 5 In your health program's coverage area, what is the primary point of detection and care of female children and adolescents who experience violence?
- 6 Are there any networks of organizations working on the problem of violence against women in your community, state/province or country?

What is the nature of the legal/administrative framework?

- 7 Are there laws in your country that criminalize violence against women within the family? What types of violence does the law address and what specific actions does it penalize?
- 8 Are there laws in the country that criminalize sexual violence? Which specific kinds of sexual abuse and violence are classified as crimes and which are not?
- 9 How effective is this legislation? Are there any data on the number of reported crimes compared to the number of sentences handed down?
- 10 Are there institutions or programs that follow up on the effectiveness and the impact of laws against violence?
- 11 Does the country have a Legal Code on Childhood and Adolescence? If so, what does it state about violence against minors?
- 12 What obligations do health service providers have with regard to situations of physical or sexual abuse? For example, are they required to report cases of violence to any legal or public health authorities? How do these obligations differ when the victim of abuse is a child, an adolescent or an adult?
- 13 What legal measures exist in the country to protect victims of violence? Who enforces them? What are the sanctions for failing to carry out these measures?

RAPID SITUATION ANALYSIS TOOL

- 14 Which law enforcement institutions are responsible for receiving reports of violence? What are the requirements and procedures for reporting violence? Are there different administrative or legal requirements and procedures for reporting violence when the victim is a minor?
 - 15 What governmental agency or institution is responsible for protecting and defending the rights of minors? What procedures are required to initiate processes of protection? What are the primary protection strategies offered by this institution in situations of incest, other forms of sexual abuse, physical abuse, negligence, or commercial sexual exploitation of children? Does this institution have an office located in your health program's coverage area?
 - 16 Regarding the collection of forensic evidence, which professionals and services in the health sector are authorized to perform forensic exams in cases of sexual violence and physical violence? Are there different procedures required when the victim is a minor? Are these services free? Are they available in the program's area of coverage? Are the individuals responsible for these procedures trained to care for victims of gender-based violence?
- What is the institutional situation within your health care organization?**
- 17 Does your institution have any experience working on issues related to any type of gender-based violence? What were the lessons learned?
 - 18 Have any staff members in your institution received training in the area of gender? Human rights? Gender-based violence? If so, when and what types of training?
 - 19 Does your organization have any written information or audiovisual materials related to the problem of gender-based violence? Has this information been made available to staff in your institution?
 - 20 Does the institution have policies and protocols that address gender-based violence?
 - 21 Has your organization collaborated with other institutions that provide services for women who experience any form of gender-based violence? What were the lessons learned?
 - 22 In cases of gender-based violence, what procedures are followed for asking women about violence, collecting evidence, recording/documenting the case, reporting, care, and referrals? Take into account community services as well as those offered in your own health care organization. Do your institution's procedures take legal requirements into consideration?
 - 23 Does your institution have any information about staff members' attitudes, beliefs and knowledge about gender-based violence?
 - 24 Within your institution, what are potential barriers to establishing and implementing a plan for addressing the needs of women who experience gender-based violence?
 - 25 What human and financial resources are available in your institution for addressing the issue of gender-based violence?

e. Identifying Goals, Objectives and Key Strategies

Regardless of what activities a health program plans to carry out, an essential part of planning any new effort is setting goals, developing objectives, and identifying key strategies and indicators that can measure whether that effort has produced the intended results. Identifying objectives and measuring progress are particularly important in the area of gender-based violence, given the need to learn more about the best way to address gender-based violence and given the potential for health services to put women at risk if their efforts are poorly designed.

While some organizations use the terms “goals, objectives and activities,” others use the terms “purpose, inputs, outputs, outcomes and impact.” Regardless of terminology, it is essential to define what you want to achieve, how you plan to achieve it, what would constitute indicators of success, and how you are going to measure those indicators. The terms developed by IPPF/WHO, as defined on the next page, will be used in this manual.³⁶

Developing a “logical framework” can be helpful for project planning, fundraising and evaluation. Once you identify objectives and strategies, these can be put into a matrix called a “logical framework.” Many donors require logical frameworks in order to obtain funding, but they can be important planning tools even when they are not required for funding purposes. More information on logical frameworks can be found in sections II.e and II.f of this manual, and a sample framework can be found in Annex A.

Recommendations and Lessons Learned

It is helpful to build a commitment to human rights and to transforming the whole organization into your goals, objective and strategies. As this manual has already discussed, improving the health service response to gender-based violence depends on a commitment to human rights and to transforming the whole organization. Building these principles into the goals, objectives and activities is an important way to ensure that these principles guide the organization’s work.

Regardless of terminology, it is essential to identify what you want to achieve, not just what activities you plan to carry out. Unfortunately, health programs often focus on how they will carry out their work, rather than on what results those activities are intended to produce. For example, they may focus on how many services they plan to provide or what types of training curricula they plan to produce, without clearly identifying what they want those services or training curricula to achieve.

IPPF/WHR's Terms		
Term	Definition	Examples
Goal	The overall problem that needs to be solved. The goal should be broad enough so that the health program can make only a partial contribution.	<ul style="list-style-type: none"> To improve the lives of women who experience gender-based violence in a given community. To reduce levels of violence against women in a given community.
Objectives/intermediate results	A specific and measurable achievement that can contribute to the broader goal. Think about what results you want to accomplish, not the process that you will use to achieve those results.	<ul style="list-style-type: none"> To improve health care providers' knowledge, attitudes, and practices related to gender-based violence.
Activities / interventions	How you propose to achieve your objectives. The activities or interventions that you will carry out to produce the results. These activities are the means to an end, but not the end itself.	<ul style="list-style-type: none"> Train health professionals in three clinics. Replace curtains with walls to ensure that medical consultations can be conducted in private.
Process indicators	The indicators that you can use to monitor the number and types of activities that you carry out.	<ul style="list-style-type: none"> The number and types of services provided. The number of staff members trained. The number and type of training materials produced. The number of walls built or strengthened. The number and percentage of female clients screened.
Results indicators	The indicators that you can use to evaluate whether or not you achieved your objectives/intended results.	<ul style="list-style-type: none"> Selected indicators of knowledge, attitudes and practices as measured by a survey of providers. Selected indicators of privacy and confidentiality as measured by a structured observation of each clinic. The perceptions of survivors about the quality and benefits of the services provided by the organization as measured by individual interviews.

SUGGESTED STEPS FOR DEVELOPING GOALS, OBJECTIVES AND STRATEGIES

STEP 1: *Select the area (or type of work) that your organization wants to address.* The first step is for the health organization to identify the general area in which it will work. For example, health organizations can work in any of the following areas:

- **The health service response:** Improving the quality of care that survivors of violence receive in a health care setting (with or without routine screening).
 - **Raising community awareness:** Raising awareness of gender-based violence as a public health problem through mass media, grassroots campaigns, educational programs for youth, etc.
 - **Educating key professionals:** Improving the knowledge and attitudes of key groups, such as judges, policy-makers, medical students, nursing students, etc.
 - **Improving laws and policies:** Contributing to improved legal protections for women, including stronger legislation and better application of the law.
 - **Research:** Increasing knowledge about the prevalence, patterns and consequences (etc.) of violence against women and/or effective interventions.
-

SUGGESTED STEPS FOR DEVELOPING GOALS, OBJECTIVES AND STRATEGIES CONT.

STEP 2: *Identify objectives that correspond to those areas.* Health programs should identify objectives based on the area in which they choose to work. As an example, below are the objectives that IPPF/WHR used for some of the areas mentioned above.

Areas	General Objectives	Specific Objectives
Health services	To improve the way that health services respond to the needs of women who experience gender-based violence.	<ul style="list-style-type: none"> To improve provider knowledge, attitudes and practices. To strengthen privacy and confidentiality of patient records and consultations. To increase providers' ability to assess danger and provide crisis intervention for women who have experienced gender-based violence. To increase women's access to services that can assist victims of gender-based violence.
Community awareness	To raise community awareness of gender-based violence as a public health problem and a violation of human rights.	<ul style="list-style-type: none"> To raise awareness of gender-based violence among the client population as a public health problem and a violation of human rights. To increase knowledge and change attitudes among selected groups (e.g. youth participating in educational programs).
Laws and policies	To contribute to improvements in legislation and the application of laws related to gender-based violence.	<ul style="list-style-type: none"> To strengthen the laws that protect women from gender-based violence. To improve the ways that the police and the judicial system apply the law. To raise awareness, increase knowledge and change attitudes of law enforcement personnel about the issue of gender-based violence.

STEP 3: *Identify the activities, interventions, or strategies to be used to achieve those objectives.* The next step is to identify the activities that will allow your organization to achieve the intended objectives/results. The rest of this manual explores different strategies that can be used to strengthen the health service response to violence, for example, but the specific activities that your organization undertakes will depend on the local setting and the resources available.

STEP 4: *Develop a monitoring and evaluation plan that includes the indicators that will be used to measure progress toward your objectives.* A monitoring and evaluation plan should be developed at the same time as your goals, objectives and strategies. The next section of this manual provides specific suggestions for developing monitoring and evaluation plans for efforts to strengthen the health service response to violence.

SUGGESTED STEPS FOR DEVELOPING GOALS, OBJECTIVES AND STRATEGIES CONT.

STEP 5: *As you carry out each strategy, remember the original objective and measure the results.* As you turn your logical framework into action, it is important to remember the purpose and intended results of each activity. Clearly identifying the objectives/intended results of each strategy is as important a way to stay focused on what you are trying to achieve as is a commitment to monitoring and evaluating the results. The table below illustrates the possible links between activities to specific objectives.

Activity	Possible Objectives
Training providers	<p>To improve provider attitudes, knowledge and practices.</p> <p>To ensure that providers understand that the institution considers violence against women to be a public health problem and a violation of human rights.</p>
Screening women for gender-based violence	<p>To make it easier for victims of violence to share their experiences of gender-based violence with their health care providers.</p> <p>To increase the ability of health care providers to accurately diagnose and care for their clients.</p> <p>To increase the proportion of women who know where to seek assistance for gender-based violence.</p> <p>To increase women's awareness of gender-based violence as a health issue.</p>
Provide referrals to women who have experienced violence	<p>To increase women's knowledge about possible sources of help.</p> <p>To help women who experience gender-based violence improve their situation (e.g. to manage, escape from or recover from violence).</p>
Provide specialized services for women who have experienced violence (e.g. support groups)	<p>To improve the lives of women who have experienced violence.</p>

f. Developing a Monitoring and Evaluation Plan

Because gender-based violence is a relatively new issue for the health sector, there is still much that we do not know about the best way for health programs to protect the health, rights and safety of women who experience violence. Ideally, a health program 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 programs carry out activities without clarifying what results they are trying to achieve or determining whether or not they did in fact achieve those results.

Health programs 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. Because monitoring and evaluation are essential ways to protect women's health, rights and wellbeing, most chapters in this manual include a section devoted to the topic.

Remember the first principle of medicine is to do no harm. If health programs do not evaluate their work, they will not find out whether they have benefited women or caused them additional risk.

Recommendations and Lessons Learned

Violence interventions can greatly benefit from collaboration between staff with expertise in program design and staff with expertise in evaluation. Evaluation and program staff members were equal participants in the planning, design and implementation of the IPPF/WHO regional

initiative—a rare privilege given that resource constraints often prevent health programs from devoting adequate staff time to evaluation. This collaboration proved to be a great strength of the initiative, and we recommend this approach to other health programs when possible.

Monitoring and evaluation should be an integral part of any intervention related to violence, not a separate or secondary activity. It is essential to incorporate plans for monitoring and evaluation into any intervention from the beginning and throughout the process. When you identify the objectives of your work, you also need to ensure that you can measure those objectives with available resources. Evaluation is not something that can be postponed until the intervention is already underway, because it usually requires baseline data that can be used to track change over time.

Monitoring and evaluation are not luxuries; they are the only way to ensure that your strategies are working. Many health programs in developing countries feel pressure to spend money on “programs” rather than “evaluation.” However, this overlooks the essential role that evaluation plays in determining whether a program is effective and how it can be improved.

Find creative ways to overcome resource constraints. Many health programs in developing countries have limited resources for monitoring and evaluation. Some lack computers, others lack staff with expertise in evaluation methods, while some simply lack funds to hire external interviewers. When health programs face these limitations, the following strategies may be helpful:

- When submitting proposals to donors, include a generous line item for monitoring and evaluation.
- Use your resources wisely; choose methods that are feasible, reliable and most likely to yield information to improve your programs.
- Don't collect more data than you can analyze or use.
- Find ways to pool resources and collaborate with other organizations. For example, in some settings, university students can offer low-cost assistance in return for research experience.

Recognize the distinction between process indicators and results indicators. Health programs tend to gather a lot of data on the process (for example, how many activities they carried out) rather than on the results or outcomes. In some cases, they often do not even try to determine whether or not their activities were effective or beneficial. This is particularly problematic when working on the issue of violence because health programs have such an important ethical responsibility to ensure that their services do no harm. The table below offers brief definitions and examples of process versus results indicators.

Information on the perspectives of clients and providers is essential. Evaluation efforts should include interviews and/or group discussions with clients and providers. In particular, it is important to make sure that health programs listen to the voices of women in the process of designing and evaluating their programs.

Health programs need to share evaluation findings with their staff. Staff members need feedback on their work, and they also need an opportunity to suggest ways to make health programs work better. Health programs that gather monitoring and evaluation data have a responsibility to share that information with staff and given them an opportunity to discuss the findings with management.

Type of Indicator	Definition	Examples
Process Indicators	The indicators used to monitor the number and types of activities carried out.	<ul style="list-style-type: none"> • The number and types of services provided • The number of staff members trained • The number and type of training materials produced • The number of walls built or strengthened • The number and percentage of female clients screened
Results Indicators	The indicators used to evaluate whether or not the activity achieved the objectives/intended results	<ul style="list-style-type: none"> • Selected indicators of knowledge, attitudes and practices as measured by a survey of providers • Selected indicators of privacy and confidentiality as measured by a structured observation of each clinic • The perceptions of survivors about the quality and benefits of the services provided by the organization as measured by individual interviews

When you cannot identify quantitative indicators of success, qualitative methods offer a valuable alternative.

In evaluating the health service response to gender-based violence, it is often difficult to find quantifiable outcomes or indicators for measuring benefits or risks. When it is not possible to measure “benefits” or “risks” in simple, quantitative terms, it is almost always possible to gather qualitative data, such as information on the perspectives of health care providers and women who come for services. The challenge of evaluating certain kinds of objectives should not be used as an excuse to avoid doing it altogether.

For each program area, identify the objective(s), indicators and ways to measure those indicators.

A complete monitoring and evaluation plan for health services can be very detailed, but a matrix that identifies the objectives, indicators and the means of verification (i.e. what types of data collection methods will be used to measure those indicators) is an essential first step in drawing up a monitoring and evaluation plan. The matrix on the following page presents some examples.

SAMPLE MONITORING AND EVALUATION MATRIX

The following matrix shows examples of objectives, indicators and methods that can be used to monitor and evaluate the effort to strengthen the health service response to violence. The indicators are written in general terms, but ideally, a detailed monitoring and evaluation plan should list very specific indicators. Each methods listed in the right hand column corresponds to a tool included in this manual. These tools are listed on the following page, along with a brief description. (The following matrix is based on a project with a three-year duration.)

(Please see next page)

SAMPLE MONITORING AND EVALUATION MATRIX

General objective: To improve the health service response to gender-based violence

Specific Objectives	Types of Indicators	Methods for Measuring the Indicators	How Often?
To improve providers' knowledge, attitudes and practices To increase providers' awareness of gender-based violence as a public health problem and a violation of human rights	<ul style="list-style-type: none"> Percentage of providers who report selected attitudes, knowledge and practices (quantitative) 	Provider KAP survey	Baseline (year 1) and follow-up (year 3)
	<ul style="list-style-type: none"> Providers' perspectives on the effort to address gender-based violence (qualitative) 	Informal monthly meetings In-depth interviews Group discussions	Monthly Midterm (year 2)
To strengthen privacy and confidentiality within the clinics To improve clinic resources, policies and infrastructure	<ul style="list-style-type: none"> Proportion of clinics with private consultation areas (quantitative) Number and types of IEC materials available (quantitative) Number and types of written policies, protocols and directories that contain key elements (quantitative) 	Clinic observation guide Management checklist	Baseline (year 1) and follow-up (year 3) Continuous
	<ul style="list-style-type: none"> Providers' perspectives (qualitative) 	Group discussions Provider KAP survey	Midterm (year 2) Baseline (year 1) and follow-up (year 3)
To increase screening, detection, documentation, and referral levels To ensure quality care during screening	<ul style="list-style-type: none"> Proportion of clients screened and referred in accordance with clinic policies (quantitative) 	Routine service statistics Random record reviews	Continuous Midterm (year 2) and follow-up (year 3)
	<ul style="list-style-type: none"> Percentage of clients who report that the screening was done in private—not during the clinical exam—and in a sensitive and respectful manner (quantitative) 	Client exit survey	Midterm (year 2)
	<ul style="list-style-type: none"> Proportion of providers that is able to demonstrate ability to screen and respond to a disclosure adequately during a role-play (quantitative) 	Role-plays	Periodically year 1
To improve the quality of care for women To improve the situation for survivors of gender-based violence	<ul style="list-style-type: none"> Client's and provider's perspectives (qualitative) 	In-depth interviews	Baseline (year 1) Midterm (year 2)
	<ul style="list-style-type: none"> Perspectives of survivors about the quality of the services and the benefits and risks (qualitative) 	Group discussions	

TOOLS IN THIS MANUAL FOR EVALUATING THE HEALTH SERVICE RESPONSE TO VIOLENCE

The Annexes of this manual contain a number of data collection tools that health managers can use to evaluate their work in the effort to improve the health sector response to violence against women. These tools can be used as written or can be adapted to the setting and individual needs of different health programs. The list below provides a brief summary of each tool, the types of data it is designed to collect, and a brief description of how it should be used.

A survey questionnaire to assess provider knowledge, attitudes, and practices (KAP). IPPF/WHO 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 you use the questionnaire immediately "before and after" a single training, you may be able to measure changes in knowledge, but changes in attitudes and practices usually take time.

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.

A client exit survey questionnaire. 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/WHO 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.

A summary protocol for collecting qualitative evaluation data on client and provider perspectives. IPPF/WHO carried out a midterm evaluation that primarily consisted of gathering qualitative data on client and provider perspectives. The full protocol is too lengthy to include in this manual. However, we have included a summary of the methods used. Gathering qualitative data on provider's and client's perspectives generally requires hiring someone with substantial experience in qualitative data collection methods and in handling sensitive topics such as gender-based violence. The methods described in this summary include in-depth interviews as well as participatory methods, such as group discussions. The summary also gives an idea of what types of providers, clients and other stakeholders were asked to participate.

TOOLS IN THIS MANUAL FOR EVALUATING THE HEALTH SERVICE RESPONSE TO VIOLENCE CONT.

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 programs, as this depends on whether or not the health program 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.

A random record review 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.

g. Gathering Baseline Data

There are at least two reasons to carry out a baseline assessment of your organization:

1. Needs Assessment: Baseline information allows you to assess your organization's current needs. What resources do you already have? What areas need to be strengthened?

2. Evaluation: Baseline data allows you to understand where your organization stands at a moment in time so that you can measure change in the future and track the results of your efforts to achieve specific objectives. A rigorous program evaluation usually requires gathering comparable baseline and follow-up data.

It is helpful to keep both of these reasons in mind. Some organizations focus so much on “needs assessment” that they neglect to design their baseline assessment in a way that allows them to measure or evaluate change over time. The specific data that you need to evaluate your work will depend on your organization and the amount of financial resources available.

The section below includes recommendations about how to carry out a baseline study. It also describes a number of tools available in the Annex of this manual. A team of program and evaluation staff from four IPPF member associations and the Regional Office wrote and field-tested these tools in Spanish, and then revised them based on experiences in the field. Other health programs may find these tools to be helpful in whole or part, with appropriate adaptation for the health program's linguistic and cultural setting.

Recommendations and Lessons Learned

Face-to-face interviews with providers have advantages if you have the resources. Face-to-face interviews are more expensive than self-administered questionnaires because they require skilled interviewers who can ask difficult questions in a sensitive way. On the other hand, face-to-face interviews probably produce better quality information because an interviewer can ensure that the questionnaire is completed correctly and can clarify any questions that are unclear. Skilled interviewers may also

allow providers to elaborate on their answers. For example, interviewers in the IPPF/WHR evaluations took extensive qualitative field notes to complement the quantitative data.

Self-administered questionnaires offer a less expensive alternative to face-to-face interviews. Although the data quality may not be as high, a self-administered approach is a good option for health programs that do not have the resources to hire interviewers. The IPPF/WHR questionnaire has been formatted so that it can be used either face-to-face or as a self-administered tool.

It may be valuable to survey all health workers who have contact with female clients, not just physicians. All health workers can have a positive or negative impact on victims of violence, whether they are receptionists, nurses, educators or physicians. Even health workers who do not formally screen clients may interact with women in ways that can be more or less supportive. IPPF/WHR consultants interviewed ALL staff who had direct contact with female clients in sexual and reproductive health clinics.

Identifying a sampling design for a small organization may not make sense. Unless your clinic is extremely large, it may not be possible to develop a meaningful sampling design for a single organization. Instead, you may want to interview all staff in the clinic who meet the eligibility criteria, rather than a sub-sample. This will give you a complete picture of the health center at the time of the survey.

For face-to-face interviews, a small number of highly-skilled interviewers is essential. Researchers who interview health professionals about gender-based violence need a number of qualities and skills, including: a) the interviewer should be able to discuss sensitive issues in a non-threatening way; b) the interviewer should be a professional with enough credibility to conduct interviews with physicians; c) the interviewer should know something about gender-based violence (or at least be willing to educate her/himself about the topic and the ethical issues related to gender-based violence research in advance).

Your baseline and follow-up instruments need to include the same questions, even if they were not perfect. After you collect baseline data, you may find that some questions were poorly worded or had other problems. Nonetheless, your follow-up evaluation needs to use the same exact questions, even if they were flawed. If you change the questions, then you will not be able to compare your baseline and follow-up data to measure change over time. You can consider adding some new questions to the follow-up questionnaire at the end, as long as the rest of the questionnaire stays the same.

Any data collection that addresses gender-based violence should adhere to ethical principles outlined by the World Health Organization. Even though this survey does not ask providers about their own personal experiences as victims of violence, there is always a chance that a respondent will reveal such experiences to the interviewers. As a result, it is important that interviewers know how to handle a disclosure of this nature in a sensitive and ethical way. The World Health Organization has developed a series of ethical guidelines for conducting research on violence against women, entitled “Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence”, that is available on its website (www.who.int).³⁷

SUGGESTED STEPS FOR GATHERING BASELINE DATA AND DEVELOPING AN ACTION PLAN

The suggested steps below are based on the experiences of IPPF/WHR, and should be adapted to meet the specific needs of each organization.

STEP 1: ***Collect information on providers' knowledge, attitudes and practices related to gender-based violence.*** Information on providers' knowledge, attitudes and practices (KAP) 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 programs can measure changes in providers' knowledge, attitudes, and practices over time. A survey offers one way to collect information on providers' knowledge, attitudes, and practices. Another possibility is to gather qualitative data on providers' knowledge, attitudes, and practices through group discussions or other participatory methods with providers. Qualitative data can provide an in-depth understanding of providers' perspectives. On the other hand, quantitative data makes it easier to measure change over time.

STEP 2: ***Assess the infrastructure, policies, written materials, and human resources in each clinic.*** 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, 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 first-hand 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.

STEP 3: ***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.

STEP 4: ***Hold a participatory workshop to share the results, identify areas that need work, and develop an action plan.*** After collecting baseline data, health programs may find it valuable to hold a workshop with a broad group of staff members to discuss the results. For example, each IPPF member association involved in the regional initiative held a workshop to discuss the baseline results, to identify areas that needed improvement, and to develop strategies for overcoming those barriers. IPPF/WHR found that it was helpful to hold these workshops after staff members had received at least some sensitization/training about the issue of gender-based violence.

STEP 5: ***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. Three years after the baseline study, the three IPPF member associations repeated the KAP Survey as well as the Clinic Observation Guide. This allowed them to compare the situation in the association at the beginning of the initiative with the situation at the end of the initiative, to measure the results of their efforts, and to determine whether or not they had made progress toward achieving their objectives.

In Practice

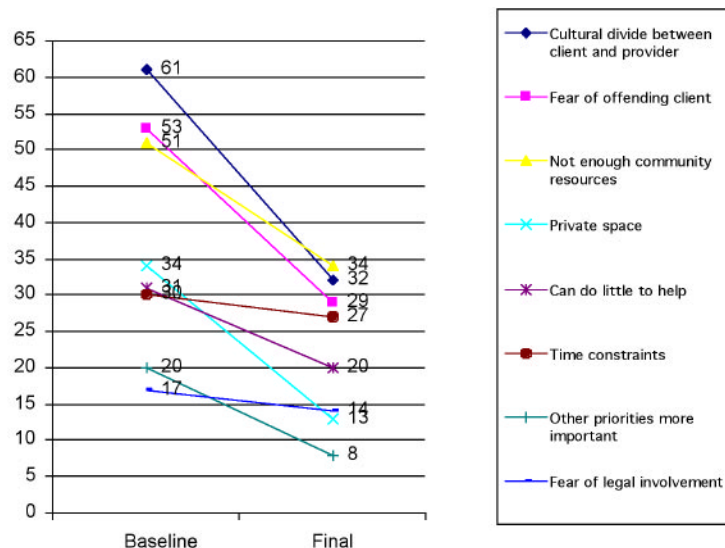
Results of the IPPF/WHR baseline and follow-up study

As part of the regional initiative's evaluation, IPPF/WHR hired external consultants to gather baseline data using a survey of provider knowledge, attitudes, and practices and a structured observation of each participating clinic. The baseline provider survey involved interviews with all (not a sample of) 79 staff members who had direct contact with female clients, including physicians, midwives, nurses, counselors, social workers, psychologists, and in some cases receptionists in participating services. Three years later, the evaluators reapplied the KAP provider survey through 98 face-to-face interviews with staff members who met the baseline eligibility requirements. During the course of the initiative, all three associations had experienced turnover and/or expanded, and as a result, 29% of respondents at follow-up had not been working at the associations at the time of the baseline. In fact, because hiring and firing practices were considered part of the intervention, the survey was deliberately designed to capture the KAP profile of the staff as a group at the beginning and at the end of the initiative. In addition to the survey, the evaluators re-applied the clinic observations in all clinics and carried out a random record review of medical charts at two different points in time to evaluate the adequacy of the written record of screening, documentation and referrals. Details of the baseline methods and findings have been published elsewhere,³⁸ but some key findings from the baseline and follow-up evaluation include the following:

The structured observations indicated that at baseline nearly all clinics lacked some key resources needed to address violence. For example, some consultation rooms could be overheard from outside; staff in some clinics filled out clinical history forms in the reception area; and most clinics lacked written information about referral services, screening questions, educational materials, and protocols for caring for women who had experienced sexual or physical violence. The vast majority of clinics had rectified those gaps by the end of the initiative when the follow-up observations were conducted.

The baseline found that many providers (58%) had discussed violence with clients, and most (85%) reported that a client had disclosed physical or sexual abuse, even before the clinics had implemented routine screening. In most cases, providers were not asking on a routine basis, but rather only when faced with signs or symptoms that led them to suspect a problem.

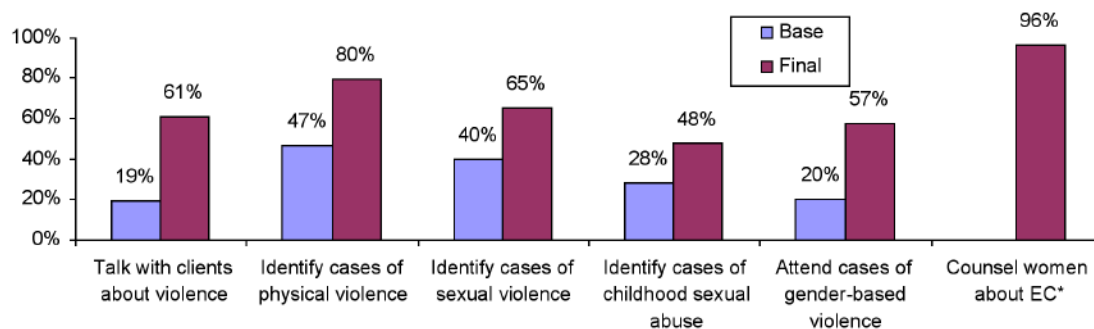
According to baseline and follow-up KAP surveys, the percentage of providers who cited the following as barriers to asking women about violence dropped over the course of the initiative.



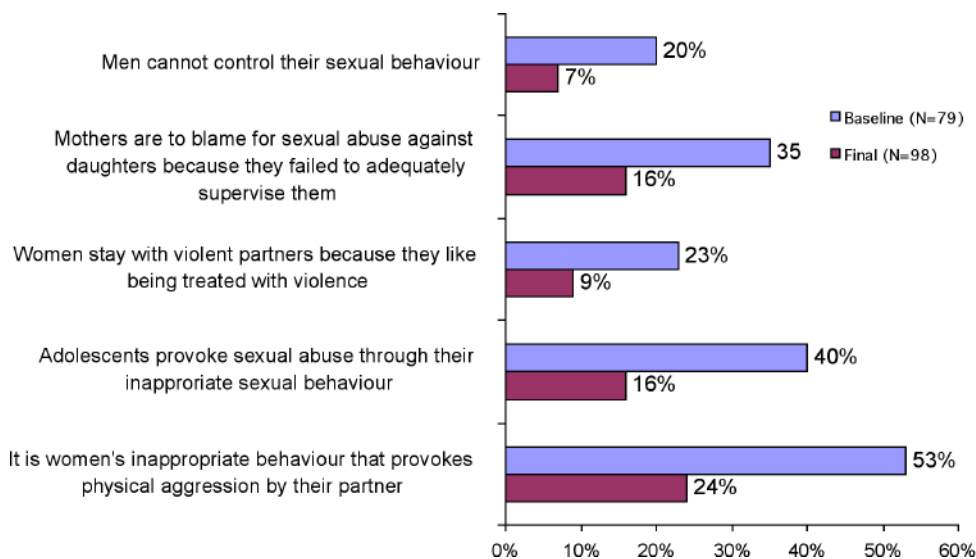
In Practice

Results of the IPPF/WHO baseline and follow-up study

The proportion of providers who felt “sufficiently” prepared to discuss violence, identify cases, and provide care to victims, rose between baseline and follow-up, as illustrated by the following key indicators:



The proportion of providers reporting attitudes that blame the victims rather than the perpetrators of physical and sexual violence dropped between baseline and follow-up, as indicated by the percent of providers that agreed of the following statements:



At baseline, some providers lacked general knowledge about gender-based violence. For example, almost half (46%) did not know that victims of gender-based violence tend to use more health services than women who have never experienced violence, and more than half (54%) were unaware of the high incidence of violence against pregnant women by their partners.

III. Improving the Health Service Response

a. Overview

The effort to address gender-based violence has implications for almost every aspect of health services, from the physical infrastructure of the clinic, to staff training, clinic policies, patient flow, referral networks, and data collection systems. One important step health organizations can take is to prepare their staff to discuss the issue of violence with clients in an informed, compassionate and respectful manner. However, as Heise et al.³⁹ and others have argued, simply training health care providers is not enough. In addition to training, health managers need to ensure that providers receive support from all levels of the organization by reviewing each clinic's written and human resources, infrastructure, policies, and procedures.

In recent years, a debate has emerged about whether, when, and how health care providers should ask women about gender-based violence. Some professional organizations have argued that providers should routinely ask patients about gender-based violence in primary care and reproductive health service settings. Others have urged caution, suggesting that screening women for violence raises ethical problems when referral services in the community are inadequate or when health programs have not done enough to change negative attitudes among providers.⁴⁰ Regardless of whether or not providers routinely screen women for violence, however, all health organizations have an ethical obligation to assess the quality of care that they provide to all women given that violence against women appears to be a public health problem in most parts of the world.

This section of the manual will review some key elements of improving the health service response to violence (each of which is discussed in more depth later in this manual) and will review the steps that health care organizations should take to protect women's safety and wellbeing before they consider screening women for violence on a routine basis.

In other words, this chapter will explore what are the minimum elements required to protect women's safety and provide quality care in light of widespread gender-based violence.

Recommendations and Lessons Learned

Health organizations cannot provide quality care to women unless they consider the implications of violence.

Health service professionals need to consider the implications of violence against their clients, both because ignorance and prejudice can inadvertently put women at risk or inflict emotional harm (for example through a breach of privacy or a negative attitude), and because health providers have a responsibility to address violence as a public health issue. Quality care to women therefore requires that health professionals recognize the health consequences of violence and take basic precautions to protect women's safety and dignity.

Improving the health service response to violence can increase quality of care for all clients.

IPPF/WHR found that improving the health service response to violence appeared to improve the quality of care for clients in general, not just for those women who experienced gender-based violence. For example, both managers and frontline providers reported that learning more about gender-based violence had made them more committed to privacy and confidentiality for all their patients, whether or not they disclosed violence.

All health programs have an obligation to review key elements of quality in light of gender-based violence.

Survivors of gender-based violence often have heightened needs for privacy, confidentiality, security, respect and emotional support, etc. Ample literature and the IPPF/WHR experience indicate that there are some essential elements necessary for providing quality health services to survivors of violence. These are elements of quality care that any health program can and should review. To this end, health managers may find it helpful to review two tools in this section:

A list of key elements of quality health care for women:

This is a list of key areas of quality care and a brief discussion of why these elements are important in response to gender-based violence; and

Management checklist: This is a checklist that contains specific questions to assess what measures an institution has taken to ensure an adequate response for women who experience violence. Managers can use this checklist for program planning or monitoring and evaluation.

KEY ELEMENTS OF QUALITY HEALTH CARE FOR WOMEN

Key elements	Why this element is important
Institutional values and commitment	The values, mission and overall commitment of an institution can have an enormous influence on the professional culture of frontline providers in any organization. Heise et al. ⁴¹ and others have argued that the most effective way for health services to respond to violence against women is for the whole institution to make a commitment to the issue (a “system’s approach”) rather than simply letting the responsibility fall on the shoulders of individual providers. Ideally, senior managers should be aware of gender-based violence as a public health problem and a human rights violation, and they should voice their support for efforts to improve the health service response to violence.
Alliances and referral networks	Before encouraging staff to discuss violence with clients, health programs have an obligation to investigate what referral services exist in the local community and to compile this information into a format that health care providers can use. This manual contains a series of recommendations and tools for developing referral directories and networks (section e of this chapter). Networks and alliances with other organizations are important for other reasons as well. For example, they allow the health sector to play a role in the broader policy debate by raising awareness of violence against women as a public health problem.
Privacy and confidentiality	Privacy and confidentiality are essential for women’s safety in any health care setting given that providers can put women’s safety at risk if they share sensitive information with partners, family members or friends without consent. A breach of confidentiality about pregnancy, rape, contraception, HIV status, abortion, or a history of sexual abuse can put women at risk of additional emotional, physical or sexual violence. Moreover, women who have already experienced violence need privacy in order to disclose those experiences to providers without fear of retaliation from a perpetrator. To protect confidentiality and privacy, health programs need adequate infrastructure and patient flow, as well as clear policies outlining when and where providers are allowed to discuss sensitive information.
Understanding local and national legislation	Educating providers about laws related to gender-based violence can prepare them to inform women about their rights and can alleviate their concerns about getting involved in legal proceedings when a client discloses violence. Both managers and service providers need to be familiar with local and national laws about gender-based violence, including what constitutes a crime, how to preserve forensic evidence, what rights women have with regard to bringing charges against a perpetrator and protecting themselves from future violence, and what steps women need to take in order to separate from a violent spouse. Health care providers also need to understand their obligations under the law, including legal reporting requirements (for example, in cases of child sexual abuse) as well as regulations governing who has access to medical records (for example, whether parents have the right to access the medical records of adolescents).
Ongoing provider sensitization and training	Providers’ attitudes, knowledge, and skills about gender-based violence can have a major impact on quality of care. Even without routine screening, clients may disclose experiences of physical or sexual violence, and providers who respond poorly can inflict great emotional harm. Moreover, providers who fail to consider the possibility of violence while counseling women about contraception, STIs, HIV prevention or health issues may be ineffective. Ignorance about links between health and violence may lead health workers to misdiagnose certain conditions and overlook the risks that some women face. Each institution must decide how much sensitization and training it can afford to provide. At a minimum, staff should be aware of the epidemiological evidence about violence, a human rights framework for understanding violence, and a basic understanding of local legislation. They should be able to respond to victims in a compassionate way and be prepared to care for women in crisis.

KEY ELEMENTS OF QUALITY HEALTH CARE FOR WOMEN CONT.

Protocols for caring for cases of violence	Protocols for screening, care, and referral of gender-based violence cases can be essential tools for health services. Developing protocols in a participatory way allows managers to engage staff in a dialogue about the best way to improve the health care response in resource-poor settings. Having written protocols readily available to health care providers can make it easier for staff to respond in an appropriate way. Moreover, anecdotal evidence suggests that clear policies and protocols can diminish the risk of harm to patients posed by negative attitudes from staff. ⁴²
Emergency contraception and other supplies	Emergency contraception is an essential service for women who experience rape and other forms of non-consensual, unprotected sex. Research suggests that women who live in a physically violent relationship often experience sexual violence, ⁴³ have difficulty negotiating contraceptive use, ⁴⁴ and may experience higher rates of unwanted pregnancy ⁴⁵ than women who do not live in situations of violence. Health programs have an obligation to ensure that clinics not only stock emergency contraception, but that their staff members know how to provide it to women.
Informational and educational materials	Displaying and distributing information in the clinic about gender-based violence (for example, in the form of posters, pamphlets, and cards) is an important way to indicate the organization's commitment to combating violence. These materials can raise awareness of the problem, educate clients about the unacceptability of gender-based violence, and inform women about their rights and local services where they can turn for help.
Medical records and information systems	Information systems play an important role in the response to violence in several ways. For example, health organizations have an obligation to ensure that providers know how to record sensitive information about cases of gender-based violence. Documenting information about violence in medical records may be important to complete a woman's medical record and in some cases may provide evidence for future legal proceedings. In order to protect women's safety and wellbeing, medical records need to be securely stored. Information systems are also important for monitoring a health organizations' work in the area of gender-based violence. For example, health care organizations can gather service statistics on the number of women identified as victims of violence, information that can help them determine the level of demand for other services.
Monitoring and evaluation	Monitoring and evaluating the quality of care is another essential way to ensure that health services are responding to violence in acceptable and supportive ways. At the level of management, administrators should receive ongoing feedback from providers to identify any problems and ways to improve the services. The input of women who have experienced violence can also be crucial for successfully refining the design of health services.
Regular opportunities for providers and managers to exchange feedback	Throughout the IPPF/WHO regional initiative, the member associations found it essential for managers to maintain an ongoing dialogue with frontline providers. The changes made throughout the organizations worked best when providers were allowed to participate in those decisions and to make improvements as the changes were put into practice. An ongoing challenge for many of the clinics, however, was to find enough ways to provide ongoing feedback to providers about the outcome of specific cases. Health care providers are often the first step in the referral process, and they may find it frustrating when there is no formal system for following-up with women who disclose violence.

MANAGEMENT CHECKLIST

	INSTITUTIONAL COMMITMENT	Yes	No
1.	Are the senior directors of the institutions (for example, the board of directors) sensitized about gender-based violence as a public health and human rights problem?		
2.	Have they voiced their support for the effort to address gender-based violence as a public health problem?		
3.	Has the institution made an explicit commitment to gender equity and human rights, ideally in writing?		
4.	Does the institution have a written policy prohibiting sexual harassment by staff that includes procedures for reporting cases of sexual harassment?		
	REFERRAL NETWORKS AND ALLIANCES WITH OTHER ORGANIZATIONS	Yes	No
5.	Have you met with representatives from other organizations working in the area of gender-based violence to identify how you can collaborate?		
6.	Is your institution part of a network or coalition of organizations that works on issues related to gender-based violence?		
7.	Does each clinic in your organization have a directory of referral services in the community that can help women who experience gender-based violence?		
8.	Do these directories include specific information about what kinds of services are available, how to access them (e.g. phone numbers, procedures, costs, etc.), and a contact name?		
9.	Do these directories include resources for special groups such as indigenous populations, clients who do not speak the predominant language, lesbians and gay men, undocumented immigrants, refugees, etc.?		
10.	Are these directories accessible to all health care providers in all clinics (for example, by distributing a copy to each staff member or by ensuring that at least one directory is located in an accessible place in each clinic)?		
11.	Have these directories been updated during the past year?		
12.	Has the institution gathered feedback from providers about the directories?		
13.	Has the institution developed a way (either formal or informal) to monitor the quality of referral services in the community?		
	LOCAL TECHNICAL ASSISTANCE	Yes	No
14.	Have you identified individuals and/or organizations in your country that could support efforts to sensitize and train health care providers on issues related to violence against women?		
15.	Have you identified individuals and/or organizations in your country that could assist your institution with the legal issues related to gender-based violence?		

MANAGEMENT CHECKLIST CONT.

	PRIVACY AND CONFIDENTIALITY	Yes	No
16.	Are consultation rooms built in such a way that clients cannot be heard or seen from outside?		
17.	If consultation areas can be overheard from outside (for example, if curtains are used to separate consultation areas), has the institution worked with providers to develop strategies to ensure privacy despite the limitations of the infrastructure?		
18.	Does the institution have written policies about confidentiality that explain the following: <ul style="list-style-type: none"> How to ensure that clinic records are kept in a secure place? 		
19.	<ul style="list-style-type: none"> Which staff members have access to medical records? 		
20.	<ul style="list-style-type: none"> Where and when staff are allowed to discuss confidential information with or about clients (e.g. not in the waiting room, not in front of other patients, etc.)? 		
21.	<ul style="list-style-type: none"> Whether adolescents have the right to keep their medical and personal information confidential from their parents or whether parents have the right to access their adolescent children's medical records without their consent? 		
22.	<ul style="list-style-type: none"> Whether and when health care providers should report cases of physical or sexual violence to the authorities? 		
23.	<ul style="list-style-type: none"> If any reporting requirements do exist, what process should providers follow for obtaining a client's consent, whether the client is a minor or an adult? 		
	STAFF SENSITIZATION AND TRAINING	Yes	No
24.	Have all staff in the institution participated in sensitization workshops that explore gender-based violence as a public health problem and violation of human rights?		
25.	Have all staff who have direct contact with female clients received in-depth training about gender-based violence?		
26.	Have all relevant staff in the institution been trained to provide emergency contraception?		
27.	Is there a mechanism to sensitize and train new staff members soon after they are hired?		
28.	Is there a mechanism to provide ongoing and repeated training concerning both general and specific issues related to gender-based violence?		
29.	Is there a mechanism for distributing written, educational information on gender-based violence (bulletins, memos, etc.) among the health staff on a regular basis?		
30.	Have health care providers received training about legal issues related to gender-based violence, including reporting requirements (if any)?		
31.	Is there a mechanism to provide emotional support to staff on a regular basis?		

MANAGEMENT CHECKLIST CONT.

	LEGAL ISSUES	Yes	No
32.	Have you gathered information on the local and national legal situation with regard to gender-based violence, including: <ul style="list-style-type: none"> • Laws related to physical and sexual violence within the family? 		
33.	<ul style="list-style-type: none"> • Laws related to sexual violence more generally? 		
34.	<ul style="list-style-type: none"> • Laws related to childhood sexual abuse? 		
35.	<ul style="list-style-type: none"> • The legal obligations of health workers with regard to gender-based violence in general? 		
36.	<ul style="list-style-type: none"> • And more specifically, whether and when health workers are required to report physical or sexual violence to the legal authorities (if ever)? 		
37.	<ul style="list-style-type: none"> • Regulations about who is allowed to collect forensic, documentary and photographic evidence of violence (including documenting injuries in medical records) in ways that can be presented as legal evidence in court? 		
38.	<ul style="list-style-type: none"> • If forensic evidence can only be documented by a physician licensed in forensic medicine: Where should providers refer women for forensic exams? How much do these services cost? What are the hours? What are the procedures for obtaining services? 		
39.	Has the institution distributed written information about legal issues to all staff members?		
	ADVOCACY AND IEC MATERIALS	Yes	No
40.	Does your institution have the following materials related to gender-based violence available in all clinics: <ul style="list-style-type: none"> • Posters or signs displayed on the walls? 		
41.	<ul style="list-style-type: none"> • Educational materials to give to clients? 		
42.	<ul style="list-style-type: none"> • Other types of materials? 		
43.	If so, do these materials address the following issues? <ul style="list-style-type: none"> • The message that women have the right to live free of physical and sexual violence? 		
44.	<ul style="list-style-type: none"> • Services available in the institution for women who experience violence? 		
45.	<ul style="list-style-type: none"> • Services offered by other institutions for women who experience violence? 		
46.	<ul style="list-style-type: none"> • Women's legal rights? 		
47.	<ul style="list-style-type: none"> • Emergency contraception? 		
48.	<ul style="list-style-type: none"> • Abortion? 		
49.	Are these materials available in all clinics/health centers?		
50.	Have these materials been validated with women?		

MANAGEMENT CHECKLIST CONT.

	PROTOCOLS FOR CARING FOR WOMEN WHO EXPERIENCE VIOLENCE	Yes	No
51.	Do all clinics have written protocols for caring for women who experience the following: • Physical violence by an intimate partner or another family member?		
52.	• Sexual violence, including rape?		
53.	• A history of childhood sexual abuse?		
54.	Do these protocols address the following: • Danger assessment and safety planning?		
55.	• Internal and external referral services?		
56.	• Reporting requirements (if any)?		
57.	• Caring for women in crisis?		
58.	• Different procedures (if any) required depending on the age of the victim (For example, minors versus adults, or clients who are above versus below the legal age of consent)?		
	EMERGENCY CONTRACEPTION	Yes	No
59.	Is emergency contraception available in all of the institution's clinics?		
60.	Are there written protocols for prescribing emergency contraception?		
	PROTOCOLS AND SYSTEMS FOR ROUTINE SCREENING (Only for institutions that ask providers to routinely screen women for violence)	Yes	No
61.	Do all clinics have a written protocol explaining which staff members should routinely screen for gender-based violence, when and how?		
62.	Do these protocols address the following: • The specific procedures in each individual clinic?		
63.	• Privacy and confidentiality?		
64.	• When to screen new clients?		
65.	• When to screen returning clients?		
66.	• Question(s) to evaluate whether the client is currently in a situation of danger?		
67.	• Safety planning?		
68.	• Emotional support and counseling, particularly in cases where the woman is in crisis?		
69.	• Internal and external referral services?		

MANAGEMENT CHECKLIST CONT.

70.	Have all health care providers been trained to follow the protocol?		
71.	Has the institution carried out role-plays with providers to see if they are able to screen women and handle a disclosure of violence in a sensitive and appropriate way?		
72.	Has the institution assessed patient flow and considered whether any adjustments need to be made in order to ensure that routine screening is always done in private?		
73.	Has the institution implemented these changes to the client flow where necessary?		
74.	Has there been an evaluation of the effectiveness of the new client flow in each clinic?		
75.	Does each clinic have a written policy or security procedures to protect staff safety (for example, if a violent spouse were to ask for information about his wife at the clinic or threaten a patient or staff onsite)?		
	DOCUMENTING INFORMATION RELATED TO ROUTINE SCREENING (Only for institutions that ask providers to routinely screen women for violence)	Yes	No
76.	Is there a system for documenting whether a client has been asked screening questions?		
77.	Is there a system for documenting the answers to screening questions (for example, a designated space printed or stamped onto the clinical history form, or a separate registry)?		
78.	Is there a mechanism for documenting the details of a case of violence (for example, information that can be used in court if a woman decides to pursue legal action)?		
79.	Is there a mechanism for gathering and analyzing data on the answers to screening questions (for example, the percentage of clients detected as victims of violence)?		
80.	Is there a mechanism for gathering and analyzing data on services related to gender-based violence (for example, how many women receive counseling services in a given year)?		
	FOLLOW-THROUGH ON REFERRALS AND COUNTER-REFERRALS	Yes	No
81.	Is there a mechanism to verify if a client went to referral services within the organization?		
82.	Is there a mechanism to verify if a client went to referral services outside the organization?		
83.	Is there any formal mechanism to determine the client's satisfaction with internal referrals?		
84.	Is there any formal mechanism to determine the client's satisfaction with external referrals?		
85.	Has the institution made an effort to investigate the quality of services provided at external referral services, including the police?		

MANAGEMENT CHECKLIST *CONT.*

	MONITORING AND EVALUATION	Yes	No
86.	Has the institution gathered baseline information on health care providers' knowledge, attitudes, and practices?		
87.	Has the institution gathered baseline information on the resources available in the clinics such as private space, protocols, referral directories, IEC materials, and emergency contraception?		
88.	Has the institution involved health workers in the process of improving the health service response to gender-based violence?		
89.	Has the institution gathered (female) clients' perspectives on the health service response to gender-based violence?		
90.	Has the institution monitored the quality of care on an ongoing basis?		
91.	Has the institution measured changes in health care providers' knowledge, attitudes, and practices over time?		

b. Aiming for Integration

In recent years, many health programs have broadened their services to ensure that they offer comprehensive, integrated health services. For example, instead of narrowly focusing on family planning services, many health programs ensure that health workers also address STI/HIV prevention and other health issues during family planning counseling, exams and prescriptions. Nonetheless, some health programs continue to have separate clinics that focus on a narrow set of health concerns. Since many health programs have not managed to provide integrated, comprehensive services in other key areas of women's health, it should not be surprising that integrating the issue of gender-based violence may be just as difficult.

The effort to integrate gender-based violence into health services may depend in part on how well the organization has managed to provide clients with integrated care in other areas. If family planning providers do not see the need to consider STI prevention in their work, then it may be equally hard to convince them to recognize the relevance of gender-based violence. In contrast, providers working in health programs that have already taken a more integrated approach to women's health may be more open to learning to recognize and care for the consequences of violence against women.

What does it mean to integrate concern for gender-based violence into health services? A concern for gender-based violence can be integrated into health services in the following ways:

- Health professionals would be aware of the prevalence, risks, and consequences of gender-based violence for a woman's health. They would consider gender-based violence as a possible explanation for recurrent STIs or suicidal depression, among other chronic health problems.
- Health professionals would take a holistic approach to women's health that recognized the extent to which a woman's social and emotional wellbeing is tied to her physical health.
- Clinical history forms would include questions about violence.
- Health programs would redesign their forms to give providers space to record details of violence directly on the clinical history form rather than ask them to

document this data on a separate register. In this way, providers would have a more complete and integrated record of a woman's health status, and could better diagnose and treat women who have experienced violence.

- Health care providers who are fully aware of the prevalence and consequences of gender-based violence would consider the connections between violence and other areas of health. For example, they would not counsel women about condom negotiation without considering the possibility that women might be living with an abusive partner or family member.
- Health programs would ensure that staff members have the skills to provide crisis intervention for victims of violence, even when psychologists are not available.
- Health programs would encourage providers to collaborate with other professions, such as psychological or legal services, as part of their work, not just as a favor to victims.
- Health programs would ensure that their mission statement and institutional objectives were broad enough to recognize gender-based violence as an issue within their scope of work.
- Managers would ask about knowledge and attitudes toward gender-based violence during job interviews with potential new staff members.
- The issue of gender-based violence would be discussed during staff trainings, quality-of-care evaluations, staff meetings, etc.

Recommendations and Lessons Learned

The IPPF/WHO regional initiative produced some broad lessons learned about how to approach the issue of gender-based violence within health services and, specifically, how to avoid some common pitfalls. These potential pitfalls and recommendations may be helpful in the process of developing a strategic plan and are summarized on the following page.

Key Recommendations for Integrating a Concern for Gender-Based Violence Into Women's Health Care

Possible pitfall	Recommendations for program managers
The professional culture of the organization is hierarchical, autocratic and/or tolerant of staff members who mistreat or disrespect each other or clients.	Health programs must begin by creating a work environment that is characterized by respect for human dignity. This includes creating an environment in which all staff members and clients are treated with respect, and where sexual harassment and abuse of any kind are grounds for dismissal. An organization can demonstrate a commitment to human rights, human dignity and nonviolence only by ensuring that these principles are respected in the workplace. Health programs need to ensure that they have written policies to address these issues and that there are mechanisms to put those policies into practice.
Some individuals or departments in the organization oppose or even undermine the effort to address gender-based violence.	Sensitize all staff in the organization before trying to design or implement reforms. Raising awareness throughout the organization about gender-based violence as a public health problem and human rights violation is an essential step to gaining broad support for the effort to address gender-based violence within health services. It is especially important to sensitize key decision-makers in the organization as a whole and in a clinic or health center. Key decision-makers may include the director of the organization, clinic managers, and influential health care providers, such as physicians.
A single training workshop for health care providers does not change health care provider behavior.	Complement training with changes throughout the clinic. Ample evidence suggests that a single training is not enough to change providers' behavior if they do not have other resources and support from the organization. Instead, Heise et al. argue, the most successful efforts to change providers' behavior occur when the organization carries out a comprehensive effort to improve the resources and policies within the health center or clinic. Without this support, some individual staff members may provide adequate care for survivors on their own initiative, but for broad sustainable improvement, health care organizations need to transform key elements of the whole system.
Health professionals agree to screen women for gender-based violence, but still do not recognize violence as a health issue and/or they believe that their sole responsibility is to refer women to psychologists or social workers. Providers may even assume that the purpose of screening is for research or to increase demand for a victims services program.	Place a high priority on educating staff about violence as a public health problem. There is a common tendency among health workers—particularly physicians—to believe that gender-based violence is not a health issue at all, but something that belongs in the area of psychology or social work. The challenge, therefore, is to educate health professionals to understand the health consequences of gender-based violence and to understand that, while screening can play an important role, it is a means to an end, not the end in itself.
An organization sets up separate or parallel services for victims of gender-based violence without really integrating the issue of violence into health services. As a result, the effort to address gender-based violence produces only superficial changes in health services.	Aim for integrating a concern for gender-based violence into health services. Integration can include the following: <ul style="list-style-type: none"> • Identifying steps toward integration as a key objective in the strategic plan. • Encouraging health professionals to recognize the health consequences of gender-based violence. • Developing systems to record cases of violence in medical records, rather than in a separate register. • Printing or stamping questions about violence on clinical history forms rather than having them written on a separate sheet of paper. • Encouraging health workers to consider the possibility that clients are living in a situation of violence when counseling women about family planning and sexually transmitted infections.
An organization develops a “project” to address gender-based violence that produces only short-term, unsustainable changes.	Avoid the project approach and aim for long-term changes. IPPF/WHR found that a “project” approach can undermine the effort to achieve long-term change. Emphasizing this effort as a “project” can lead staff to believe that the organization is making a temporary commitment to the issue, rather than trying to create lasting change in the way that health services are delivered.

In Practice

The pitfalls of the “project” approach

Many health programs think in terms of developing a “project” to address gender-based violence. Indeed, IPPF/WHO often referred to the regional initiative as the “gender-based violence project.” There are sensible reasons for taking this approach. For example, the effort to strengthen the health service response may require hiring one or more staff members who can dedicate their time to organizing training, developing protocols, setting up monitoring and evaluation efforts, etc. It often makes sense to write a proposal and seek funding for these activities over a limited period of time. However, IPPF/WHO found that the “project” approach could lead to a number of serious problems.

Sustainability. The first and most obvious problem is sustainability. When the project funds run out, what happens to the staff and services paid for by project funding?

Mistaking the “project” for a short-term research project. Emphasizing the idea of a short-term “project”, especially one that is focused on collecting routine screening data, can lead providers to assume that the “project” is just a research study to document prevalence of violence among clients, rather than an effort to transform the overall response of the organization to gender-based violence.⁴⁶

Mistaking the “project” for a short-term set of services for victims of violence. One IPPF member association found that an emphasis on the “gender-based violence project” led some physicians to think that the “project” simply aimed to provide specialized services to victims for a limited period of time. Initially, that association had emphasized the “gender-based violence project” as a separate entity. It gave it a unique name, developed a unique logo, and promoted services under that name among women in local communities. It hired specialized administrative, legal and psychological staff to work exclusively on “project” activities. It emphasized the project as a separate unit of the association with its own administrative structure. As a result, many physicians thought that their only responsibility was to ask screening questions and refer women to other services, without necessarily making broader changes to the way they provided health care to women. Eventually the association recognized the negative consequences of this approach. In the long run, it found that putting less emphasis on the “gender-based violence project” allowed it to achieve a greater degree of integration across the institution.

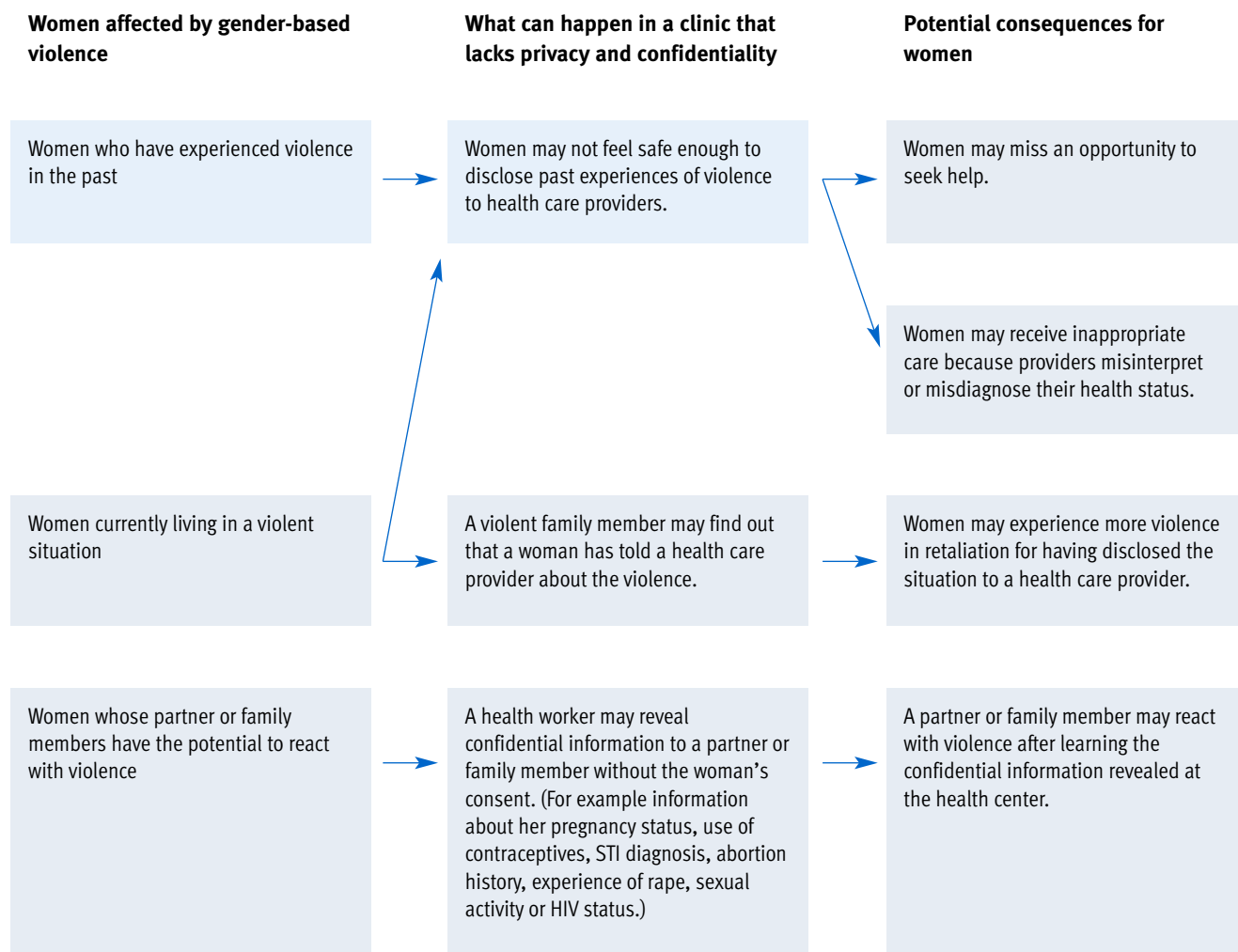
In contrast, one IPPF member association avoided the “project” approach from the beginning. It did not give the project a name or logo or even refer to the effort as “a project” among staff. All forms and correspondence went out under the association’s name. Medical staff were involved in participatory planning efforts at all stages along the way. The Executive Director made it clear to staff that the association was making a long-term commitment to integrating a concern for gender-based violence into the work of the association and that she expected staff to do more than simply screen and refer. This association had a relatively high level of success integrating gender-based violence into sexual and reproductive health services—particularly among physicians.

The challenge, therefore, is to ensure that an intensive effort to reform services produces long-term, sustainable changes throughout the organization. Improving the health service response to gender-based violence probably requires one or more staff to take a dedicated leadership role, and funds to pay for a series of specific activities for achieving specific objectives. Whenever possible, however, health programs should emphasize that these efforts are just the beginning of a long-term commitment to transforming the whole institution.

c. Ensuring Privacy

One important step that a health program can take to improve the quality of care for women is to strengthen the organization's commitment to privacy and confidentiality within health services. Privacy and confidentiality give women the confidence to reveal a history of violence and abuse to their health care provider. They also protect women from future violence, as women who tell health care providers that they are experiencing abuse may be at risk of further violence if the aggressor finds out that the woman has revealed this information. Furthermore, revealing other health related information—such as that a woman is pregnant, has had an abortion, or has a sexually transmitted infection—can place a woman at risk of violence if that information is shared with family, friends or employers without permission.

Potential consequences of lack of privacy and/or confidentiality in a health clinic



In Practice

The relationship between privacy, confidentiality and quality care

The midterm evaluation of the IPPF/WHR initiative found some evidence that improving privacy and confidentiality could improve the quality of services for all women. Clinic managers and providers told evaluators that the heightened emphasis on privacy and confidentiality raised awareness among staff about these issues for all of their clients.

Recommendations and Lessons Learned

These pages outline some key questions that managers can ask to assess the extent to which their services respect women's privacy during consultations at the clinic or health center.

Key concerns regarding privacy	Challenges and recommendations
Do the clinics have enough private space? <ul style="list-style-type: none"> Is there enough space for health care providers to consult with patients <u>individually</u>? Is there enough space to collect intake information in a private room rather than the reception area? Is there enough space to allow health workers to counsel women in situations of crisis without holding up all other medical appointments? 	<p>Many health centers do not have enough private consultation rooms to meet with patients individually. Some clinics have private rooms for doctors, but not for counseling women in times of crisis or for collecting intake information. To overcome these challenges, health managers can increase the amount of private space available by using space more efficiently (e.g. cleaning out a back room), dividing rooms in two, or actually expanding the clinic. If this is not possible, managers should consider ways to adjust patient flow, for example, by reassigning responsibility for collecting intake information from a receptionist to a different provider.</p>
Can patients be seen or heard from outside consultation rooms? <ul style="list-style-type: none"> Are the walls and doors of consultation rooms solid enough to prevent patients from being seen or overheard from outside the consultation room, such as hallways, adjoining rooms or reception areas? Are curtains used to separate any consultation areas? 	<p>In resource-poor settings, many consultation areas can be seen or heard from hallways or adjoining areas because doors or walls are thin or nonexistent. In some cases, health centers use curtains to separate consultation areas. Ideally, managers would be able to strengthen the walls and doors of consultation rooms to ensure privacy. When this is not possible, however, managers can take a number of steps: a) they can work with staff to determine whether it is possible to speak more softly so that they cannot be overheard; b) they can ask colleagues to vacate adjoining rooms or hallways in selected cases; and c) they can develop policies to ensure that discussions about sensitive information are restricted to those areas of the clinic that are in fact private.</p>
Do staff members protect women's right to privacy in practice? <ul style="list-style-type: none"> Do receptionists ask women to state the reason for their visit in front of other patients in the reception area? Do staff members collect intake information in the waiting room? Do staff members routinely interrupt or walk in on consultations or counseling sessions? 	<p>In many health care settings, health workers routinely fail to ensure women's privacy. For example, it is common for receptionists to ask women to state the reason for their visit in front of other patients in the reception area—even though women may consider that information to be highly personal. Similarly, in some clinics, health workers collect intake information (such as name, address, medical history) in public areas such as the waiting room, or they walk in on consultations without knocking. When these problems exist, managers should work with staff to reduce these practices. For example, staff should severely limit what they ask women to say in reception areas; they can try collecting information in writing if women know how to read and write. Otherwise, staff should wait until they can meet with women in private before asking them to share personal information out loud.</p>

<p>Have staff been trained to understand the importance of clients' privacy?</p> <ul style="list-style-type: none"> Have all staff, including receptionists, been trained to understand the extent to which a breach of privacy and confidentiality can put a woman's health and safety at risk? 	<p>In many settings, respect for privacy and confidentiality has simply not been a part of the professional culture within health services, either because of space limitations or because it has not been a priority of the organization. Managers can address this by ensuring that all staff members are trained to understand the potential risks of lack of privacy and confidentiality.</p>
<p>Are children over two years old allowed to be present during consultations?</p> <ul style="list-style-type: none"> Are providers aware that discussing sensitive issues such as violence or sexual and reproductive health around children over two years of age can place a woman at risk of violence? Does the clinic have a space where children can play within view of a staff person, such as a receptionist? Are any staff members willing to look after small children when women need to speak to a health worker alone in situations of crisis? 	<p>Children who are too young to understand a conversation can still repeat information to a potentially violent family member. This presents a challenge for health care providers because women often bring small children to health centers and most health centers do not provide childcare. Managers can take a number of steps to address this issue. First, they can establish a policy that providers should not ask women about violence (or other sensitive issues) in front of children over two years of age. Second, they can find strategies to help women meet with a provider alone, for example, by setting aside a corner of the waiting room where children can play under the supervision of the receptionist, or by identifying staff members who agree to look after children in selected cases, such as when a woman is in crisis.</p>
<p>Do women have the opportunity to see health workers without partners, family or friends?</p> <ul style="list-style-type: none"> Are providers aware that the person who accompanies the patient may be or may reveal information to a perpetrator of violence? Do providers ask women about violence in the presence of partners, family members or friends? Do providers know creative strategies for getting a moment alone with patients to ask whether she would like to discuss anything without her partner, family member or friend present? Do health workers know how to distract a family member or friend long enough to ask a woman about abuse when they suspect that she has been a victim of violence? 	<p>Many women want their partners, family members or friends to be present when they meet with a health worker, and health centers need to respect their wishes. However, health care providers also need to understand that in some cases, the partner or family member accompanying the woman may be an abuser, may have the potential for violence, or may reveal confidential information to a violent member of the household. Managers need to work with staff to develop policies about when to allow family and friends to accompany women at different stages of the consultation. These policies should balance the need to protect women's privacy with the need to respect women's preference for having a family member or friend present during the consultation. Clear-cut policies are not sufficient, however. Protecting women's privacy may require that providers understand the potential risks, use their judgment about what information to discuss in front of family members, and find creative strategies to obtain consent and to distract family members who may actively try to prevent women from consulting a health worker in private.</p>
<p>Has the clinic established norms and protocols to protect women's privacy, including rules that:</p> <ul style="list-style-type: none"> Prohibit staff from asking women to discuss personal information (such as medical history or test results) in public areas such as hallways? Identify when and how staff members are allowed to interrupt a consultation or counseling session? 	<p>Many health organizations could benefit from holding discussions with staff members about how to strengthen privacy and confidentiality in their clinics and then developing a set of norms, policies, or guidelines. In resource-poor settings, where private space is limited, staff may need to work together to find creative ways to help each other protect the privacy of their clients. The process of developing norms and policies allows staff to share ideas and then establish clear norms for how to carry out their work. Written norms and policies ease the burden on individual health workers to solve these problems on their own.</p>

In Practice

How to decide who to allow in the consultation room and when

Some confusion exists about whether or not health programs should require providers to examine women alone. On the one hand, if an abusive partner insists on being present during the entire visit to a physician, then a woman may not have an opportunity to disclose that she has been a victim of violence. On the other hand, many women want a partner, friend or family member to be with them during a consultation with a health worker, especially with a male physician. Moreover, women who have been sexually abused in the past may feel that it is especially important for a friend or family member to accompany them during a clinical examination.

One way to balance these concerns is for health care providers to begin the consultation by seeing the woman alone while she is still dressed. This gives the provider a chance to ask questions about violence and to ask the client whether she would like to have a friend or family member present for the remainder of the consultation. Some clinics have had a positive experience with the strategy of having signs in all consultations rooms stating the clinic policy that patients not be accompanied during the first part of the consultation.

It is important to note that the clinical exam is generally not an appropriate time to ask women difficult questions about violence, since women often feel more vulnerable while they are undressed or being touched by a health worker. It is better for staff to ask direct questions about violence when a woman is fully dressed. Therefore, it makes sense to allow women to be accompanied during the clinical exam. If providers find a reason to suspect that a client is a victim of violence during the course of the clinical exam, then they may have to find creative strategies to distract the person who accompanies her in order to speak to the client privately for a second time.

Whatever approach a health program decides to take, it is recommended that the program puts that policy in writing and informs all clients about the policy.

d. Strengthening Confidentiality

Confidentiality is an essential component of quality care and patient rights in any health-care setting. However, confidentiality is particularly important when women experience violence because breaches of confidentiality can have life-threatening consequences for women living in situations of violence.

Key concerns regarding confidentiality	Challenges and recommendations
<p>Are medical records stored in a secure place?</p> <ul style="list-style-type: none"> Are clients' medical records kept in a secure place that can be locked and is closely supervised? Do the clinics have written policies about who is allowed to access client records? Has the health center raised staff awareness about the importance of guarding the confidentiality of medical records? 	<p>In any setting, breaches of confidentiality can occur if medical records are kept out in the open, in an unsecured place, or in reach of anyone who comes into the clinic. Moreover, in many health centers in developing countries, patients may see whichever doctor is available that day, rather than having their own personal physician. In such settings, many different health workers have access to medical records. Each health center should develop policies about who can access medical records and under what conditions. Managers should train staff to understand the risks of breaching confidentiality.</p>
<p>Does the health center have clear policies about confidentiality, including:</p> <ul style="list-style-type: none"> Whether and when they are allowed to share information with: <ul style="list-style-type: none"> Other staff members? Family members? Parents of minors? Local law enforcement authorities? When and how staff should obtain consent from women before sharing information about her situation to a third party? Informing women and especially girls about any limits to confidentiality? 	<p>Health workers often face difficult questions about whether and when to reveal medical information about a patient. For example, if an adolescent girl has been beaten or raped by her boyfriend, or if she is pregnant, do the parents have a right to know? What if the girl wants to keep this information secret from her parents? What if there is evidence that the girl's family will subject her to further abuse or mistreatment? Is there a legal requirement to report this information to the authorities? What if the local law enforcement system itself is abusive? Does the clinic want to follow the legal reporting requirements? These are questions that should be addressed at the level of the clinic through norms and policies. Health workers should participate in developing those policies, but they should not be forced to make these decisions alone without guidance or support from the institution.</p>

<p>Does the staff have basic knowledge and awareness about the importance of confidentiality?</p> <ul style="list-style-type: none"> • Does the staff understand why a breach of confidentiality can put a woman at great risk? • Is the staff trained not to reveal client information without permission? • Does the staff know what kinds of information, if any, it is legally required to report to the authorities, for example, evidence of physical or sexual abuse of children, gunshot wounds, or physical violence against women? • Is there a mechanism in the clinic for getting feedback from staff about how well the clinic policies are working? 	<p>Ideally, every organization or individual clinic would develop norms and policies about confidentiality, with the participation of staff. The next step is to ensure that health personnel actually know what the policies are, support those policies, and understand the reasons behind them. Some clinics do not have any written policies about confidentiality. In other cases, norms and policies about confidentiality exist, but were not developed with adequate participation or feedback from providers. In many settings, clinic policies exist on paper, but the staff has not been adequately informed about what the policies are and what they are expected to do. If providers disagree with a policy or find it unworkable, they may simply ignore it. When the clinic management involves providers in developing the policies and monitors how well those policies work, it can resolve problems and refine the system to ensure that patient confidentiality is better protected.</p>
<p>Does the staff protect confidentiality during follow-up contacts?</p> <ul style="list-style-type: none"> • When health workers try to follow-up with patients at their home, do they take steps to protect women's confidentiality, including for example: <ul style="list-style-type: none"> • Asking women in advance whether and how they would like to be contacted in the future? • Refraining from mentioning the name of the clinic or the reason for the contact when speaking to a member of the household? 	<p>Health workers who try to contact patients in their homes by phone, mail or in person after the patient has visited the clinic can inadvertently alert other members of the household to the fact that she has sought out and received services. If she is living in a potentially violent situation, this information can place women's safety at risk. Health centers need to require staff to take precautions to protect women by asking clients in advance whether and how they would like to be contacted if health workers need to reach her in the future. Health workers can also use creative strategies, such as asking a woman if she can be contacted through a trusted friend or neighbor. Or when trying to contact women by phone, if a family member answers the phone, health workers can give their first names, but not the name of the clinic.</p>

In Practice

Balancing confidentiality with the need for complete medical records

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 counseling and medical services). For example, if a woman discloses a history of violence to a family planning counselor 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 counseling, 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.

e. Developing Referral Networks

Women who experience gender-based violence often need services that go far beyond medical care. For example, women who experience violence may need legal advice, temporary shelter, emotional support, psychological services, police protection, housing, employment, and services for children. For women in situations of crisis, including women who face a high risk of further violence, the need for these additional services may be urgent and even lifesaving.

This need for other services is one feature of violence against women that sets it apart from other public health issues. Medical professionals are used to being able to “treat” infections and care for health problems on their own. They are often used to having a solution and are not always trained to think about what non-medical services their patients may need. As one physician from the Dominican Republic said,

Before, I thought this was not part of my job. I limited myself to medical treatment, but ignored the psychological and legal aspects and simply didn't ask questions about them. Now, when I identify [a case of violence], I make appropriate referrals to legal or psychological services.

For many (but not all) health programs in developed countries, encouraging providers to make referrals to legal or social services is relatively straightforward because there is often a network of high-quality services for survivors of violence in the community. Most cities in the United States, for example, have nongovernmental organizations exclusively dedicated to caring for women who experience domestic violence or sexual abuse. In these communities, health programs may simply need to give providers a list of phone numbers and local organizations.

However, in developing countries (and even some resource-poor settings in developed countries), networks of accessible, high-quality, affordable services generally do not exist; even the capital cities in developing countries rarely have emergency shelters for women. Nongovernmental organizations that offer services for survivors do exist in some places, but they tend to struggle with funding constraints, and their coverage tends to be limited to select urban areas. Referral services that do exist tend to be located in capital cities, rather than rural areas. They also tend to be few and far between—accessible to some of the urban population but not to all. Public or governmental services for women who experience violence tend to be limited as well, and many are notorious for their incompetence and outright abusive treatment of women who seek their assistance. The lack of adequate referral services in many settings poses a major challenge for health programs that want to address the issue of gender-based violence, because it means that health professionals who identify victims of violence cannot always help women get the specialized services that they need.

In particular, the legal systems in most developing countries are often so weak that laws are either not enforced at all or are enforced in inconsistent and arbitrary ways. In countless settings, researchers and advocates have documented that police, judges and other law-enforcement officials mistreat women, fail to enforce the law, or interpret laws in ways that put women at greater risk of additional violence.⁴⁷ As a result, in many developing countries, it is simply not safe for a physician to tell a woman that she should go file a complaint at the local police station by herself.

Despite all of these problems, health programs have an obligation to find out what services do exist in their communities. Putting this information into a referral directory may increase the likelihood that women will get the help they need, and may allow providers to feel that there is something that they can offer to women who disclose violence. Furthermore, identifying existing services in the area can help avoid duplication of efforts and can determine which services are most needed in the community.

Recommendations and Lessons Learned

The IPPF/WHR initiative produced a number of lessons learned and suggestions for dealing with the challenge of inadequate referral services in the community, including the points noted below.

Health programs need to begin by researching what does exist in the community. It often takes time and effort to find out what services exist in a community, and many health programs simply have not invested the resources in finding out what services do exist for survivors. But health programs may find more existing services than they expect. When a community lacks nongovernmental organizations exclusively dedicated to the needs of survivors of violence, then health programs may need to look at other public and private institutions whose services might be useful to women who experience violence, even though they may not be designed exclusively for that purpose.

In resource-poor settings, health programs need to do more than record the name and contact information of referral services. Just because services exist does not mean that they are accessible, affordable, of adequate quality, or even likely to be around in the future. For example, exactly what services does the organization offer? Is it still operating full time? What are its hours and fees? Is it a stable organization, or is its situation precarious and likely to change in the near future? Most important, health programs need to gather some information on the quality of services provided.

Health programs should be sure to investigate services offered by governmental institutions. In addition to services offered by NGOs, health programs should gather information on governmental services such as police, public prosecutors, and forensic medical exams (which are sometimes provided only by public agencies), as well as information on exactly where and how women can access services related to child custody, divorce, property settlements, and orders of protection.

Putting this information into a referral directory is a basic step in the effort to provide external referrals to survivors of violence. Once health programs have gathered information on local services, this information should be compiled into a referral directory and made available to all staff, either by distributing copies to all health care providers or by ensuring that at least one copy is available in a convenient place in each health clinic. Creating a directory of local institutions to which providers can refer clients can be done with minimal resources. The directory can be developed either by staff members or by external consultants. The rest of this section provides some tools for developing a directory of referral services in the surrounding community, including a five-step guide, a sample interview guide, and a sample format for a referral directory page.

Creating formal referral and counter-referral networks with other organizations is ideal, but challenging. At the beginning of the IPPF/WHR regional initiative, the participants hoped to establish formal referral and counter-referral networks with other organizations. In many cases, this proved to be challenging. Moreover, because of limitations on staff time, it was particularly difficult to establish a system that would formally track and monitor the services provided at other institutions. Figuring out how to set up low-cost partnerships remains an area that needs more work.

When adequate quality referral services don't exist, health programs can work to improve them. The health sector has the potential to help improve the quality and accessibility of referral services for survivors, although this often requires a high level of resources and experience. For example, the IPPF members associations reached out to other NGOs and established partnerships or agreements to provide services to their clients. In addition, one of the associations—PROFAMILIA—worked extensively with local police, judges and prosecutors to improve the treatment of women through staff training and procedural reform. It is helpful to remember that the health sector often has credibility in the eyes of these institutions because it can raise awareness of violence against women as a public health problem. As advocates for women's health, health programs can make a contribution to improving the quality of referral services more generally.

Another way for health programs to protect women is to allow staff to accompany women to certain kinds of referral services. This strategy requires that the health program invest money in staff time and training, but IPPF/WHR found that some women greatly appreciated this help, and that sending a professional to accompany a woman (whether a lawyer or a health worker) could dramatically improve the way that the woman was treated (especially by law enforcement personnel).

When all efforts fail to find adequate external referral services, it may be necessary to establish basic services in house. When a health program finds it impossible to locate adequate, quality, external referral services in the community, it may be necessary to consider providing at least some minimal services in house, such as crisis intervention, emotional support, and support groups for women. In Chapter V, this manual provides suggestions for how health programs can do this at low cost.

Alliances with other organizations can bring benefits above and beyond referral networks. For example, networks can be essential ways to share information and tools, to identify gaps in the services available, to monitor the quality of public services, and to work toward improving legal protections for women who experience violence.

In Practice

A note of realism about external referrals

The IPPF member associations found that even toward the end of the initiative, less than 5% of women who disclosed violence accepted an external referral. The rest declined to seek assistance outside the organization or seemed to find what they needed within the association. Nonetheless, a referral directory is critical because it allows the provider to repeat the message that there is some place for the woman to turn if she needs services in the future. It is also a way to ensure that your organization does not duplicate services.

There are many reasons why women do not use external services. Sometimes these reasons are as simple as not having enough money to pay for the bus to get to another part of town, or not knowing how to find the location, even when given a written direction. In other cases, women are hesitant to use services without being accompanied by someone. These examples highlight the need to ask women about the barriers to accessing referral services and go beyond simply drawing up a list of other organizations.

SUGGESTED STEPS FOR DEVELOPING A REFERRAL DIRECTORY

- 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. On the following page is a brief interview guide and format for presenting the information.
- 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 program 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.

BRIEF INTERVIEW GUIDE FOR DEVELOPING A REFERRAL DIRECTORY

First, gather practical information, such as:

- What is the full name and acronym of the institution?
- What is the contact information (address, phone numbers, fax, email, etc.)?
- What is the name and title of the director of the organization?
- What is the name and title of the person providing information?
- What types of services are available at this organization?
- What are the hours of operation?
- What is the process by which clients can obtain services? For example, is an appointment required? Can clients get service by dropping in during open hours?
- What is the cost of services?

Then ask more specific questions about the types of services available for women who experience gender-based violence, for example:

- Do you currently provide services designed specifically for women who have experienced gender-based violence?
- If so, what types of gender-based violence do you address?
- Do you have any information about the profile of victims of gender-based violence whom you serve?
- If your organization does not specifically offer services for women who have experienced violence, what services do you offer that might be useful to women in that situation?
- Do you provide direct services or do you primarily refer women to other organizations? To what other organizations do you refer clients?
- What criteria do you use for making referrals?
- Do you have any formal referral arrangements with other organizations? If so, how do they work?
- What other activities does your organization undertake to address the issue of gender-based violence (e.g. research, advocacy, educational campaigns, sensitization, training, production of materials, etc.)?
- Do you have educational or informational materials about gender-based violence that you would be willing to share with other organizations working on these issues?
- Do you know of other institutions in this area that provide services that could be helpful for women who have experienced violence?
- Is your organization a member of any networks of organizations that work on the issue of gender-based violence?

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:	<ol style="list-style-type: none"> 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

f. Understanding the Legal Issues

One important step in the effort to strengthen the health service response to gender-based violence is to ensure that staff members of the health program have an adequate understanding of the legal issues related to violence against women. There are a number of key reasons why understanding the legal issues are important for the health sector, including the following:

- Health programs should be aware of any legislation that directly regulates health care providers' behavior. For example, health care providers may be legally required to report suspected cases of child sexual abuse to the authorities.
- Health care providers need to know who is allowed to collect legal evidence about violence (either forensic evidence or information in the medical chart); otherwise, they can make serious errors that can harm their clients.
- Some health care providers do not want to talk about violence with their clients because they are afraid of getting involved in legal disputes. Learning more about how the legal system actually works can alleviate many of these concerns.
- Health care providers cannot give clients legal advice, but they should be able to give clients some basic information about their legal rights and where to go for legal services and police protection if needed.
- Finally, health care programs need to understand the legal issues related to confidentiality of medical information, especially with regard to whether or not adolescent girls have the legal right to obtain services without parental consent or to keep their medical records confidential from their parents.

While physicians cannot be expected to dispense legal advice, it is important for them to know basic information about the laws, their clients' rights, their own legal obligations as health care providers, the procedures for seeking legal redress, and the best ways to help clients avoid being re-traumatized by an abusive law enforcement system. For example, health care providers need basic legal information in order to adequately handle a case of rape. In many Latin American countries, health care providers can document legal evidence of physical violence, but not sexual violence. In Peru, Venezuela, the Dominican Republic and Brazil, for example, legal evidence of rape must be documented by a physician specifically licensed in forensic medicine; the courts do not consider a medical exam performed by an ordinary physician to be valid as evidence.⁴⁸ This means that health services need to explain the requirements to victims of rape and send them offsite to the specialist in order to preserve the possibility of bringing charges. In many settings, the visit to the forensic doctor is notoriously impersonal and sometimes traumatic. In general, these physicians view their role as strictly limited to collecting evidence; they generally do not feel it is their responsibility to address the victims' needs for STI prophylaxis or emergency contraception, much less their needs for emotional support.

Recommendations and Lessons Learned

Understanding the legal context is an essential part of strengthening the health service response to violence. For all the reasons mentioned above, health managers have an obligation to research the legal situation in their local community, state/province and country. It is important to understand both the laws and the ways that the laws are applied in practice.

Managers should find ways to share this information with providers in easy-to-understand language. Ideally, health managers should find ways to document this information in an easy-to-read format and should distribute it to providers either in writing or through sensitization or training workshops with health program staff.

Health programs can help their staff handle legal issues by developing clear policies. It may also be important for the health program to establish clear policies for addressing legal issues, such as reporting requirements and legal regulations regarding the confidentiality of medical records. For example, when reporting requirements exist, the health program can write up a policy about exactly when, how and to whom health providers should report cases of violence to the authorities, if ever.

Health programs may need to turn to outside organizations for help in understanding the legal issues. Health programs may not have personnel on staff who know how to interpret the laws or how to find out exactly how the laws are applied in practice. Therefore, it may be necessary for health managers to find other organizations that can help, including NGOs that work on the legal issues of gender-based violence. In some settings, however, no organization or individual has done much work to understand the sometimes complex issues that relate to the intersection of violence, health care, and the legal framework. It is important to understand that this is a highly specialized area and most lawyers are not familiar with these issues.

The attached tool can help health programs identify what kinds of questions they need to answer in order to keep their staff informed about the most important issues. To help health programs identify what they needed to know, IPPF/WHR consultants developed a “legal guide” tool that contains a list of questions about how violence against women is legally defined, service providers’ obligations under the law, reporting requirements, the rights of women within families, and how to obtain orders of protection. Each country (and sometimes even each province) has different laws to address these issues. It is hoped that this legal guide can help health programs identify what they need to know and what information they need to share with health care providers.

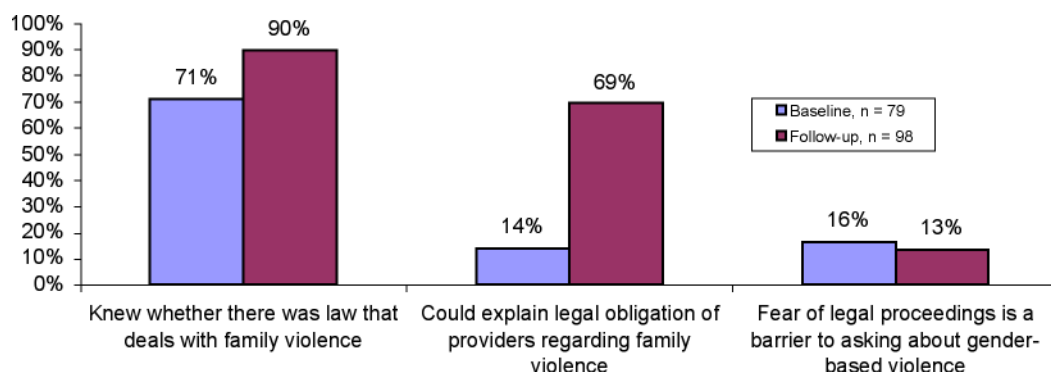
In Practice

Providers' knowledge and attitudes about legal issues

Through surveys, interviews and group discussions, the IPPF/WHR evaluation gathered quantitative and qualitative data on various aspects of providers' knowledge, including knowledge about the legal implications of sexual and physical violence. At baseline, only 14% of providers were able to explain the legal obligations of health care providers when faced with a case of "family violence." Few providers were aware of their obligation to report cases of sexual abuse against minors. Some providers—including physicians who had cared for victims of rape in the past—were not aware that only a physician licensed in forensic medicine was allowed to perform a forensic exam on a rape victim. And 8 out of 36 physicians cited fear of getting involved in legal proceedings as a barrier to asking about sexual or physical violence, although no one mentioned negative consequences for ignoring the law. As one provider put it, "there are many incoherent aspects of the law governing our work." And another reflected that, "in the end, each (provider) interprets the law as they wish."

The final evaluation suggested that providers' knowledge about relevant legislation had increased over the course of the initiative, and the proportion of physicians who cited fear of getting involved in legal proceedings as a barrier to asking about gender-based violence dipped slightly.

Percentage of providers surveyed who could explain the law and who cited fear of getting involved in legal proceeding as a barrier to asking about gender-based violence, at baseline and follow-up



Nevertheless, at follow-up, some still expressed confusion about their obligations as health care providers, including their obligation to report cases of sexual abuse against adolescents and children. Clinic observations found that only 4 of the 12 clinics had managed to produce written materials about the laws for providers to give to clients, and the interviewers did not find that any physicians had written materials available in their consultation rooms, even though such materials had been distributed among clinics and given directly to physicians during training.

LEGAL GUIDE FOR SERVICE PROVIDERS

LAWS RELATED TO PHYSICAL VIOLENCE AND HARRASMENT

Is there a law (or laws) against “domestic violence” or “family violence”?
According to the law, how is “domestic violence” or family violence defined and classified?
What acts of domestic or family violence constitute a crime? Under what circumstances does the law apply?
Are there criminal, civil or administrative penalties for violating the laws against domestic violence? If so, what are the penalties?
How often are these penalties applied in practice?
Are there other laws that prohibit physical violence, stalking, harassment, or threats against women by non-family members, for example, by a current or former boyfriend? Under what circumstances do these laws apply?

LEGAL GUIDE FOR SERVICE PROVIDERS *CONT.*

LAWS RELATED TO SEXUAL VIOLENCE

How does the law define and classify the crime of rape? Under what circumstances does the law apply?		
Does the law consider rape to be a crime against the person or against family “honor”?		
Does the legal definition of rape include:	YES	NO
a. anal penetration?		
b. oral penetration?		
c. penetration with an object or fingers?		
If the legal definition of rape does NOT include penetration with an object or fingers, does the law recognize a separate type of crime (for example, “sexual assault”) for this offense?		
Is rape defined as a (felony) offense punishable by imprisonment or a lesser offense/infracton (not punishable by imprisonment)? If it can be classified both ways depending on the case, please explain what circumstances determine how it is categorized.		
Does the law define marital rape as a criminal offense? If so, under what circumstances does the law apply?		
Does the law recognize any non-penetrative types of sexual aggression against an adult woman as a crime? If so, how are these acts classified and under what circumstances does the law apply?		
What type of evidence is generally required to prove rape or sexual assault against an adult woman?		
What are the penalties for rape and sexual assault against an adult woman?		
What actions are classified by the law as criminal sexual acts when the victim is a minor ? Are there differences in the way that these acts are classified if the victim is a minor versus an adult?		
When an adult has sexual relations with a minor below the age of 18 with her (or his) consent, under what circumstances does the law consider this a crime?		
When sexual aggression is committed against a minor, does the law classify or penalize these acts differently if the victim is a child versus an adolescent?		

LEGAL GUIDE FOR SERVICE PROVIDERS *CONT.*

According to the law, is there a legally-recognized “minimum age of consent”? For example, is there a specific age under which sexual intercourse with a child is always recognized as rape?

When an act of sexual aggression is committed against a minor, does the law classify or penalize this act differently if the victim is a boy versus a girl?

In cases of rape of a minor, can the aggressor evade criminal responsibility for his act by marrying the victim? If so, specify whether this depends on the age of the victim.

What are the penalties for sexual crimes against a minor and how do they vary depending on the following aggravating factors?

a. age of the victim?

b. relationship between victim-offender?

c. a large age difference between the victim and the perpetrator?

d. other aggravating factors? (specify _____)

Does the law recognize other kinds of sexual crimes such as corruption of minors, commercial sexual exploitation of children, child prostitution, pornography, etc.?

LEGAL OBLIGATIONS OF HEALTH CARE PROVIDERS TO REPORT VIOLENCE

Are service providers required by law to report cases of any type of physical violence to the authorities?	YES. (Specify which types of violence.)	NO
a. When the victim is an adult woman?		
b. When the victim is a minor?		
Under what circumstances does the law require health providers to report sexual violence (including abuse, rape, assault, etc.) to the authorities?	YES. (Specify which types of violence.)	NO
a. When the victim is an adult woman?		
b. When the victim is a minor but has already reached the minimum age of consent?		
c. When the victim is below the minimum age of consent?		
d. Other? (specify _____)		
Are there criminal, civil, or administrative sanctions for not reporting a case? If so, what are they? Are they ever imposed, and how often?		
Has your institution developed a policy that lays out the circumstances in which staff members would be expected to report cases of violence to the authorities? If so, when and what types of violence?		

LEGAL GUIDE FOR SERVICE PROVIDERS *CONT.*

PROCEDURES FOR REPORTING VIOLENCE TO AUTHORITIES WHEN REQUIRED BY LAW

What procedures should staff members follow for reporting each type of violence mentioned below? (Please include details such as: what type of report health care providers need to prepare, e.g. verbal, written, etc.; where health care providers should submit the report; what is the name of the specific legal or administrative authority.)

a. Violence (physical or sexual) within the family against an adult woman.

b. Physical violence within the family against a minor.

c. Sexual violence by a family member against a minor.

d. Sexual violence (including rape, assault, molestation) against a minor by someone who is not a family member.

COLLECTING AND PRESERVING FORENSIC EVIDENCE

In cases of physical violence, are any staff members in your organization legally allowed to collect or document evidence that could be admissible in court (for example, by writing up a case report or photographing an injury)? Which types of staff and which types of evidence?

In cases of sexual violence, are any staff members in your organization legally allowed to collect forensic evidence that would be considered legally admissible by the judicial system, or does the law require that only physicians licensed in forensic medicine be allowed to conduct a forensic exam in cases of sexual violence?

Under what circumstances would a health care provider be required to get involved in a legal proceeding about physical or sexual violence experienced by his or her patient? (For example, would a provider ever be asked to testify about a patient's injuries in a criminal proceeding?)

In practice, what is the chance that this would ever happen?

If a provider were to get involved in a legal proceeding related to violence against a patient, what kind of support would the health care organization offer the provider?

ACCESS TO LEGAL ABORTION IN CASES OF RAPE OR INCEST

For countries where induced abortion is highly restricted: Does the law allow abortion in cases of rape or incest?

If so, what procedures must be followed in order for a woman to obtain a legal abortion? (In other words, what evidence is required to demonstrate that the pregnancy occurred as the result of rape or incest? What are the procedures for making the request? Where does the woman have to go, etc.?)

Are the procedures different if the victim of rape or incest is a minor? If so, what are those procedures?

LEGAL GUIDE FOR SERVICE PROVIDERS *CONT.*

CONFIDENTIALITY OF MEDICAL RECORDS

Do adolescent girls have a legal right to keep their medical information confidential from their parents, guardians, husband, or other family members? If not, what are the limits to confidentiality?		
Do health services have a legal obligation to share medical records of adolescents with their parents?	YES	NO
Can parents sue to get access to these records?	YES	NO
Do adolescent girls have the legal right to obtain health services and procedures without their parents', guardians' or husbands' knowledge or consent, including:	YES	NO
a. family planning services?		
b. prevention, testing or treatment of sexually transmitted infections, including HIV/AIDS?		
c. any services related to induced abortion, including post-abortion care?		

WOMEN'S LEGAL RIGHTS WITHIN THE FAMILY

With regard to economic support (for example, a food allowance):		
Can a man be legally required to provide economic support to any of the following:	YES	NO
a. his wife?		
b. his live-in partner?		
c. his ex-wife?		
d. his ex-live-in partner?		
e. his children from the current marriage/union/relationship?		
f. his children outside the current marriage/union/relationship?		
Where should the request be made?		
What should the request include? In other words, what information or evidence is needed to request economic support?		

LEGAL GUIDE FOR SERVICE PROVIDERS *CONT.*

WOMEN'S LEGAL RIGHTS WITHIN THE FAMILY *CONT.*

With regard to paternity:		
a. Is it possible for a woman to bring a paternity suit /ask a court to recognize a man as the father or her child?	YES	NO
b. If yes, what is the procedure for requesting a paternity investigation?		
c. How is paternity determined and who makes the final ruling (e.g. a judge)?		
d. Is it possible to appeal the ruling?	YES	NO
With regard to divorce:		
a. What are the reasons for divorce allowed by law?		
b. What are the rights of women in divorce cases?		
c. How is the separation of property/assets carried out?		
d. If the woman leaves the common residence for any reason, what is the procedure for avoiding being accused of abandoning the home?		
With regard to child custody:		
a. Under what circumstances can a mother lose custody of her children (if any)?		
b. Where can women go for assistance with child custody disputes?		

LEGAL GUIDE FOR SERVICE PROVIDERS CONT.

ORDERS OF PROTECTION *Orders dictated/issued by legal authorities, such as a judge, to break the cycle of family violence and to prevent continued aggression against the victim(s).*

Who is eligible for an order of protection? (Orders of protection are sometimes limited to women with a specific relationship to the aggressor.)	YES	NO
a. A woman who is currently married to the aggressor?		
b. A woman who is not married to but is currently living with the aggressor?		
c. The ex-wife of the aggressor?		
d. A woman who was never married to or living together with the aggressor, but has a child in common with(or is pregnant by) the aggressor?		
e. A woman who never married, lived together or conceived a child with the aggressor?		
f. Another type relative or family member? (specify _____)		
g. Other? (specify _____)		
Are there other types of protective measures for women who do not meet the eligibility criteria for orders of protection mentioned above, for example, orders of protection, injunctions against harassment, etc.. If so, specify.		
What types of orders of protection are available within your country's legislation? (Please check all that apply)	YES	NO
To provide food upon request?		
To refrain from any contact with the victim?		
To refrain from bothering, intimidating, or threatening the victim?		
To refrain from interfering in the provisional or definitive child custody arrangement agreed to under the law or a judicial order?		
To provide police assistance to the victim?		
To require the immediate departure of the offender from the common residence?		
To prohibit the possession of arms in the common residence?		
To prohibit the transfer, sale, disposal, or hiding of the victim's assets (property) or commonly owned assets?		
To prohibit the aggressor from entering the residence?		
To compensate the victim of violence for expenses such as legal expenses, medical treatment, professional counseling, housing, etc.?		
To conduct an inventory of assets and household furniture?		

LEGAL GUIDE FOR SERVICE PROVIDERS CONT.

PROCEDURES FOR OBTAINING AN ORDER OF PROTECTION

Regarding a request for an order of protection:	YES	NO
Can it be requested directly by the person affected?		
Can it be requested by a lawyer without the victim being present?		
Can it be requested by institutions?		
Can it be requested by providers of violence-related services?		
Must it be requested in person?		
Must it be requested in writing?		
When the victim is a minor, does the request have to be made by a parent or guardian? What happens if the parent or guardian does not give consent or is the aggressor?		
Where can the orders of protection be requested? (Provide address, name of courthouse, etc.)		
Does the request for an order of protection need to be made within a certain period of time after an act of violence, abuse or a threat occurs?		
What is the procedure for requesting orders of protection? Are there different procedures for different types of orders of protection?		
What is needed to complete a request for an order of protection? In other words, what specific information should the request include?	YES	NO
a. Name and surname of the person filing the report?		
b. Marital status?		
c. Occupation?		
d. Information about the offender (name and surname)?		
e. Exact address of the offender, for notification?		
f. Address or other contact information for the victim making the request?		
g. Other? (Specify _____)		

LEGAL GUIDE FOR SERVICE PROVIDERS CONT.

Does the court protect the confidentiality of the victim's information, such as the address and contact information?	YES	NO
Can any organization's health care providers' exams and reports of women in situations of violence be accepted as proof/evidence of abuse?	YES	NO
What other evidence or proof must be provided?		
How long does it take to implement the order of protection once the request for one has been made?		
What happens if the offender fails to comply with the legal orders of protection?		
How long do orders of protection last?		
Can they be extended, renewed or requested again? If so, how many times and what is the procedure to be followed?		
Are there other legal resources in addition to orders of protection that are available? If so, please give the name and a description of the recourse.		

g. Sensitizing Staff

Health professionals—like all other members of society—often have deeply-rooted beliefs about the roles of women and men in society, the nature of sexuality, and the rights of children, adolescents, men, and women within the family. Unfortunately, health professionals sometimes share negative attitudes toward women in general or toward victims of violence in particular that are common in the wider society. In addition, many health professionals have misconceptions about violence, including about the prevalence of violence against women, the nature and dynamics of abuse, the consequences of violence, and the types of barriers that women face in the effort to protect themselves, escape or recover from violent experiences. Health professionals often have beliefs and attitudes about their own role as health care providers that prevent them from responding appropriately to clients who experience gender-based violence. For example, providers may resist discussing violence with their clients because they believe it is not a health issue and therefore is not their responsibility, because they are afraid of offending women, or because they feel that they cannot help.

In the effort to change providers' attitudes, beliefs, knowledge, and practices, it may be helpful for managers to think about sensitization and training as two distinct but related stages, as follows:

Sensitization

Sensitization can be described as the effort to educate and to raise awareness about the magnitude, patterns, dynamics, and consequences of gender-based violence. Sensitization can educate staff about the needs of women who experience violence and how the health sector can help meet those needs. Above all, sensitization can help persuade health professionals to view gender-based violence as a public health problem and a violation of human rights. Ideally, organizations should try to sensitize staff from all levels of the institution, including boards of directors, senior managers, health care providers and receptionists.

Training

In contrast, training is aimed at improving specific kinds of knowledge and skills, such as how health care providers can identify cases of violence, discuss violence

with women, provide emotional support, assess risk, manage crisis situations, assist with safety planning and provide care, conduct forensic exams, and refer women to other services. Health care organizations can arrange training for health professionals, such as physicians and nurses, as well as other kinds of frontline staff, such as receptionists and security personnel, who often have direct contact with clients. Health care managers and administrators could also receive training as they may play an essential role in designing ways to improve the delivery of clinical services.

Sensitization workshops can cover such topics as:

- the international data on the prevalence and health consequences of gender-based violence;
- data available on the patterns and magnitude of gender-based violence within the clinic population, community, country or region;
- the links between violence and health, and the arguments demonstrating why gender-based violence is a public health problem that is directly relevant to the work of health care providers;
- the relationship between gender-based violence, gender inequality and human rights;
- international definitions of gender-based violence and the types of violence recognized in international human rights agreements;
- the dynamics of gender-based violence, including the cycle of domestic violence and the reasons why many women find it difficult to leave an abusive relationship;
- myths and realities about victims and aggressors;
- the impact of gender-based violence on women's health;
- the needs of survivors;
- the attitudes and beliefs that providers hold about women's rights, gender roles and sexuality, including stereotypes, myths and misperceptions about victims and aggressors that can harm women in clinical settings; and
- the potential role of the health sector in caring for victims of violence, educating the community, and advocating for women's rights.

Recommendations and Lessons Learned

The IPPF/WHR regional initiative produced a host of lessons about sensitization and training. The following section describes some general recommendations that emerged or were confirmed by the IPPF/WHR experience:

Do not underestimate the challenge of changing attitudes and beliefs about gender-based violence. The first lesson that IPPF/WHR learned was how much everyone involved the initiative had to learn—both in terms of knowledge and attitudes. It was challenging to agree on both a conceptual framework and an approach to addressing gender-based violence. Debate began as soon as the team tried to establish common definitions of violence. Even more difficult was reaching a consensus on how to address gender-based violence in a clinical setting. Part of the problem stemmed from the lack of published and accessible literature in Spanish, including theory, formative research or clinical experience. In addition, while some participants had worked with feminist groups within their countries, not everyone shared their views or agreed on what it meant to view violence from a gender or human rights perspective. These debates initially took planners by surprise because all three associations had made efforts to incorporate a gender-perspective within their work and had previously worked on some aspect of gender-based violence—whether services, advocacy, or research—presumably laying the groundwork for this initiative.

Begin by presenting the epidemiological evidence, as it can be a powerful tool for changing providers' views. Despite the growing body of evidence demonstrating the impact of violence on women's health, many health workers are not aware of the evidence demonstrating that gender-based violence is a public health problem. Often they view it as a social or cultural phenomenon, and they see it as an issue that is better addressed by psychologists or social workers. Cecilia Claramunt, who spearheaded the training efforts in the IPPF/WHR initiative, argues that it is important to begin with the epidemiological evidence, particularly with physicians. The epidemiological evidence about the consequences of violence is a language that health professionals can understand. Once health workers begin to see gender-based violence as a serious public health issue (not just a social issue), then they may be more open to explanatory frameworks, such as gender and human rights. In contrast, when training begins with abstract discussions

of gender or rights, some providers simply resist the training altogether and reject the ideas being discussed.

Both sensitization and training should be grounded in a gender and human rights perspective. The IPPF/WHR initiative found that the more associations had done to educate their staff about gender issues, the easier it was for them to integrate the issue of gender-based violence into their work. Staff members who embraced or were at least familiar with a gender and human rights perspective were more likely to acknowledge the underlying gender-based inequalities that make women more vulnerable to violence. Providers who have been sensitized to gender issues may be able to move more quickly on to the next step in the training process: how to address the issue within their practices. In contrast, in settings where staff members were less familiar with the concepts of gender inequality and/or human rights, it was harder to gain support from providers and to overcome negative attitudes.

Do not underestimate the importance or the challenge of getting health professionals to adopt a gender and human rights perspective. As mentioned earlier, IPPF/WHR found that the issues of gender and human rights met with a certain amount of initial resistance and controversy, despite the fact that all three organizations involved in the regional initiative had substantial experience working on issues related to the links between women's health and women's rights.

It is essential to sensitize staff at all levels of the organization, not just physicians. To build support for addressing gender-based violence within a health organization, it is essential to sensitize staff at all levels of the organization about gender-based violence as a public health problem. It is particularly important to raise awareness of gender-based violence among the leadership of the organization and the physicians who play a key role in enacting the necessary changes required to fully integrate gender-based violence into the work of a health program.

In Practice

Many health professionals are simply unaware of the health consequences of violence against women because the topic was not part of their professional training. In the IPPF/WHO baseline survey, 72% of providers said that they had never received any training related to violence. The midterm evaluation of the regional initiative found that the epidemiological evidence about the health consequences of gender-based violence was a powerful tool.

h. Training Health Care Providers

I began to change. First, by changing at home. I began not to speak so harshly to my daughters, not to fight as much with my wife. Because I thought, how can it be that I argue and I am violent at home and then I am telling women ‘I know how you feel, if I were in your place, I would feel the same’? How could I be giving them support, when I was living a double standard? So for me the change has been wonderful. I feel like I have become enriched as a person, like I have grown. I have learned things that I didn’t understand before.

—GYNECOLOGIST FROM THE DOMINICAN REPUBLIC

Gender-based violence is often not adequately addressed in medical schools, nursing schools, or other kinds of health professionals’ education (particularly in developing countries). Thus, to improve the quality of care provided to women who experience violence, health organizations probably need to ensure that staff members receive additional training in knowledge and skills related to violence against women. Most staff in a health care organization—including administrators—can benefit from general training about gender-based violence. In addition, certain kinds of staff members may need in-depth training in skills that apply to their particular specialties. For example, gynecologists may need to learn how to detect and document signs of violence during a clinical exam, or, depending upon local regulations, how to gather forensic evidence that can be admitted in court.

Health organizations can approach the need for training in a variety of ways, including:

- holding intensive training workshops for staff with the help of outside experts or institutions;
- sending selected staff to courses or workshops in other organizations or universities;
- hiring new staff with specific expertise in the area of gender-based violence;
- 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; and
- incorporating the issue of gender-based violence into other training workshops for health care professionals.

Once providers have participated in more general kinds of sensitization and training activities, it may be valuable to arrange for more specialized training. For example, physicians may need training in how to document lesions from physical beatings using a body map. Physicians may also need training in how to provide care for victims of sexual assault, for example, including how to provide emergency contraception. Counselors or psychologist may need specialized training in how to care for victims of abuse, and in some cases, staff may benefit from training in how to run a support group.

In Practice

IPPF/WHR's Sensitization and Training Strategy

The process of sensitizing and training providers at IPPF associations involved the following stages:

- 1 Key staff from associations in Brazil, the Dominican Republic, Peru and Venezuela attended a regional sensitization/training.
- 2 A trainer with extensive experience in the area of gender-based violence traveled multiple times to each association to carry out sensitization and training workshops. Some of these workshops addressed gender-based violence more generally, while others were designed to provide more specialized skills (e.g. in crisis intervention) to certain kinds of professionals.
- 3 Each association held local training sessions, run by local consultants or staff members whose skills and knowledge had grown over the course of the initiative.
- 4 Each association set up mechanisms for health workers to learn from each other, for example, by holding monthly meetings to discuss cases and ongoing challenges.
- 5 In some cases, associations sent selected staff members for specialized training at local organizations.
- 6 After the initiative had been underway for a couple of years, South-to-South exchanges allowed associations to learn from each other's strengths. For instance, while one organization had developed considerable expertise in conducting support groups for survivors, another association had developed a successful program for training law enforcement agents and lobbying for improved legal protections for women.

Recommendations and Lessons Learned

Understand the limitations of a single sensitization or training workshop. A growing body of published research suggests that single training sessions have only a limited impact on providers' behavior.⁴⁹ IPPF/WHR quickly learned the limitations of a single training workshop, even one given by an extremely qualified and experienced trainer. Gender-based violence is a complex topic, and providers need repeated opportunities to learn about the issue, as well as broad support from the institution to change their attitudes and practices.

Do not expect a training of trainers' approach to be feasible under most circumstances. The regional initiative planners had originally proposed to hold a single regional workshop to train staff from four associations, who could then return to their respective organizations and train others. IPPF/WHR quickly found that gender-based violence was too complex a topic for this approach, and a one-week workshop could not adequately prepare staff to address gender-based violence on their own, much less to become full-fledged trainers. A "training of trainers" approach is probably unrealistic for organizations that are just beginning to address gender-based violence in a clinical setting. Instead, the IPPF member associations decided to take a longer-term approach with multiple training workshops and ongoing efforts to improve providers' knowledge, attitudes and practices. This approach seemed to be effective and appreciated by health care providers.

Use great care when deciding who will carry out the training. The quality and effectiveness of any gender-based violence training depends largely on the background and skills of the trainer. It is most effective when conducted by a person who has proven knowledge about and experience with gender-based violence; who is able to communicate complex and sensitive issues in a non-threatening way; and who has professional credibility with staff (particularly important when training physicians). IPPF/WHR found that a number of criteria are helpful for choosing a person who can provide effective sensitization and training. Ideally, the person should:

- have a grasp of gender and human rights;
- know the epidemiological evidence and the dynamics of violence;
- have substantial experience working on gender-based violence in the local area, or at least the country or region;

- know about and have experience working on the medical, legal, social and psychological dimensions of gender-based violence;
- be able to communicate such difficult issues as gender in a non-threatening way, given that in some cases these ideas may challenge providers' fundamental belief systems; and
- have professional qualifications and skills that give them credibility with health workers, including physicians. For example, the person may need to present scientific evidence, speak in an articulate and scientific fashion, and understand public health issues.

Sensitization and training must address providers' individual experiences and perceptions. Training is an indispensable means for understanding and confronting violence against women. However, developing a comprehensive training program is no easy task, particularly considering the fact that most of us at some point in our lives have experienced gender-based violence, whether as victims, witnesses, or even aggressors. The natural need for rationalizing these experiences leads us to a set of responses and reactions that are often dictated and reinforced by our cultural and social context rather than through our own conscious and deliberate reasoning. Thus, gender-based violence training must begin from the premise that nearly all of us have some experience of gender-based violence that influences our perceptions of the issue. It should therefore not be directed at teaching participants about unfamiliar territory, but rather at giving new meaning to these experiences.

Incorporating personal experiences into the training process can enrich standard training material by exposing how our beliefs can lead us to accept discrimination and violent conduct and to thus reinforce gender inequalities. It can also present several challenges, as it calls into question entrenched beliefs about learning and facilitation methods. Traditional pedagogy polarizes the "expert" trainer and the "inexperienced" or "ignorant" pupil, discounting the inclusion of personal experience. Another common belief is that training should focus only on abstract concepts, theoretical discussion, and working techniques and methods. Trainers who are not comfortable including subjective experience into their teaching methods often reinforce these barriers.

A vibrant, dynamic training program focuses on training as a *process* that is facilitated by critical thinking and that

synthesizes our experiences with the *a priori* presence of learned beliefs. It is a dialectical process between the trainer and the participant, and as such is a continuing dialogue. It disrupts convention because it involves criticism and questioning of the myths that tolerate and justify gender-based violence. It can allow us to understand and work with individuals of different cultures, values, socioeconomic positions, and sexual orientation, and thus can become the basis for sharing, promoting and defending the human rights of women.

At its best, training can be a comfortable forum in which we can explore our own behaviors of tolerance toward gender-based violence as well as our prejudices, values, and sentiments toward women who have experienced gender-based violence.

In Practice

Providers' perspectives on training

Many providers in the IPPF member associations reported that the training they received transformed not only their attitudes toward their clients, but also their attitudes about women and men more generally and their behavior in their personal life. In the follow-up survey, the vast majority of providers said that the trainings had greatly changed their knowledge (77%), their way of thinking (82%) and the way they carried out their job (81%). Many spoke of a greater recognition of women's rights. A female counselor said "Before, I justified violence; I said that women should cater to their husbands." Others spoke about a transformation in their personal life. In the words of a gynecologist from the Dominican Republic, "I arrived at the training looking to learn about technical issues; afterward, my life, my relationship with my wife and two children can never be the same."

One doctor at PROFAMILIA in the Dominican Republic explained that before training, he was aware that many of his clients were victims of gender-based violence, but he did not know how to talk to them about their experiences. "Women wouldn't talk out of fear," he says, "and the doctors preferred not to bring up the topic because they didn't have the tools to respond to women. When doctors did talk, we often defended the man." He remembers that if a client did disclose violence, he would try to tell her that violence was not acceptable and that she should leave the relationship. But just like most providers who have not received training about gender-based violence, he was not aware of the dangers that the woman could face in doing so. The first training workshop he attended had an extraordinary impact. He recalls that the trainer "showed us how providers could begin to change the way they relate to clients, and how they could help clients begin to talk about violence."

A final but important lesson was that some providers simply will not change, no matter what training they receive. In some clinics, a small core of staff continued to express negative attitudes about victims of gender-based violence. One potentially meaningful finding was that attitudes and knowledge among staff who joined the associations after the initiative began was often better (as long as they had received training) than staff who had been with the organizations for a longer period of time. This suggests that hiring and firing practices can be just as important as training current staff.

KEY ELEMENTS OF TRAINING ON GENDER-BASED VIOLENCE FOR HEALTH CARE PROVIDERS

(Based on recommendations from Warshaw and Ganley et al.⁵⁰ and Heise et al.⁵¹)

All health care providers who care for women should be trained to respond to a disclosure of gender-based violence in a sensitive and appropriate way. Some providers need specialized skills (such as how to collect forensic evidence), but the key elements of training for all health care providers are summarized below. It should be noted that training works best when it follows the type of sensitization described in the previous section of this manual. In other words, once providers have been sensitized to the issue of violence from a gender and human rights perspective, they are ready for training that prepares them for the following:

How to recognize the links between violence and health.

As mentioned earlier, many providers are not aware of the typical signs and symptoms, the health consequences, or the risks of future harm that are associated with gender-based violence. For example, training can educate providers about a) the epidemiology of violence; b) clinical signs and symptoms that might indicate that a client has experienced psychological, physical or sexual violence; c) the types of controlling behavior by male partners associated with abuse; d) the extent to which women living in situations of violence may be at risk of injury, infection, trauma, suicide or femicide; and e) the needs of women who experience gender-based violence, including women at high risk of additional violence and women in situations of crisis. It is also important for health care providers to understand that any woman may have experienced gender-based violence, whether or not there are signs and symptoms. Violence against women is not restricted to women of particular social classes or personality types.

How to ask women about gender-based violence.

Providers need to learn how to ask women about physical, sexual and psychological violence. Providers can learn how to ask about violence in direct or indirect ways, in the form of routine screening questions, or in response to signs or symptoms that a woman has already experienced violence or is at risk of future violence.

How to validate women's experiences. When a woman decides to disclose that she has experienced violence, she is placing her trust in that provider and is seeking help. A provider's reaction at this moment can have an enormous positive or negative impact on her safety, her emotional wellbeing, and her future decisions. It is important for health care providers to believe what she says, to validate the distressing nature of her experience, to reassure her that women have the right to live free of violence, and to communicate that she is not to blame.

How to provide emotional support. Many health professionals (especially physicians) are hesitant to discuss violence with their clients because they lack confidence in their ability to listen to or respond to women who express emotional distress. Training can prepare providers with the skills and practice needed to improve their ability to provide compassionate support following a disclosure of violence.

How to assess whether a woman is at risk/in danger.

Women who experience gender-based violence may be at risk of additional violence, suicide, homicide, unwanted pregnancy, or exposure to STIs, including HIV/AIDS. In some cases, women are in imminent danger, for example when they return home from the clinic. In other cases, they face risks that are serious but not necessarily immediate. Providers should be trained to assess the level of danger that a woman faces and discuss the risks to her health and wellbeing.

How to help women in danger develop a safety plan.

To address situations in which a woman is in imminent danger of harm from an abuser, providers need to learn how to help women develop a safety plan. A safety plan can involve thinking about the best way to leave a home quickly in case violence begins to escalate. It can involve alerting trusted neighbors or friends about the situation and enlisting their help. It can also involve planning ways to leave an abusive spouse to prevent the type of violence that is common at the time of separation.

KEY ELEMENTS OF TRAINING ON GENDER-BASED VIOLENCE FOR HEALTH CARE PROVIDERS CONT.

How to inform women of their legal rights. Most countries have legislation that addresses various dimensions of gender-based violence. Providers cannot be expected to provide comprehensive legal advice, but they can give women basic information about their rights and where to turn for additional assistance. Women living in situations of violence may need information on local legislation related not only to criminal law, but also to divorce, civil protection measures, property disputes, child custody, and child support.

How to respect women's autonomy. A classic mistake that health professionals sometimes make is to tell a woman to leave an abusive partner as if it were a simple thing to do. Many women cannot or will not take this advice (at least not immediately). As a result, providers often become frustrated and women sometimes feel worse for not being able to resolve their situation as easily as the provider seems to expect. Women who experience violence often feel powerless and stripped of control over their lives. Providers who tell women what to do may reinforce those feelings of powerlessness. Providers need to understand the complexity of abuse as well as the social, legal and economic challenges that women face. Trying to impose simplistic solutions often obscures the complexity of abusive situations. Moreover, providers need to understand that the risk of injury and death escalates sharply when a woman decides to leave a violent partner.⁵² Women need to be informed about their options and allowed to make their own decisions, especially when the decision to leave a relationship can increase the danger that they face.

How to inform clients about emergency contraception. Many women do not know about emergency contraception, how it works, or how to obtain it. Health care providers have an obligation to offer emergency contraception to all women who experience sexual assault. This can be a life-saving way to avoid pregnancy, prevent unsafe abortion, and avoid the potentially devastating social consequences of an unwanted pregnancy. Educating women about emergency contraception can be important for many other women as well. For example, knowing about emergency contraception before they need it can be important for women living in physically violent relationships, since these women often have difficulty negotiating sexual relations and contraceptive use.

How to document cases of violence. Providers should be trained to document cases of violence in ways that protect client confidentiality, preserve the possibility of pursuing legal action (when applicable), and ensure the completeness of medical records so that women can obtain appropriate medical care in the future. Health care providers need to know the legal regulations and institutional policies that relate to documenting cases of violence, including who is allowed to have access to medical records, whether adolescents are allowed to keep medical records confidential from their parents, and whether medical records can be used as legal evidence in court.

How to preserve and collect forensic evidence or refer women to a forensic physician. Different settings have different legislation regarding what kinds of forensic evidence are admissible in police reports or court proceedings, how this evidence needs to be collected, and who is qualified to do so. Health providers need to be familiar with these legal regulations and institutional policies so that they can refer women to a site that is legally eligible to collect, store and present admissible evidence. For example, following sexual violence (such as rape), providers may need to advise a woman not to wash or shower, but to go directly to see a physician who is qualified to conduct a forensic exam (recognizing how uncomfortable this may be for the woman). Those professionals who are allowed by law to collect such forensic evidence need in-depth training in the technical and interpersonal skills required.

How to make appropriate referrals to other services. Training should prepare health care professionals to make appropriate referrals for women who experience violence. In general, providers need written information (ideally in the form of a formal directory) about what internal and external referral services are available in the local area, how to use the directory, how to document a referral, what information to give women to help them decide whether and how to access those services, and what kinds of services are appropriate for different situations.

KEY ELEMENTS OF TRAINING ON GENDER-BASED VIOLENCE FOR HEALTH CARE PROVIDERS *CONT.*

How to consider gender-based violence when providing family planning or STI/HIV counseling. Professionals who provide family planning and STI services need to consider the possibility that some clients are experiencing violence within the family or are at risk of violence in the future. Women who live in situations of violence may have limited control over when and how they have sexual intercourse and what contraceptive method they and their partners use. Understanding a client's relationship with her partner is an important part of counseling women about family planning and STI prevention. In many contexts, condom use is still associated with multiple partners and unfaithfulness. Proposing condom use in the context of a long-term and (supposedly) monogamous relationship can sometimes be problematic. Research suggests that in some cases, women's attempts to adopt condom use and access STI treatment services can lead to abuse.^{53, 54} Providers should also consider the issue of violence when counseling women both prior to and after HIV testing. Research has shown that women may be at increased risk of violence when they choose to disclose their HIV status. The need for partner notification must therefore be carefully balanced against a woman's risk of violence from her partner or other family members.⁵⁵

How to continue educating themselves. Because there is a great deal to learn about the medical, emotional, economic, social and psychological challenges that women face, it is important for providers to continue educating themselves about the dynamics of violence and the role of the health care provider. Trainers can provide additional reading material and suggest other sources of information for providers to use in the future.

i. Developing Key Policies and Protocols

This manual has argued that the best way to improve the health service's response is to take a "systems approach" that involves every level of the way a health care organization operates. One way to do this is to ensure that the health care organization has developed policies and protocols in a number of key areas. Well-written policies that are developed with the participation of staff members can be an important way to guide staff members' work and support the efforts of individual providers to address gender-based violence.

This section will briefly summarize the kinds of policies and protocols that may help a health program protect women's health, safety and wellbeing. Sample protocols and policies have not been included in this manual, since each health program has individual characteristics and needs. However, there are sample policies and protocols available on the Internet in various language for those health programs that want to find sample policies to adapt.⁵⁶ The table below outlines policies and protocols that health programs should consider developing.

Type of policy or protocol	Why this type of policy or protocol is important and what it needs to contain
Sexual harassment policy	Every health care organization should have a written policy that prohibits sexual harassment by staff members against other staff members and against clients. The policy should 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.
Policies and protocols about 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.
Protocols for treating cases of violence against women, including sexual abuse and rape	Ideally, health care organizations should develop protocols for caring 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 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.
Protocols for 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.

In Practice

Sexual harassment

As part of the IPPF/WHR regional initiative, all three member associations developed or revised their written sexual harassment policies, and two associations subsequently fired staff members who violated that policy. One manager said that if the institution had not been actively involved in the effort to address gender-based violence, they might not have believed the woman or acted decisively against the aggressor.

Recommendations and Lessons Learned

Ideally these policies should be developed with input from a range of staff members. Although it may be time consuming to involve staff in the development of policies and protocols, such participation can improve their quality and effectiveness.

All staff who participate in writing these policies need to have been sensitized previously to issues related to gender-based violence. It can be counterproductive to include staff members who have not been sensitized to the issue of gender-based violence in the development of key protocols and policies, as it opens up the possibility for heated and wasteful debates.

Written policies and protocols should be made available to all staff members. Often, policies or protocols exist, but staff members don't know where they are or do not have easy access to them. Ideally, written policies and protocols should be distributed to all staff in the context of a training on how to follow the policies and protocol, or at least placed in a convenient and accessible location in each clinic or health center.

Be sure to revisit the protocols and policies periodically to monitor their effectiveness. After a protocol or policy has been in effect for a period of time, health managers should gather feedback from staff and review any relevant service statistics to determine whether or not the policy or protocol is working as well as it should be.

j. Improving Danger Assessment

When health care providers identify women who are living in situations of violence, they have both an opportunity and an obligation to assess the danger and risks that women may face and to help women find viable solutions for improving their safety. Providers need to be alert to the danger that victims of physical and sexual violence may face.

One way to assess risk is to ask women directly whether they feel in danger. In some cases, women will tell providers that their lives are in danger, and it is essential for providers to take their words seriously. In other cases, however, women do not recognize the danger that they face. For example, at least one study from the United States found that about half of women whose partners tried to kill them did not realize that their lives were in danger until the attack occurred.⁵⁷ In particular, providers should be aware that women are most at risk during the period when they decide to leave an abusive relationship and just after they have left.⁵⁸ Health care providers often have a misconception that women will be safe as soon as they leave an abusive partner. In reality, however, research suggests just the opposite—that women face the greatest risk of being killed or injured by their partner precisely around the time that they leave. This time of separation is the period when providers need to be most willing to listen to their clients and to ask the right questions.

Recommendations and Lessons Learned

Managers should not assume that danger assessment tools from other countries can be used in any setting without adaptation. Much has been written about danger assessment based on research from developed countries, but these materials cannot always be simply imported into other countries without adaptation or additional validation. For this reason, health managers should educate themselves about the types of dangers that victims of gender-based violence face (see page 90), as well as the types of danger assessment tools that have been used in different settings.

In Practice

Adapting danger assessment tools to developing country settings

Researchers in developed countries such as the United States have written extensively about risk factors and danger assessment, and they have published different tools designed to assess a woman's level of risk. One of the most well-known examples is the "Danger Assessment" tool developed by Jacquelyn Campbell,⁵⁹ which has been extensively field-tested in the United States. This tool is primarily designed to assess the danger of lethal violence against women living in physically abusive relationships. It includes a calendar and a list of 15 questions, such as whether the partner has access to a weapon and whether the partner uses alcohol and drugs. It is based on research into which factors are most likely to predict injury or femicide in the United States context.

The IPPF member associations translated the questions from this tool into Spanish and began using it in Venezuela at PLAFAM clinics (see the original 15 questions at the end of this section). However, when PLAFAM tried to use this tool in the Venezuelan setting, nearly all women who completed this questionnaire had high scores, and therefore PLAFAM could not use the tool to distinguish between women who were in higher and lower levels of danger. Based on this experience, the three member associations worked together to find a more feasible way to assess danger in their settings. They began using two danger assessment questions whenever a woman disclosed any type of gender-based violence, as follows:

- 1) Will you be safe when you return home today?
- 2) Are you afraid that your partner or another person will cause you harm?

In the IPPF member associations, these two questions seemed to work better than the 15-question assessment tool mentioned above. In addition, PROFAMILIA added another question to its clinical history form, asking providers: "Do you think this woman is at risk?" Providers could answer this questions using whatever information they gathered from the client. IPPF/WHR was not able to collect hard evidence to determine how well these questions worked to identify women in danger of further violence. Nonetheless, the health care providers felt that they worked well in the clinic setting. Overall, the experience of PROFAMILIA, PLAFAM and INPPARES highlighted the challenge of adapting tools from one setting to another, especially from developed country settings such as the United States.

TYPES OF DANGER ASSOCIATED WITH GENDER-BASED VIOLENCE

Imminent danger of harm. This refers to situations in which a woman is in danger of harm during the next few minutes, hours or days. For example, women may ask health providers to help them escape or hide from an aggressor who has threatened them. Some women are concerned that a violent spouse might come looking for them at the clinic itself. In other cases, women are afraid of what may happen when they return home from the clinic, or what may happen in the next few days. In cases of ongoing sexual abuse, girls and women may continue to be in danger of additional victimization if the perpetrator still has access to their home or workplace.

The danger of femicide. The risk of being killed by an abuser is a real threat for many battered women. Researchers from developed countries such as the United States have identified a number of indicators that have been successfully used to assess the danger of femicide, though it is not clear whether these findings apply in other settings. For example, one indicator of life-threatening danger is a woman's own perception of her situation. Women sometimes tell health care providers that their life is in danger. However, women may not necessarily be aware of all the risk factors, for example that the danger of lethal violence increases around the time that a battered woman separates from an abusive partner. Studies have shown that most women who are killed by their partners were in the process of leaving. Researchers have identified other indicators of danger,⁶⁰ such as:

- a batterer's unemployment;
- his access to lethal weapons;
- threats of deadly violence;
- escalating severity and frequency of abuse;
- severe incidents of abuse that result in injuries, fractures and bruises in the head, shots, severe burns and beatings that have required medical attention, among others;
- the aggressor's abuse of alcohol or drugs; and
- a woman's substance abuse (which could reduce her ability to escape from a violent situation).

The danger of self-inflicted harm. Many women who experience gender-based violence consider suicide. The possibility of self-inflicted harm is particularly important to keep in mind for girls and women who are currently living in situations of sexual abuse, incest or physical

violence. Many women feel powerless when faced with the threats from the aggressor. They often have already tried several alternative strategies—such as seeking help from their families or the police—and nothing has worked. Women may feel frustrated or to blame, and they may consider suicide as a way to end the torture. For these reasons, providers should be alert to the clinical signs of depression. As is the case with other kinds of risk, asking a woman direct questions can be the simplest way to find out whether she has thought about killing herself or whether she has already attempted suicide in the past.

Providers should take precautions when offering medications to women who are in danger of suicide (or femicide). In general, psychotropic medications are not recommended because these medications reduce a woman's capacity to stay alert and escape situations of abuse. For women who have thought about or tried to commit suicide, these medications can also become a tool for ending their lives.

The danger of severe sexual and reproductive health consequences. Women who experience gender-based violence may also be in danger of sexual and reproductive health consequences, such as unwanted pregnancy and/or sexually-transmitted infections, including HIV/AIDS. These are serious threats not only for victims of sexual assault and victims of ongoing sexual abuse, but also for those women who live in physically abusive relationships who often have difficulty negotiating sex and contraception/condoms. It is important to recognize that both unwanted pregnancy and STIs (including HIV) can have devastating—even life-threatening—medical, social and emotional consequences for victims of gender-based violence. Depending on the setting, for example, rape victims who experience unwanted pregnancy may resort to unsafe abortion or may be thrown out of their homes by unsupportive family members. HIV/AIDS can

TYPES OF DANGER ASSOCIATED WITH GENDER-BASED VIOLENCE *CONT.*

obviously be a death sentence in settings without adequate medical care. In some cases, women have already been exposed to unprotected sex and need emergency contraception or STI prophylaxis or treatment. In other cases, women face a danger in the near future of such exposure, and these risks need to be incorporated into safety planning.

The danger of harm to any children involved. In a situation of domestic violence, abuse may often be directed both at women and her children. Additionally, threats made by an aggressor against a woman may include the threat of harm, or actual harm, to her children. Therefore, it is very important to ask the woman whether she knows or suspects that her children (if she has any) are at risk of being abused. This is particularly important in cases where custody is shared or when the aggressor has unsupervised visiting rights.

SAMPLE DANGER ASSESSMENT QUESTIONS

(Adapted from the Danger Assessment Tool developed by Jacquelyn C. Campbell, copyright 1998. Additional information on Campbell's original Danger Assessment tool can be found at the Johns Hopkins University, School of Nursing Web site www.son.jhmi.edu.)

IPPF/WHR found that although the following questions have been extensively field-tested and validated in the

United States, they were not as useful when used to identify women at high risk in Caracas, Venezuela because nearly all women who lived with an abusive partner answered yes to these questions. This experience highlights the need to validate and adapt tools to different settings. It may be that this kind of tool would be helpful in other countries, but this issue needs to be addressed through more research.

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?
(If you have never been pregnant by him, check here ____)
11. Is he violently and constantly jealous of you? (For instance, does he say “If I can’t have you, no one can.”)
12. Have you ever threatened or tried to commit suicide?
13. Has he ever threatened or tried to commit suicide?
14. Is he violent toward your children?
15. Is he violent outside of the home?

k. Providing Safety Planning

When providers identify a woman at risk, they should respond following emergency procedures so that they will have all of the necessary resources at their disposal in order ensure the woman's safety. The woman is the expert about the level of risk that her partner represents, and therefore she should participate actively in developing a safety plan for herself and her children.

After health care providers assess a woman's level of danger, the next step is to help her develop a safety plan. Safety planning can involve developing a plan for separating from an abusive spouse, or it can involve taking measures to increase a woman's safety even before she is ready to leave a violent relationship. Safety planning can also be helpful for women who are considering sharing information about their pregnancy or HIV status with their partner or other family members and are concerned about the possibility of violence.

Health managers will find that most of what has been written about safety planning has been based on research from developed countries. Just as in the case of danger assessment, health managers may need to work with staff and seek the help of local resources to identify strategies for safety planning that are adapted to the local setting. To do this adequately, managers need to be aware of the basic issues involved in safety planning, some of which are summarized below.

Recommendations and Lessons Learned

When adapting the principles of safety planning to the Latin American setting, the participants in the IPPF/WHR regional initiative found the following points to be helpful:

Safety planning needs to be adapted to the local setting. Health care providers need to have a realistic understanding of the reality that women in that community face. For example, many developing countries lack shelters for battered women or strong enough legal systems to enforce orders of protection against a violent husband or former husband. Health care providers who work in resource-poor settings can come up with creative

and resourceful ways to increase women's ability to protect their safety, but only if they listen carefully to what women themselves have to say and are informed about the local services that exist in the community.

Providers should consider the woman to be the expert in how to maximize her own safety. Health care providers can facilitate the safety planning process by counseling women about the possibility of future violence and possible measures that they can take when confronted with potentially dangerous situations. However, health care providers should never tell a woman what to do.

Safety planning can include a wide range of details, but providers and clients may find it helpful to think through the following:

- Identify 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) 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 in the case of sexual violence.
- Notify one or more trusted neighbors 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.

If the woman is taking psychoactive medication, such as sedatives, it is important to explore the possibility that she stop taking the medication while she is in danger. Women living in situations of violence need to be alert enough to make potentially lifesaving decisions. In cases

where a client absolutely needs to continue taking her medication, health providers can suggest that she inform a relative or close friend of her condition.

Consider developing different safety plans for situations inside and outside the home. A provider can help his/her client think through safety measures in situations outside the home, such as in the workplace and in public, or in a situation where the perpetrator of violence does not live with her.

After developing a safety plan, a woman should memorize it and destroy any paper copy. A safety plan can place a woman at risk if a violent partner or family member finds a written plan. Any paper copy should be destroyed.

As part of safety planning, providers need a realistic understanding of the legal system. One important element of safety planning in a developing country is understanding whether any legal protections exist for women who experience violence, whether those protections are effective in practice, and, just as important, whether women face additional risk of mistreatment at the hand of law enforcement should they decide to seek protection from police or report violence to the authorities. If the local law enforcement system is known to mistreat women who report violence, then health programs have an obligation to do more than simply refer women to the local police. Health programs can take a number of steps to ensure that women do not experience additional revictimization from the law enforcement system. For example, they can arrange for women to be accompanied by a staff member or a volunteer; they can help women access legal advice about how best to navigate the legal system; or they can form an alliance with local nongovernmental organizations that provide support to women who need legal protection.

As part of safety planning, providers need to understand the laws and procedures about divorce and separation.

For example, in some Latin American settings, judges routinely require couples seeking divorce to try for reconciliation—a process that can elevate the risk for women whose partner is prone to physical violence. In at least one country in the region (Chile), a woman can legally force an abusive spouse to leave the residence for six months, but after that period of time she must let him return. These types of issues can be important to consider when providers help women develop safety plans.

I. Providing Emergency Services to Survivors of Sexual Violence

Survivors of sexual violence, particularly forced sexual intercourse, may experience many consequences, including:

- unwanted pregnancy;
- sexually-transmitted infection (STIs), including HIV/AIDS;
- complications from an incomplete or unsafe abortion; and
- unwanted childbearing.

When survivors access adequate quality health services in time, the consequences of unwanted pregnancy, unsafe abortion and STIs can be prevented or reduced through emergency contraception, safe abortion, post-abortion care, and STI prophylaxis or treatment. As a result, health care organizations that care for survivors of violence have a responsibility to address women's sexual and reproductive health needs, often on an emergency basis. Failure to do so can put survivors' health, well-being and even their lives in jeopardy.

Women living in physically abusive situations often experience sexual violence as well, and they may have difficulty negotiating the use of contraception or condoms. Health care organizations need to remember that emergency services may be needed by any survivor of sexual violence/coercion, not just women who have been raped by a stranger.

This chapter will discuss key issues that health managers need to consider as they work to ensure a high-quality, comprehensive response for survivors of sexual violence.

Key emergency services for survivors of sexual violence/abuse:

Treatment for physical injuries: Some but not all survivors of sexual violence have physical injuries that need immediate attention, including general injuries and lacerations of the genital area. Treatment can include, for example, first aid care and tetanus shots.

Preservation of forensic evidence: Depending upon the local and national regulations, health care providers may or may not be able to collect forensic evidence without

special certification. In any case, providers need to ensure that they do not take actions that will preclude the possibility of collecting forensic evidence, either by staff in the organization or by a forensic physician at another facility.

Emergency contraception: Emergency contraception (or EC) refers to methods that can prevent pregnancy after unprotected sexual intercourse has taken place. EC includes special doses of ordinary birth control pills, as well as the insertion of an intrauterine device (IUD).

Safe abortion counseling and services: Many women resort to self-induced or unsafe abortions when they become pregnant as a result of sexual violence. The availability of safe abortion services varies widely from country to country, but even when abortion is legally restricted, the law may include an exception for survivors of rape or incest (at least in theory). Safe abortion counseling can help survivors understand the dangers of unsafe abortion, decide whether to undergo a safe abortion when such services are available, and find out how to overcome barriers to care.

Post-abortion care (PAC): Post abortion care services include emergency treatment for complications of spontaneous or induced abortion, designed to reduce morbidity and mortality from incomplete and/or unsafe abortion.

STI prophylaxis: Prophylaxis for sexually transmitted infections can be given to survivors in the form of special doses of antibiotics, anti-retroviral drugs, or vaccinations. If given soon enough after exposure, STI prophylaxis can prevent disease.

The following pages describe in greater detail issues related to providing emergency contraception, safe abortion counseling and services, post-abortion care and STI prophylaxis to survivors of gender-based violence

Emergency Contraception

Emergency contraceptive pills are sometimes referred to as ‘morning-after’ or ‘post-coital’ pills, but the term ‘emergency contraceptive pills’ is preferred because it conveys the important message that the treatment should not be used as an ongoing contraceptive method, and it avoids giving the mistaken impression that the pills must be taken on the morning after sex.

THE INTERNATIONAL CONSORTIUM
FOR EMERGENCY CONTRACEPTION⁶¹

Emergency contraception (EC) refers to contraceptive methods that can prevent pregnancy after unprotected sexual intercourse. EC includes special doses of ordinary birth control pills, as well as the insertion of an intrauterine device (IUD) within a short time after unprotected sexual intercourse. Women can use EC when a regular method (such as a condom) fails or when no method was used at all. Depending on the method used, emergency contraception can reduce a woman’s risk of becoming pregnant from a single act of intercourse by 75% to 99%.⁶²

Since most forced sex is unprotected, emergency contraception is an essential option for women who experience rape and other forms of non-consensual sex. Research suggests that EC is also important for women living in physically abusive situations, because they may have difficulty negotiating contraceptive/ condom use and may be forced to have unprotected sex.^{63, 64}

Emergency contraceptive pills (ECPs) are the most common form of emergency contraception. ECPs are hormonal methods of contraception that should be taken within 72 hours of unprotected intercourse, though recent studies suggest that they may be effective up to 5 days after sex.⁶⁵ Because women have such a short window of opportunity to use ECPs, health organizations have an obligation to help women access this method as soon after sexual assault as possible.

Even though EC has been around for over 30 years lack of awareness is common:

- Many women do not know about emergency contraception;
- Many health care professionals remain unaware of EC;
- Other health care providers know about EC generally, but do not have training or experience providing these methods;
- Many health care providers have misconceptions or prejudices about EC that make it impossible for them to counsel or inform women about their options.

In an ideal world, all survivors of sexual violence would receive care within 72 hours of the assault and most resulting pregnancies would be prevented by emergency contraception. Unfortunately, many barriers prevent women from seeking immediate care, including lack of information, the stigma associated with being a victim of sexual violence, fear of poor treatment by health workers, lack of money to pay for health services, and fear of revealing the abuse, especially when the perpetrator is someone close to them, such as a family member, friend, teacher or boss. In other cases, women do seek health services but receive inadequate care.

To facilitate women’s access to emergency contraception, health care organizations can inform clients about emergency contraception on a routine basis to raise women’s awareness of this option *before* they need it. Women living in physically abusive situations may benefit by receiving supplies of EC in advance that they can use in the future if they are ever forced to have unprotected sex by their partner. This may be a particularly important strategy in cases when providers know that women may have little control over when they have sexual intercourse or whether they use contraception/condoms.

Health managers should ensure that the organization has written protocols for distributing EC and that providers have received training that includes: information on indications for ECP use; recommended ECP regimens; mode of action; efficacy; side effects and their management; precautions and screening; client information and counseling needs; and follow-up procedures. In addition, since ECPs are a back-up method, the training should also include information about other contraceptive methods, including those that offer STI/HIV protection. Training tends to be more

effective if it is participatory in nature and includes exercises to build participants' skills in the areas of screening, counseling, and follow-up. (Provider-training curricula are available at the International Emergency Contraception Consortium's website: www.cecinfo.org.)

Health programs should work to increase women's awareness about EC by:

- Routinely informing women about ECPs at the time of regular family planning visits;
- Instituting mass-media informational campaigns and advertising ECP services;
- Providing women with an advance supply of ECPs;
- Providing ECPs through non-clinical settings, such as through community-based services, social marketing programs, and the commercial sector (e.g. pharmacies).

Safe Abortion Counseling and Services

In circumstances where abortion is not against the law, health systems should train and equip health-services providers and should take other measures to ensure that such abortion is safe and accessible.

THE UNITED NATIONS GENERAL ASSEMBLY,
1999⁶⁶

Sexual violence and coercion contribute to two serious threats to women's health and wellbeing: unsafe abortion and unwanted childbearing. Studies among survivors of rape report that between 5% and 17% become pregnant as a result of forced sex.^{67, 68} Evidence suggests that a disproportionate number of women who seek abortion are survivors of sexual assault or ongoing sexual and/or physical violence.⁶⁹ When safe, legal abortion is not accessible, survivors who become pregnant often try to terminate their pregnancy through unsafe abortion services or by trying to self-induce abortion. Many more survivors go on to experience the serious negative medical, emotional, and social consequences of unwanted childbearing,

Lack of access to safe abortion has serious health consequences for survivors of sexual violence:

- Studies report that between 5% to 17% of rape victims become pregnant as a result of rape.
- Worldwide, an estimated 20 million women undergo unsafe abortion each year.
- An estimated 80,000 women die from unsafe abortion each year.
- Hundreds of thousands of women suffer serious disabilities following unsafe abortion;
- Research suggests that a disproportionate number of women who seek safe and unsafe abortion are survivors of sexual and physical violence.
- Survivors of sexual violence who cannot access safe abortion, often try to self-induce abortion.
- Between 10% and 50% of women who undergo unsafe abortion need medical care for complications.
- Frequent complications include infection, hemorrhage, and injury to internal organs.

SOURCES: WHO, 1997⁷⁰; HOLMES ET AL. 1996⁷¹;
MULUGETA ET AL. 1998.⁷²

The legality, accessibility and safety of induced abortion vary throughout the developing world. For example, abortion tends to be less restricted in Asia (e.g. India and China) and more restricted in Africa and Latin America. Even when legal abortion is severely restricted, however, the law often permits abortion when pregnancy results from rape or incest and/or when the pregnancy presents a threat to women's physical or mental health. According to a recent review of legislation worldwide, survivors of rape and incest may have a legal right to terminate their pregnancy in 131 developing countries.⁷³

Even when safe abortion is legal, however, there are many reasons why survivors of sexual violence may not be able to access these services. For example, many health care providers, policymakers and women in general are not aware that survivors of sexual violence may be lawfully entitled to a safe, legal abortion. In other cases, safe abortion services are simply not available or the barriers to access are too difficult to overcome.

Survivors of violence resort to unsafe abortion, even when they have a legal right to safe abortion, for a number of reasons:

- Women may not know that they have the right to a legal, safe abortion.
- Health care providers may not know that survivors of sexual violence have a right to a safe, legal abortion.
- Health care providers may not tell survivors about their rights because they are personally opposed to abortion.
- Health care providers may fail to provide comprehensive counseling to survivors of sexual violence.
- Safe abortion services may not be available or affordable, even if they are legally allowed.
- Adolescent girls may believe that unmarried adolescents are not entitled to a legal, safe abortion;
- The bureaucratic or legal procedures for obtaining a safe, legal abortion may be too complicated or unworkable.
- Accessing safe abortion may take too long because of barriers to care.
- Safe abortion may be too expensive.

Health care organizations have an ethical responsibility to protect women's rights, wellbeing, lives and health by ensuring that women are informed of the services that women are entitled to by law, including safe abortion in states and countries where it is legal. The experience of health programs in various parts of the world suggests that integrating safe abortion counseling and services into health services as one more key component of care is more appealing and acceptable to health care providers than separating abortion as a stand-alone issue and service. Health programs that want to begin offering these services may find it helpful to reach out and communicate with other programs throughout the world that have been successful in incorporating abortion services into a package of comprehensive services for survivors of sexual violence in order to develop strategies and training sessions and to discuss ideas, doubts, and questions. For example, health programs have had some success increasing access to legal abortion for survivors of sexual violence in Mexico, despite the restrictive legal environment.^{74, 75}

Health managers can prevent unsafe abortion by increasing access to safe, legal abortion through the following steps:

- Increasing awareness of the laws about abortion among health care providers, policymakers, clients, and the general public. This includes the legal rights of adolescent survivors.
- Ensuring that health care providers understand the law that recognizes rape within marriage as a crime (in settings where this is the case); this information can give survivors of marital rape more options when abortion is legal in cases of rape.
- For organizations that have the capability to offer safe, legal abortion services, protocols of care should include the use of medications such as mifepristone and misoprostol where available, as well as manual vacuum aspiration. They should also include different options for pain control pre-, during, and post-procedure.
- Health programs should not impose unnecessary administrative or judicial procedures that prevent women from receiving services or referrals. For example they should not require women to press charges or to identify the rapist. Avoiding additional delays is essential for women who may already be several weeks into their pregnancy when they seek care. Further delays can make the abortion procedure more complicated or impossible.

To protect women's rights, health and lives, health care providers can do the following:

- Inform women about the risk of unwanted pregnancy following sexual assault;
- Inform women about the dangers of unsafe abortion;
- Inform women about their legal rights with regard to pregnancy termination;
- Counsel women in a nonjudgmental way that will allow to make their own reproductive health decisions about whether or not to carry a forced pregnancy to term;
- Help survivors access safe abortion.

Post-Abortion Care (PAC)

Postabortion care (PAC) is an approach for reducing injuries and deaths from incomplete and unsafe abortions and their resulting complications, and for improving women's sexual and reproductive health and lives.

THE POST ABORTION CARE CONSORTIUM (2002)⁷⁶

According to the World Health Organization, of the estimated 20 million women who undergo unsafe abortion each year, between 10% and 50% experience complications.⁷⁷ Those complications include incomplete abortion, sepsis, hemorrhaging and injury to internal organs. Many other women experience an incomplete spontaneous abortion. These complications often require urgent post-abortion medical care. Unfortunately, inadequate post-abortion care is widespread in many areas and contributes to maternal mortality.

Post-abortion care is an essential service for many survivors of sexual violence. Limited but compelling research suggests that a substantial number of women who seek care for complications of spontaneous or induced abortion are survivors of sexual violence. Moreover, studies from various countries show that physical violence occurs in approximately 4% to 15% of pregnancies, and women living in violent situations are at greater risk of spontaneous abortion.^{78, 79, 80, 81}

Unfortunately, in many settings, health professionals often hold negative, judgmental attitudes about women who experience abortion complications, especially in countries where most abortion services are legally restricted. In these settings, even women who experience incomplete **spontaneous** abortions may be accused of having illegally induced an abortion and may be treated poorly as a result. For survivors of sexual violence, judgmental attitudes on the part of health workers may compound the emotional trauma that they have experienced. Moreover, such attitudes threaten the ability of health workers to deliver life-saving care. For example, women may hesitate to seek services if they expect to be treated poorly, and health workers cannot provide high-quality care to people whom they treat in a degrading manner.

The health sector has an important obligation to improve post-abortion care for all women, but especially for survivors of violence. Health managers can begin by working to ensure that health workers treat all women with respect by sending a clear message to all staff that it is not acceptable to let their personal views interfere with their professional responsibility to provide humane care to all women seeking post-abortion care.

In recent years, the PAC Consortium Community Task Force and other organizations have called on the health sector to take a broad approach to post-abortion care.⁸² Rather than focus narrowly on immediate medical care, they have called on health systems to provide a broad set of services that includes counseling, referrals, post-abortion family planning services and other kinds of reproductive health care. This comprehensive approach not only allows providers to manage current complications but is also an important way to ensure that women receive high-quality care and the information and services they need to prevent unsafe abortions in the future.

Prophylaxis and Treatment of Sexually Transmitted Infections (STIs)

Survivors of sexual violence sometimes contract a sexually-transmitted infection (STI), including HIV, as a result of the assault, yet many STIs can be prevented if survivors receive prophylaxis soon after an assault. STI prophylaxis can include post-exposure administration of antibiotics, the vaccination for Hepatitis B, and other medications that can prevent sexually transmitted disease. In cases in which the assault did not occur recently or the woman has experienced repeated sexual abuse over time, health care services should consider the possibility that the survivors may have already contracted an STI, and hence diagnosis and treatment may be essential for women's health, wellbeing and survival.

As a result, health organizations that care for survivors have a responsibility to help women access STI counseling, prophylaxis and treatment, often on an emergency basis. Managers in organizations that already offer counseling, prophylaxis and treatment may need to evaluate these services to ensure that they meet national standards and the specific needs of survivors. Some organizations may want to expand their services by developing protocols, obtaining supplies, and training providers. Organizations that do not have the capacity to

offer these services can train staff to counsel women about the risks and refer women to appropriate services elsewhere.

The World Health Organization and other key agencies have published many excellent tools and guidelines for clinicians who provide counseling, prophylaxis and treatment of STIs for women who experience sexual violence^{83, 84, 85}

Health managers should consider a few key points when developing STI prophylaxis protocols:

Protocols for certain STIs may differ depending on the prevalence levels in that particular setting. Prophylaxis for certain STIs, such as trichomoniasis and Hepatitis B, may need to be included in treatment protocols for victims of sexual violence, depending upon prevalence levels in that geographic area.

Protocols should be based on the latest knowledge about the risks and benefits of HIV prophylaxis. There is currently much debate about the risks and benefits of providing post-exposure prophylaxis (PEP) for HIV following a sexual assault. There is little hard evidence about the risks and benefits as this manual goes to press. Prophylaxis for HIV is not standard procedure in developing countries, but has become more common in high prevalence settings such as South Africa. Once again, managers need to stay informed about recommended practices and to ensure that their protocols reflect best practices in their particular settings.

Protocols should include the shortest possible regimen. A substantial proportion of women who experience sexual violence do not return for follow-up visits. To ensure the best care, it is important to provide the shortest possible regimen for STI prophylaxis and treatment.

Do not test for STIs immediately following a single incident of sexual assault unless there is strong justification. Some researchers argue that women should not be tested for STIs immediately following a single incident of sexual assault.⁸⁶ Such tests are expensive, and they may not be useful. Tests performed immediately following sexual assault *cannot* detect STIs that result from the rape until the incubation period has passed. They can only detect pre-existing STIs and have occasionally been used in court to attack a rape victim's character. They may even produce false positives from the perpetrators' semen. On the other hand, there are cases in which STI/HIV testing is sensible, for example, if the sexual abuse has occurred over time. If there is a possibility that the survivor is already HIV positive (before the assault), then HIV testing and counseling could help the clinician decide on the best course of care. Given the complexity of this issue, however, health care organizations should consult local and national guidelines and make an informed decision about the risks and benefits of STI testing immediately following rape before including it in their protocols.

Recommendations and Lessons Learned

A review of the literature suggests at least three key recommendations for providing immediate care to survivors of sexual violence:

Health programs should provide a comprehensive set of services and referrals. Survivors of sexual violence/coercion need a broad range of services, depending on how soon they seek care. Health programs need to develop a comprehensive approach that considers the prevention of unwanted pregnancy and childbearing, STIs, and the complications of incomplete or unsafe abortion. Women may need information, counseling, services, and in some cases referrals. Providing incomplete care can put women's wellbeing, health and survival in jeopardy.

Health programs should take steps to help women access services as soon as possible. There are many reasons why women may not be able to access services in a timely manner. Women who experience forced sex may be unaware that something can be done to prevent pregnancy after intercourse; they may be unwilling to disclose the assault and therefore hesitate to seek services; they may be concerned they will be blamed for the assault by the medical provider. In other cases, they seek services but encounter delays because the provider refers them to other sites or because administrative

barriers are in their way. Health programs can address these problems by educating women about EC in advance, by offering as many services on site as possible, and by streamlining the process of care. In the long run, improving the quality of care and advertising the services can encourage women to seek help more quickly.

Health programs need to develop policies and protocols that minimize emotional trauma. The evaluation of the IPPF/WHR initiative gathered information on the perspectives of survivors of sexual violence. They mentioned that asking women to repeat their story multiple times could cause frustration and shame. As one adolescent survivor of sexual violence explained: "They ask and ask the same thing. I felt ashamed after everything that had happened to me." Health programs can minimize additional trauma in many ways. For example, they can provide kind, compassionate, respectful care. They should not ask survivors to repeat their experiences over and over. They should not conduct repeated pelvic exams. They should try to provide as many services on site as possible. And they should protect women's confidentiality and privacy.

The table on this and the following page presents a brief checklist of some key elements of providing comprehensive, quality care to survivors.

Key elements of comprehensive emergency care for survivors of sexual violence

Develop a comprehensive package of emergency services for survivors of sexual violence that includes:

Informing women about the possibility of unwanted pregnancy and STIs/HIV following sexual assault.

Counseling women about EC, STI prophylaxis, and safe abortion.

Informing women about their legal rights to services, including EC and safe, legal abortion (if available).

Provision of emergency contraception or referrals to sites that provide EC.

Safe abortion or referrals to sites that provide these services (if available).

Post-abortion care or referrals to sites that provide these services.

STI prophylaxis and treatment or referrals to sites that provide these services.

Testing and counseling for HIV/AIDS.

Follow-up care to ensure that women's broader sexual and reproductive health care needs are met.

Collection of forensic evidence by a qualified practitioner or referrals to sites that provide this service.

<i>Carry out planning and preparation, as follows:</i>
Ensure that the organizations offers as many services as possible on-site.
Identify referral sites that offer accessible, quality care for any services that cannot be offered on-site.
Ensure that the organization has adequate supplies, including EC and STI prophylaxis drugs.
Create/ adapt protocols for providing these services and ensure that they are available to all providers.
<i>Ensure that the organization has written protocols for these services that are based on the following:</i>
The types of emergency contraception available within the organization.
The local situation with regard to laws about and availability of safe, legal abortion services.
Local guidelines for STI prophylaxis and treatment (STIs may be resistant to certain drugs in some areas).
Local guidelines about HIV prophylaxis (not generally recommended in low prevalence areas).
Up-to-date local and international recommendations on best practices.
Lessons learned from the experiences of other health programs in the country or region.
Strategies to ensure that forensic evidence is not destroyed in the process of providing care.
Ways to protect the safety of women living in situations of violence.
Strategies to minimize the number of exams, the number of times survivors are asked to repeat their story, and the number of places women need to go for services.
Kindness, compassion and respect for confidentiality and privacy.
<i>Ensure that the written protocols address the needs of the following subgroups:</i>
Women who seek services immediately following sexual assault vs. those who seek services at a later time.
Children, adolescents and adults (each group may require different drug dosages and/or have different legal rights).
Women living in ongoing situations of violence vs. women who experience a single incidence of sexual assault.
<i>Provide sensitization and training to providers that tries to accomplish the following:</i>
Raise awareness of the need for EC and STI prophylaxis and treatment following sexual assault.
Increase knowledge about emergency services for survivors of sexual violence.
Understand women's legal rights.
Improve attitudes toward survivors of sexual violence and services such as EC and abortion.
Equip providers to counsel women about EC, safe abortion, STIs, and broader reproductive health concerns.
Ensure that providers have the technical skills to provide key services and that they can apply the written protocols.
Ensure that providers do not let their personal views prevent them from informing women about their rights, offering non-judgmental counseling, and letting women make their own decisions about their reproductive health.
<i>Monitor and evaluate the effectiveness and acceptability of the written protocols:</i>
Include survivors' perspectives in evaluations.

Sources: These recommendations have been drawn from the resources listed on the following pages.

KEY RESOURCES

COMPREHENSIVE EMERGENCY SERVICES FOR SURVIVORS OF SEXUAL ASSAULT

World Health Organization (WHO)

http://www.who.int/reproductive-health/publications/rhr_02_8/rhro2_8.en.html

Several international agencies, including the WHO, have published an excellent guide entitled: *Clinical Management of Survivors of Rape: A guide to the development of protocols for use in refugee and internally displaced person situations*. Although it is designed for refugee settings, it is one of the few comprehensive guides that is written for an international audience and may be helpful for managers working in other settings as well.

American Medical Association (AMA) and IPPF/WHR

www.ama-assoc.com

www.ippfwhr.org

The AMA included clinical guidelines for providing STI prophylaxis in its publication entitled: *Strategies for the Treatment and Prevention of Sexual Assault*, which IPPF/WHR translated into Spanish. This publication is available in both languages on the respective websites listed above.

Office for Victims of Crime, United States Department of Justice (USDJ)

www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf

The USDJ has published a comprehensive guide. Although it was designed for the United States, it includes detailed discussions of the issues and recommendations that could be helpful for managers in other settings as well. The title of the publication is: *Sexual Assault Nurse Examiner (SANE) Development and Operation Guide*. Minneapolis, Minnesota, Sexual Assault Resource Service.

EMERGENCY CONTRACEPTION

Consortium for Emergency Contraception

www.cecinfo.org

The mission of the Consortium for Emergency Contraception is to expand access to and ensure safe and locally appropriate use of emergency contraception worldwide within the broader context of family planning

and reproductive health, with emphasis on developing countries. Several useful resources are available on the Consortium's website, including policy statements, guidelines and materials for clients.

Latin American Consortium on Emergency Contraception (LACEC)

www.clae.info

LACEC is a network of public and private organizations working to reduce unwanted pregnancy, maternal mortality, and unsafe abortion in Latin America through advocating for, promoting, and distributing emergency contraception. The website includes news, EC information by country, and current research. Languages: Spanish, Portuguese and English.

Center for Reproductive Rights

www.reproductiverights.org

The Center for Reproductive Rights (formerly known as Center for Reproductive Law and Policy – CRLP) provides information about a wide range of issues pertaining to contraception and women's health. Its publication: *Emergency Contraception: Contraception, Not Abortion: An Analysis of Laws and Policy Around the World* offers an analysis of the world's abortion and contraception laws and their implications for emergency contraception. (See: www.reproductiverights.org/pub_bp_icpdec2.html)

Princeton Office of Research and Population

www.ec.princeton.edu

Operated by the University of Princeton, this site includes up-to-date information about emergency contraception methods (including regimens for a wide variety of oral contraceptive pills), answers to frequently asked questions, and information about worldwide product availability. Languages: English, Spanish, French and Arabic.

Journal of the American Medical Women's Association (JAMWA)

www.jamwa.org/vol53/toc53_5.html

(Volume 53, Number 5, Supplement 2 published in 1998) A special issue of JAMWA includes a global overview of research on emergency contraception, as well as specific articles on service delivery, access to emergency contraception, and use of EC in resource-poor settings in various countries, including the United States, Mexico, and Tanzania.

KEY RESOURCES CONT.**Program for Appropriate Technology in Health (PATH)**

www.path.org/programs/p-wom/emergency_contraception.htm

The PATH website contains information about a US-based project that allows pharmacists to prescribe ECPs directly to women (including a Pharmacist Training Manual); tools for expanding access to emergency contraception (www.path.org/resources/ec_tools.htm); sample client brochures in 13 languages; and links to other online resources.

Population Council Mexico

www.en3dias.org.mx/

This Spanish-language site provides general information about emergency contraception, country-specific information, a news media page, a bibliographic page listing reproductive health resources, and links to other sites of interest. The site also offers general information about several other types of contraceptives.

Language: Spanish

World Health Organization (WHO), Department of Reproductive Health and Research

www.who.int/reproductive-health/

The WHO makes several resources available on its website, including “Emergency Contraception: A Guide for Service Delivery” (WHO/FRH/FPP/ 98.19). A hard copy of this document can also be ordered free of charge by contacting publications@who.int.

ABORTION AND POST-ABORTION CARE**Ipas**

www.ipas.org

Ipas works to increase women’s ability to exercise their sexual and reproductive rights and to reduce deaths and injuries of women from unsafe abortion. Ipas’ website offers many publications related to safe abortion and post-abortion care, including policy papers, training curricula, and service delivery guidelines.

World Health Organization (WHO), Department of Reproductive Health and Research

www.who.int/reproductive-health

WHO has published a number of resources related to safe and unsafe abortion, including a publication entitled “Safe abortion; Technical and policy guidance for health systems.” This document was published in 2003 and the

full text is available on the Internet at the site mentioned above. Other resources include guidelines for medical abortion and other related publications.

Post-Abortion Care Consortium

<http://www.pac-consortium.org>

The Postabortion Care (PAC) Consortium works to inform the reproductive health community about health concerns related to unsafe abortion, and to promote post-abortion care as an effective strategy for addressing this global problem. Its website has a section of general information, resources, and clinical tools on post-abortion care.

Catholics for a Free Choice

www.catholicsforchoice.org/

Working in the Catholic social justice tradition, Catholics for a Free Choice does research, policy analysis, education and advocacy on issues of gender equality and reproductive health worldwide. Information is available in English, Spanish and Portuguese.

Fundación ESAR

www.fundacionesar.org

ESAR is a non-profit foundation based in Colombia with the purpose of promoting sexual and reproductive health and preventing the adverse effects of unsafe abortion in Latin America, primarily through training and certifying health workers. Information is available in English and Spanish.

Latin American and Caribbean Women’s Health Network

www.reddesalud.web.cl

The Latin American and Caribbean Women’s Health Network is a group of organizations and individuals working to promote women’s health, the full exercise of women’s civil and human rights, and women’s citizenship through the cultural, political and social transformation of the region and the world from a feminist perspective. Information is available in Spanish.

KEY RESOURCES CONT.

STI PROPHYLAXIS AND TREATMENT:

World Health Organization (WHO), Department of Reproductive Health and Research

www.who.int/reproductive-health

The World Health Organization Department of Reproductive Health and Research offers a number of publications that are useful for health programs that want to improve their policies related to STI prophylaxis and treatment for survivors of sexual violence. For example, see WHO (2001) *Guidelines for the Management of Sexually Transmitted Infections*. Geneva, World Health Organization. (A revised edition is due out in 2004.) Many of these documents are available on the Internet, and often are translated into multiple languages.

m. Developing Educational and Informational Materials

The health sector has an important role to play in educating clients and the broader community about violence against women as a public health problem and a violation of human rights. One way that health programs can contribute to this effort is to produce or at least distribute information within clinics and community-based fora. These materials can include videos for clients and providers, pamphlets that discuss issues related to violence against women in depth, cards with information about local resources for survivors, and/or posters that can be put up around clinics or other places in the community.

Health programs may want to create or distribute materials on many different topics that are directly and indirectly related to violence, including:

- Patient rights within health services (e.g. for privacy and confidentiality)
- Family violence
- Intimate partner violence
- Sexual violence, including rape
- Childhood sexual abuse
- Services available for survivors of violence
- Laws about violence against women
- Prices of services that survivors might need
- Sexual and reproductive rights
- Women's rights
- Human rights in general

Recommendations and Lessons Learned

The experience of IPPF/WHR and many other organizations suggests a number of key recommendations in this area, including:

Consider women's safety when designing and distributing materials. Keep in mind that women living in situations of violence may be at greater risk if an abusive partner finds that she has received materials about violence. Moreover, women may come to the clinic accompanied by their partners, and may not feel free to pick up materials in waiting rooms. One strategy is to develop small cards that women can hide in their clothing. Sometimes it is helpful to put only the address and phone number of referral services on a card, so that a perpetrator will not realize what it is if it is found. Other health programs have found that it can be helpful to place information (whether cards, pamphlets or posters) in bathrooms, where women can look at them without being observed by a male partner.

Use resources efficiently by sharing materials whenever possible. Creating materials from scratch can be time consuming and expensive, and may require special expertise. If your organization does not have funds to produce materials about gender-based violence, it may be possible to get copies of materials produced by other organizations. For example, the Johns Hopkins University Center for Communications Programs has created an online resource center of documents, reports, journal articles, policy documentation, training materials, posters, radio programs, novelty items and other important information in the area of gender-based violence. The site (www.endvaw.org) was developed to provide researchers, health communication specialists, policy-makers, and others with the information and materials they need for their work to end violence against women. Another resource is the Family Violence Prevention Fund, which has developed excellent materials in English (and some in additional languages) that can be adapted for different settings. Many of its resources can be ordered online at: <http://www.endabuse.org>

n. Monitoring and Evaluating Quality of Care

A commitment to monitoring and evaluation is an essential component of quality care, and perhaps the greatest strength of the IPPF/WHR regional initiative was the emphasis on monitoring and evaluation. The initiative was designed to foster collaboration between staff with expertise in managing programs and staff with expertise in evaluation, and the planners devoted a substantial portion of the funds to monitoring the progress and evaluating the results of the associations' work. This collaboration not only allowed the initiative to produce the tools and lessons learned documented in this manual, but just as important, it allowed the associations to ensure that the changes they made to their services were feasible and acceptable to both providers and clients.

Health programs can take a variety of approaches to monitoring and evaluation at different points in time, including formal and informal, qualitative and quantitative. For example, the participating associations in the IPPF/WHR initiative adopted a mix of approaches, as described in the table below:

<i>Examples of different approaches to monitoring and evaluation</i>	
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

Recommendations and Lessons Learned

Collecting baseline data is essential for measuring change over time. As previously discussed, baseline data is essential because health managers can only measure change if they have a point of comparison. Baseline data and follow-up data collection should be a part of any effort to strengthen the health care response to gender-based violence.

Every new policy or tool should be field-tested and evaluated in both the short and long term. It is essential to monitor and evaluate each new policy and tool. Even when a policy has been effective in other settings, this does not guarantee that it will work in a new country, region, language or even another clinic in your own organization. The IPPF associations found it very helpful to use quick, informal data collection methods, including quantitative methods (for example, looking at how many times a policy or tool was actually used and what were the preliminary results) and qualitative data (for example, what providers or clients thought about the tool). Even a small amount of information gathered in a short period of time can be helpful for understanding how a new policy or tool is working and whether it needs to be refined.

Efforts to plan, monitor and evaluate improvements in quality of care must include the participation of staff. Managers need to involve staff in evaluating the acceptability and the effectiveness of new policies and tools. Their perspectives are the most important part of understanding whether a new policy is working and whether it needs to be adjusted. These perspectives can be measured through formal methods, such as focus groups, or informal methods, such as regular staff meetings or informal discussions with staff.

Efforts to evaluate improvement in quality of care should include the perspectives of clients, including survivors of gender-based violence, if possible. Women's perspectives are another essential element of evaluating quality of care. However, gathering information among clients may require more resources and skill, not to mention an understanding of ethical issues related to researching issues linked to violence.

Changes in knowledge can be measured immediately, but changes in attitudes take time. Improving providers' attitudes and beliefs is an essential component of strengthening the health care response to violence. However, while knowledge can change quickly, attitudes about violence often take years to change. Managers can measure changes in knowledge immediately after a staff training, but measuring changes in attitudes may require a long-term approach.

Efforts to monitor and evaluate the health service response to gender-based violence need to take ethical issues into consideration. Evaluating quality of care can raise a number of ethical issues related to gender-based violence. The most obvious example of this is when health programs want to gather information on the perspectives of survivors and need to consider how to protect their safety. Health managers should be aware that it is highly possible that there are survivors of violence among staff members themselves, and managers need to consider their safety and wellbeing when gathering information related to gender-based violence. The World Health Organization has developed a set of guidelines for carrying out research related to gender-based violence, and efforts to monitor and evaluate quality of care should adhere to these guidelines.⁸⁷

Be willing to devote money to monitoring and evaluating quality of care. Many health care programs in developing countries face chronic resource constraints and are often hesitant to divert badly-needed funds from programs to evaluation. However, programs that do not invest adequate resources in evaluating their work may never know whether the programmatic funds are in fact being used as effectively or efficiently as they should be. In the area of gender-based violence, there is a particularly compelling reason to invest in monitoring and evaluation—namely, that a poorly-planned program may not only be ineffective, but rather it may actually cause harm. Thus, there is an ethical, as well as a practical, obligation to monitor and evaluate efforts to strengthen the health service response to gender-based violence.

IV. Implementing a Routine Screening Policy

a. Overview

When writing about screening for gender-based violence, researchers have used a number of different terms. To ensure clarity, this manual will categorize different types of screening in the following ways:

Screening:	Asking women about experiences of violence/abuse, whether or not they have any signs or symptoms.
Selective screening:	Asking women about violence when a health care provider has some reason to suspect violence/abuse based on certain signs and symptoms.
Universal screening:	Asking all women in a given health care setting about experiences of violence/abuse, whether or not they have signs or symptoms.
Routine screening:	Systematically asking women about experiences of violence/abuse whether or not they have signs or symptoms. This can include screening ALL women in the clinic (i.e. universal screening) or screening ONLY certain groups of women, for example new clients of reproductive health care services.

A growing number of researchers and professional organizations, including the American Medical Association, the American College of Obstetrics and Gynecologists, and the British Medical Association, have called upon health providers to routinely screen women for gender-based violence.^{88, 89, 90} Recently, however, a debate has emerged about whether there are circumstances in which health programs should not require providers to screen women for gender-based violence.

Arguments in favor of routine screening

Research from many different settings has shown that when health providers ask women direct questions about gender-based violence, many women will disclose their experiences of abuse. That evidence also demonstrates that giving providers a standardized list of written questions to use with every client helps to assess women's experiences of violence in a more efficient and systematic manner. Those who advocate for routine screening argue that screening is an important opportunity to ensure adequate care for clients and to help women get the services they need. Specific arguments in favor of routine screening include the following:

Evidence indicates that gender-based violence is a major public health problem. Gender-based violence has many consequences for women's health, including injury, gynecological disorders, STIs, pregnancy complications, miscarriage, low birth weight and pelvic inflammatory disease.⁹¹ Intimate partner violence alone is a major cause of disability and death among women. Some studies suggest that gender-based violence may be as prevalent as other conditions for which providers already screen.⁹²

Routine screening may improve sexual and reproductive health-related diagnosis, treatment and counseling. Routine screening can help providers understand the underlying cause behind many health conditions and thereby provide information that is essential for accurate diagnosis and treatment. For example, sexual violence may increase the risk of emotional or gynecological disorders that are otherwise difficult to diagnose or treat, such as depression, chronic pelvic pain, and recurrent vaginal infections.⁹³ Moreover, it may not be possible to provide adequate family planning or STI/HIV counseling without asking women about violence given that women living in violent situations may not be able to negotiate contraceptive use, particularly condoms.

Routine screening may help providers identify victims early before violence escalates further. Early recognition of the problem has been shown to significantly reduce the morbidity and mortality that results from violence.⁹⁴

In the long run, routine screening may reduce women's need for health services. Studies in countries as varied as Nicaragua, the United States and Zimbabwe show that women who experience physical or sexual assault use health services more often than other women.⁹⁵ Victims of violence tend to average more visits to the physician and pharmacy, a greater number of surgeries, more hospital stays, and increased mental health consultations. Routine screening may save time and resources in the long run by helping providers understand the underlying reasons behind health problems experienced by victims of violence and by helping women access services to address the underlying issues.

Simply waiting for women to spontaneously disclose violence can be problematic. Some women do spontaneously tell their health care providers that they have experienced gender-based violence, but in many cases, women wait until they are asked. Some women are afraid to bring up the topic for fear of how the provider will react. Others blame themselves or do not recognize their experiences as abuse. Providers who begin a dialogue about violence with the message that everyone has the right to live free of violence can make women feel comfortable revealing their experiences and asking for help.

By waiting for signs and symptoms of violence, providers will overlook many women living with violence. Although learning about typical signs and symptoms of violence can help health care providers in some situations, many victims of violence do not have obvious indicators showing that they have experienced gender-based violence. Women from all social and economic backgrounds can experience violence, and providers can care for the same clients for years without realizing that they have experienced physical or sexual abuse.

When done well, screening can be a transforming and therapeutic experience. Interviews with survivors of violence suggest that when health care providers screen women with skill and compassion, that experience can be transformative and healing. It can raise women's awareness of the risks that they face and of their own right

to live free of violence. In many cases, it can start a woman on the road to assistance and recovery.

Health care providers are often the only professionals who interact with most adult women. In many developing countries, the health care system is the only institution that interacts with almost every woman at some point in her life. Consequently, health care providers have a unique opportunity to identify survivors and help women find other referral services that they need.

Arguments for a cautious approach to routine screening:

On the other hand, some researchers have urged health programs to be aware that routine screening may put women at additional risk, particularly in resource settings that lack referral services in the community. For example, García Moreno⁹⁶ and others⁹⁷ have noted the following reasons to be cautious about routine screening:

It is not clear that gender-based violence screening meets traditional standards of reliability and effectiveness. Traditionally, the medical community has believed that two prerequisites should be in place before health providers begin screening for a condition or disease: a) they should have the ability to identify a condition with good specificity and sensitivity; and b) they should be able to provide an effective treatment or response, whereby the benefits outweigh the risks. Garcia Moreno points out that it is unclear whether either of these conditions is met with regard to gender-based violence.

Many health centers lack the resources to protect women's privacy and confidentiality. In many resource-poor settings, clinics do not have adequate safeguards in place to protect women's safety during and after a disclosure of violence. If a perpetrator finds out that a woman has disclosed violence to a provider, she could be at risk of additional injury or even death.

Many providers have negative attitudes toward victims of physical and sexual abuse. Many providers share the beliefs of the larger society that often considers violence against women to be justifiable or the women's own fault when committed by male partners and family members. Providers who screen women and then respond to disclosures of violence without sensitivity or respect can cause great harm.

Many, if not most, developing country settings lack adequate referral services. Thus, in many settings, it is simply not possible or realistic for providers to refer women to services in the community once they have been identified as a victim of violence.

It is still unclear what constitutes an effective response to a disclosure of violence. Helping victims of violence is often a difficult, complex and long-term process, especially when the violence is ongoing in the household. Little rigorous research evidence exists about whether screening benefits women in the long run, or even how benefits can be measured. Planning an effective response to a disclosure of violence is especially important in developing countries where adequate referral services in the community may not exist and poverty places severe restrictions on women's choices. Some argue that disclosing violence to a health worker can be therapeutic in and of itself, but others challenge the idea that such disclosure is always beneficial.⁹⁸

Addressing gender-based violence may involve a host of potential risks and unintended consequences. For example, a provider who screens women but cannot offer support, services or referrals may leave women feeling more hopeless. In general, not enough is known about the risks and unintended consequences of screening for gender-based violence in resource-poor settings, which makes it difficult to weigh benefits of gender-based violence screening against the risks.

Recommendations and Lessons Learned

There are sensible arguments on both sides of this debate, and therefore, routine screening policies should be implemented with caution. IPPF/WHO found reasons to agree with both sides of this debate. On the one hand, evaluation studies found that routine screening helped transform health services in participating clinics and benefited many women who had experienced violence. On the other hand, the process of setting up routine screening policies exposed many potential risks that could have caused problems for women if the organizations had not addressed them in time. The key principle is to ensure that whenever a health program decides to implement routine screening, it should be done with a great deal of attention to the measures that are required to protect women's safety and wellbeing.

The tools in this manual can help to reduce the risks associated with routine screening. To address the concerns about the risks of routine screening, this chapter will share some lessons learned about when and how to implement routine screening in ways that protect women's safety and increase opportunities for improving women's lives. Specifically, this section presents recommendations for how to decide when a clinic is ready to implement a routine screening policy and how to develop screening protocols, screening questions, referral networks, information systems, and evaluation strategies.

There are a number of key knowledge gaps related to routine screening that need to be addressed through research. After presenting the arguments in favor of a cautious approach to screening, García Moreno concluded that "there needs to be greater clarity on who should ask the questions, of whom, in which settings and after what training."

In Practice

What are the potential benefits of screening?

One argument in favor of routine screening is that many women living in situations of violence do not recognize their situation as “abuse” or “violence.” They may consider their situation to be the “normal” condition of women or conversely the result of their own individual mistakes and shortcomings. When women do not recognize that they can and deserve to live without violence, they rarely seek help spontaneously.

IPPF/WHR found that routine screening, when done well, can be a powerful tool to raise women’s awareness that they deserve to live a life free of violence. During midterm and follow-up interviews, both health care providers and clients argued that screening has the power to transform women’s views by reframing violence as a health issue. Specifically, they noted, providers can make women aware that violence can put a woman (and her children) at risk of injury and in some cases death. Providers’ ability to reframe sexual and physical abuse as a health issue was cited by women as a major catalyst for deciding to confront their situation and for seeking ways to change it. One survivor in the Dominican Republic described this experience in the following terms:

I was dying without realizing it. When the physician told me that my health problems were related to what was happening in my house, I started to understand what was going on with me. It was as if a veil was lifted from my eyes and I started to think that I didn’t deserve this.

In particular, some women may not be aware that intimate partner violence tends to go in cycles and generally escalates over time. They may believe that they can manage the violence by changing their own behavior or by hoping that their partner will change. Asking women about violence and sharing information about the dynamics of violence can encourage women to make a more informed decision about when and how to seek help.

b. When to Implement Routine Screening

The organizations involved in the IPPF/WHR initiative implemented routine screening under relatively ideal conditions. With generous funding from the European Commission and the Bill and Melinda Gates Foundation, these member associations were able to improve their clinic infrastructure, revise their policies and protocols, and find experienced consultants to train staff, share ideas and experiences, and carry out extensive monitoring and evaluation efforts. This level of resources proved to be essential for ensuring that routine screening was done in a way that reduced risk and protected the safety and wellbeing of women.

Although much remains to be learned about the benefits and risks of routine screening in different settings, the experiences of PROFAMILIA, INPPARES and PLAFAM suggest that routine screening can benefit women without placing women's safety unduly at risk as long as programs commit themselves to putting adequate safeguards in place. The key principle to keep in mind when considering whether or not your health program is ready to implement a routine screening is the classic principle of medicine: DO NO HARM.

"Make a habit of two things—
to help, or at least **do no harm.**"

HIPPOCRATES, *The Epidemics*

Recommendations and Lessons Learned

A clinic is not ready for routine screening until it can ensure clients' privacy, safety, and confidentiality.

RISK TO AVOID: Women living in situations of violence may be at even greater risk if the abusive partner finds out that she has told a health care provider or law enforcement officials.

For this reason, health programs should not implement routine screening before clinics have adequate measures to ensure clients' privacy, safety, and confidentiality, including: consultation rooms where women cannot be overheard or seen from the outside; secure storage areas for records; policies about who has access to records and when providers are allowed to disclose client information; and well-trained staff who understand the risks that women face in the cycle of intimate partner violence.

A clinic is not ready for routine screening until it can ensure that providers have appropriate attitudes and skills.

RISK TO AVOID: Providers' misconceptions and attitudes that blame the victim rather than the aggressor can inflict further emotional damage on a woman who has experienced violence.

How a provider reacts to a disclosure of violence can have a tremendous impact—positive or negative—on a survivor. A sensitive and supportive reaction by a health worker can be the turning point that helps a woman find a way out of a violent situation or begin the process of recovery. In contrast, a blaming or judgmental reaction can be emotionally devastating. Some health workers' attitudes will not change, even with intensive training over a long period of time. If these providers are required or even encouraged to screen women, they may inflict additional harm. Health programs should consider which staff members are really ready to screen routinely. (In the worst cases, a health program can consider asking staff members with negative attitudes to leave the organization.) Health programs can use various strategies to assess providers' attitudes and beliefs, both formal and informal. For example, in addition to carrying out a survey of providers' knowledge, attitudes and practices, the IPPF member associations asked providers to undergo a

role-play to ensure that—at least in a role-play setting—providers could handle a disclosure in an appropriate way.

- ***A clinic is not ready for routine screening until it can ensure that providers have something to offer women.***

RISK TO AVOID: Providers may have nothing to offer women in terms of services when adequate referral services do not exist either in the clinic or in the community.

The unfortunate reality is that adequate referral services for victims of violence simply do not exist in many developing country settings, even capital cities. At a minimum, “adequate” services should be geographically accessible, affordable, and of decent quality (i.e. they will not re-victimize women). Most developing countries and even capital cities lack adequate shelters, social services, legal services and law enforcement agencies. Rural areas tend to be even worse off than urban centers. Some argue that even in the United States, some rural communities or inner cities do not have adequate referral services to justify screening for violence in health care settings. This begs the question: ***Is it ethical to screen for gender-based violence in communities where adequate referral services do not exist?***

Some say NO. They argue that as long as referral services do not exist, are too far away, are too expensive, or are of too poor a quality for women who need them, it is not reasonable or ethical to ask physicians to screen for violence.

Although this is a reasonable concern, the counter-argument is that there are a number of ways to help women in the absence of community resources. Some argue that simply asking women about violence in a health care setting may have therapeutic value as long as it is done well. Others point out that knowing about clients’ experiences of violence may allow health professionals to provide better care through more accurate diagnosis and more effective family planning and STI/HIV counseling. Finally, even in the absence of community services, health programs can consider providing low-cost interventions in-house, such as support groups (see Chapter V).

Nonetheless, it is clear that: ***When adequate referral services in the community do not exist, health programs have a particularly great responsibility to ensure that screening benefits women.*** For example, it can be argued that when adequate referral services do not exist:

- Health programs have a responsibility to ensure that all providers who screen can handle a disclosure of violence in a sensitive and supportive way, and that at least some staff in the clinic can provide basic safety planning, crisis intervention, and information about legal issues (for example, information about separation and divorce).
- Health programs have a responsibility to assess and monitor the quality of services provided by referral agencies—including law enforcement agencies—to which providers may refer clients. Providers should not refer women to agencies that put them at risk of additional harm.
- Health programs need to consider the possibility of setting up services within their own organizations, including support groups for survivors for example. (See Chapter V for more information on providing specialized services.)

Managers may also want to use the management checklist to determine whether their program is ready to implement routine screening. The management checklist presented in Chapter III, section a of this manual was specifically designed to help managers review the types of resources that they need before their services are prepared to address the needs of women who experience gender-based violence. It can also be used to assess whether the organization is ready to implement a routine screening policy.

IN SUMMARY: MAKE SURE THAT YOUR ORGANIZATION HAS THE RESOURCES TO PROTECT WOMEN WHO DISCLOSE VIOLENCE AND HAS THE RESOURCES TO OFFER THEM SOME KIND OF BENEFIT. OTHERWISE, DO NOT IMPLEMENT A ROUTINE SCREENING POLICY.

c. How to Implement a Routine Screening Policy

Once a health program has decided that it has (or will have) adequate resources, implementing a routine screening policy involves a number of stages, which are summarized below. The list below is simply a summary of the stages, each of which is discussed in more detail throughout this section.

Recommendations and Lessons Learned

IPPF/WHO found that the following were important steps in the process of developing and implementing a routine screening policy:

Assess and improve your clinic's physical and human resources. Before implementing a routine screening policy, assess and improve privacy and confidentiality, providers' ability to respond to victims in a supportive and nonjudgmental manner, and the clinic's ability to offer women, particularly women in crisis, some kind of assistance, whether through referral services or in-house services.

Identify operational definitions of violence. Identify exactly what types of gender-based violence the health program is going to address, and formulate working definitions of each category of violence, based on the local situation. Having clear "operational" or "working" definitions of violence prevents confusion and makes it easier to develop screening questions and relevant clinic policies and protocols.

Develop screening questions. Formulate or adapt questions that correspond to the operational definitions of violence and make sense in the local language. Choose words that are specific, comprehensible and literal (rather than value-laden), keeping in mind the perspective of the women who come to your health services. You may also want to decide what follow-up questions providers will ask when women answer "yes", including who was the aggressor, when did it occur, and whether the woman feels she is still in danger.

Develop a data collection system. Decide how providers will record answers to screening questions. Will dedicated space be printed or stamped onto the clinic history form?

Will there be a special registry or additional specialized forms? Will the data system be manual or computerized or both?

Develop a written screening protocol. Decide the "who, what, where, when and how" of implementing routine screening. The protocol can address preparing clinic records, asking screening questions, making referrals, caring for women in crisis, and other related aspects. It is important to involve providers during the protocol development process because routine screening may require changes to patient flow or clinic procedures, and because providers are ideally positioned to judge whether the protocol will be feasible and efficient.

Ensure that providers are adequately prepared to screen, refer and care for women who have experienced violence. Health programs should not implement routine screening policies until they have made some effort to assess providers' attitudes or practices. For example, one option to assess providers' preparedness for screening is to observe a role-play in which a staff member plays the part of a woman.

Address providers' concerns and train staff to implement the screening protocol. In addition to training all staff to follow the written protocol, health programs need to discuss providers' concerns and do everything possible to support staff in their effort to screen.

Provide support to health care providers who routinely screen clients. Providers who routinely screen women for violence often experience frustration, fatigue, or other negative emotions unless the health program organizes ongoing support, such as opportunities to discuss difficult cases or activities that concentrate on emotional support.

Monitor and evaluate routine screening. Finally, health programs should monitor and evaluate routine screening on an ongoing basis. This includes gathering information on: a) provider perspectives about how well the routine screening protocol is working and whether adjustments need to be made; b) service statistics about screening levels, detection rates and referral numbers; and c) women's perspectives about the quality of care and the acceptability and benefits of screening.

d. Developing Operational Definitions

Before deciding what screening questions to ask, it is important to identify what kinds of violence your health care providers are going to identify through screening, and what categories and words you will use to define

those types of violence. Having clear “operational” or “working” definitions of violence prevents confusion and makes it easier to develop screening questions and relevant clinic policies and protocols.

In Practice

IPPF/WHR working definitions of gender-based violence against adolescent and adult women

The three associations involved in the IPPF/WHR regional initiative developed working definitions that reflected the types of violence most common among their client population. As mentioned earlier, because the vast majority of their clients are adolescent and adult women, these definitions did not include violence against children.

Violence within the family*

DEFINITION: Physical, psychological and/or economic abuse of a woman by her partner or ex-partner(s) or by another person within the home or family. It includes:

- *Physical violence:* punching, mutilation, burns, use of weapons, domestic incarceration, etc.
- *Emotional /psychological violence:* encompasses a broad range of manifestations such as humiliation, exploitation, intimidation, psychological degradation, verbal aggression, deprivation of freedom and rights, etc.
- *Economic violence:* economic blackmail, taking away the money the woman earns so that the male partner has absolute control over the family income, etc.
- *Perpetrators can include:* partner, ex-partner, father, another family member, or any other person at home.

**Sexual violence often accompanies physical domestic violence, but to facilitate the classification of data, the IPPF member associations grouped all sexual violence into one category regardless of who perpetrated the abuse.*

Sexual abuse/rape

DEFINITION: Sexual abuse is a broad concept that includes all forms of sexual coercion (emotional, physical and economic) against an adolescent or adult woman. It may or may not include rape (for example, imposing certain sexual practices such as fondling, exhibitionism, pornography, etc. is considered sexual abuse). Rape means the use of physical and/or emotional coercion, or threats to use it, in order to penetrate an adolescent or adult woman vaginally, orally or anally against her wishes.

Perpetrators can include: partner, ex-partner, boyfriend, father, another family member, another person at home, teacher/educator, boss, colleague at work or school, another acquaintance, or a stranger.

History of sexual abuse in childhood

DEFINITION: Sexual abuse in childhood means utilizing a minor of 12 years of age or younger for sexual pleasure. Sexual abuse in childhood may involve physical contact, masturbation, sexual intercourse (inclusive of penetration) and/or oral and anal contact. It can also include exhibitionism, voyeurism, pornography and/or infant prostitution. Having a history of sexual abuse in childhood means that an adolescent or adult woman had such an experience in the past.

Perpetrators can include: father, another family member, another person at home, teacher/educator, boss, schoolmate, another acquaintance, or a stranger.

Recommendations and Lessons Learned

The steps outlined below can guide the development of standardized, operational definitions of gender-based violence.

STEP 1: Begin with the United Nations Definition.

In 1993, the United Nations (UN) adopted the first international definition of violence against women. That declaration stated that violence against women includes:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.⁹⁹

The UN declaration names specific kinds of violence against women and asserts that gender-based violence encompasses, but is not limited to:

Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, and forced prostitution; Physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.

STEP 2: Identify what types of violence the organization will address.

For example, health programs can consider the following:

What types of gender-based violence are most prevalent in your community? For example, the patterns and prevalence of gender-based violence vary depending on the cultural and social contexts. Neither female genital mutilation nor dowry-related violence is common in the Americas, but they are widespread in other settings. In contrast, the IPPF member associations felt that “economic violence” (deliberately and capriciously withholding money from a woman, often to the point that she cannot feed herself or her children) is widespread in Latin America and the Caribbean.

What types of gender-based violence are most prevalent among your client population? For example, the types of violence that are most relevant to a health program’s clientele will vary if that program serves children versus adults, stable populations or refugees, etc. The IPPF member associations primarily served adolescent and adult women, rather than children, so they chose to include a history of childhood sexual abuse, rather than ongoing abuse of children, as one of the types of violence they would address.

What types of gender-based violence make sense for your organization to address given the types of services that it offers? For example, emergency rooms may be particularly well-placed to detect certain kinds of physical and sexual violence, but may not consider it feasible to ask clients about a history of childhood sexual abuse. In contrast, as providers of sexual and reproductive health services to adolescent and adult women, the IPPF associations felt that a **history** of sexual abuse in childhood was highly relevant for their work.

STEP 3: Agree upon specific categories and wording to describe specific types of violence.

The next step is to agree upon specific categories and wording to describe each type of violence that your organization intends to address. This is more complex than it might appear. Within the parameters of the United Nations definition of gender-based violence, researchers and program managers have defined and sub-categorized violence in many different ways. For example, violence can be characterized by:

- **The type of harm inflicted:** such as physical, sexual, psychological, emotional or economic harm.
- **The characteristics of the victim:** for example, by distinguishing between child molestation versus sexual assault of an adolescent or adult woman.
- **The type of perpetrator:** for example, the classification “intimate partner violence” groups all forms of violence against women—including sexual violence—perpetrated by a partner or husband, while “family violence” includes family members as well as partners.

Health programs can choose categories that make sense for their cultural and institutional setting. For example, in the case of IPPF/WHO, the organizations decided to include forced sex within marriage with all other kinds of sexual violence (by any perpetrator), while maintaining a separate category for physical and psychological violence within the family. This decision may or may not work for other organizations. Health programs may also want to consider legal factors when developing operational definitions of violence. For example, legal definitions of child sexual abuse and statutory rape differ from country to country. It is helpful for the operational definitions to correspond to the legal obligations that health workers may face in their day-to-day practice. For example, in the IPPF/WHO initiative, the organizations had to identify the boundary between child sexual abuse and sexual abuse of an adolescent to make it easier to develop policies for how providers should handle such cases in their clinics.

e. Developing Screening Questions

Some health organizations encourage their staff to ask women about violence but do not provide standardized questions. Other organizations draft one or more written questions that providers can use with each client. Both the IPPF/WHR experience and other published research suggests that written screening questions are an important component of a successful routine screening policy.^{100, 101} Many health care providers initially feel uncomfortable raising the issue of gender-based violence with their clients, often because of lack of experience or concerns about how women will react. Written screening questions can make it easier for these providers to begin routinely screening women.

Advantages of written questions:

They can make routine screening easier and more efficient. Written screening questions can make it easier

for providers to ask women about violence because providers do not have to consider how to word the question(s) for each different client.

They allow providers to reassure women that they are not being singled out. Providers can reassure women that they are not being singled out since it is a clinic policy to ask all women these exact questions.

They allow health programs to collect systematic data on multiple kinds of violence. Standardized questions allow health programs to collect comparable data on carefully defined types of violence. This data can be useful for understanding the needs of a health program's client population and for estimating demand for specialized services. Additionally, this data can be used for the purpose of raising awareness at the community level about the prevalence of different types of violence.

In Practice

Introducing written screening questions at PLAFAM, Venezuela

Before the regional initiative began, PLAFAM had implemented a screening policy that required family counselors to screen women for violence without written screening questions. When PLAFAM changed its policy in 1999, the association carried out an evaluation to compare providers' and clients' perspectives before and after introducing written screening questions.

Before written screening questions were introduced, providers found it challenging to word questions about gender-based violence for each new client. As a result, they often took "breaks" and did not ask every client. The screening tool removed the anxiety about how best to word the questions, and seemed to increase the proportion of women who were actually screened. Detection rates rose from an average of 7% of clients per month to more than 30% with the screening tool.

Providers liked to be able to explain to women, "I ask all my patients these questions; it is the clinic-wide policy." As one PLAFAM counselor explained, "The assurance for the provider is that she will be supported by specific questions . . . The assurance for the client is knowing that the questions are systematic. . . . This gives credibility to the questions and confidence to the woman in responding."

Before the written tool was introduced, family planning counselors at PLAFAM usually asked just one general question about violence. Nearly all gender-based violence victims identified in this manner had experienced physical aggression. "This was probably how the client understood violence," commented Susana Medina (the Gender-Based Violence Coordinator), "and thus that's what she responded to." In contrast, the written screening tool gave counselors an efficient way to ask about multiple types of violence, including psychological violence and a history of childhood sexual abuse.

Recommendations and Lessons Learned

GUIDELINES FOR ADAPTING SCREENING QUESTIONS TO THE LOCAL SETTING

The following guide includes some suggested steps for adapting screening questions to your organization's own cultural, linguistic and clinical settings.

STEP 1: Gather examples of screening questions that correspond to your working definitions.

Many different questions have been used to screen women for experiences of gender-based violence in different settings and languages, and an increasing number have been made available through the Internet and through published articles. Many of these questions were developed in English and tested only in the United States and Britain, but an increasing number of health programs have tested screening questions in other settings. Depending upon the location of your health program, you may or may not be able to find screening questions that have already been tested in the language and cultural setting of your organization.

Nonetheless, finding examples of screening questions that have been used by organizations can prevent health programs from having to reinvent the wheel, even if the questions have to be adapted to suit local needs. The participants in the IPPF/WHO regional initiative gathered examples of screening questions in both English and Spanish from various countries. They tried to find several sample questions for each of the types of violence identified in their operational definitions so that they could consider the strengths and weaknesses of different questions.

STEP 2: Ensure that the wording of the questions suits your own cultural and clinical settings.

The next step is to consider whether and how those questions can be adapted to the linguistic and cultural settings of your organization. A few key principles may be helpful when developing screening questions for gender-based violence, including:

Choose words that are suitable for your country, city and client population. Remember that the meaning and connotation of certain words may vary from one setting to the next. Slight differences in meaning from one place to another can have a big impact on how well the question

works and on whether or not the question is asked in a sensitive, understandable and appropriate way.

Avoid value-laden words such as “violence” or “abuse”.

Words such as “violence” or “abuse” are abstract concepts, and women in the community may have a different idea about what they mean than staff in your health program (or the United Nations, for that matter). For example, in communities where it is widely considered normal or even acceptable for husbands to beat their wives or to force them to have sex, women may not classify this behavior as “violence” or “abuse”. If asked whether they have been “abused”, they may well say “no”. Moreover, even when the broader community norms would recognize certain kinds of behavior as abuse, individuals may not have labeled their own personal experiences in those terms. For example, in response to a screening question, one woman responded that her father used to get in bed with her and kiss her neck and body. She said, “I didn’t know if that was good or bad, but I didn’t like it.” Even a traumatic event may not be understood by a woman as “abuse” if she has not shared it with anyone else or received any type of counseling.

Instead of value-laden terms, screening questions should ask about specific actions, such as hitting, kicking, slapping, sexual touching that made a person uncomfortable, etc. In other words, choose wording that is literal, objective and open to as little misinterpretation as possible.

Be aware that translation is an art, not a science.

Translating questions from one language to another should be done with great care. It is better to find words that are adapted to the linguistic, cultural and social settings than to try to recreate the wording used in another country. For example, in Spanish, the term “abuso” generally implies something sexual, while the corresponding term “abuse” in English, is often used to refer to physical as well as sexual behaviors.

A diverse group of (sensitized) staff should decide how to word the screening questions.

Staff who provide care to women on a daily basis need to be involved in developing screening questions, since they know best what questions their clients will understand. Moreover, in settings where physicians and management do not speak the local indigenous languages, it is essential to include staff who do speak the local languages, even if the official screening questions are going to be written in the national language.

STEP 3: Field-test the questions among staff and clients and make revisions as needed. It is essential for health programs to field-test the screening questions first among staff and then among clients to make sure that they are easy to understand and that they do in fact detect the kinds of experiences that you are seeking to address. It is

especially important to test questions that have been translated from one language to another. One way to validate screening questions is to hold an informal focus group with clients (not necessarily survivors), as long as you avoid asking women to reveal their own individual experiences in the group setting.

In Practice

Screening questions developed by the IPPF/WHO initiative

IPPF/WHO developed four screening questions adapted to the needs of the regional initiative in a Latin American/Caribbean setting (specifically, the Dominican Republic, Peru and Venezuela). They had strengths and weaknesses, but over the course of several years, the participating associations found that they worked fairly well. Please note, however, that the following questions are only a translation from the Spanish original and that the English version has NOT been field-tested. Screening questions need to be carefully translated and adapted if they are going to be used in different linguistic and cultural settings.

(Translated from Spanish)

Introduction

Since abuse and violence are so common in women's lives, we have begun asking these questions of all women who come to _____ (name of the clinic).

Psychological/emotional violence in the family

1. Have you ever felt harmed 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, etc.)*

If Yes, → when did this happen? _____
Who did this? _____

Physical violence

2. Has your partner or another person important to you ever caused you physical harm? (Examples: hitting, burning or kicking you?)*

If Yes, → when did this happen? _____
Who did this? _____

Sexual violence

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

If Yes, → when did this happen? _____
By whom? _____

Sexual abuse in childhood

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

If Yes, → when did this happen? _____
By whom? _____

Safety

5. Will you be safe when you return home today?
6. Are you afraid of your partner or another person causing you harm?

**Note: Each association decided to work out its own description of acts of physical and psychological violence, depending on what it felt were common practices in its country setting.*

f. Documenting the Results of Screening

The next step in the process of implementing routine screening is deciding how to record and collect women's answers to screening questions. Some health programs may be tempted to leave their data systems unchanged and to let providers record affirmative answers in an unsystematic way. However, without a systematic approach, providers may be uncertain about what information to record, and the results are likely to be inconsistent. A systematic approach may encourage providers to screen and document cases of violence in a consistent manner. A systematic approach also allows health programs to monitor detection rates (and possibly screening levels). Finally, a systematic policy for documenting the results of screening increases the likelihood that information about violence will be incorporated into a woman's medical record, and thereby improve the quality of care she receives.

Systematic data collection can document information such as:

- whether a woman was screened
- whether she said “yes” to any screening questions
- what type of violence she experienced
- who committed the violence
- when it occurred
- whether she still feels in danger
- whether she accepted a referral to another service (and what kind)
- what other details of her experience are relevant to her medical situation

The clinics involved in the regional initiative used several different methods to collect data at different points in time. For example, PLAFAM used a separate registry when it first began screening. Eventually all three organizations developed a stamp that they used to mark each clinical history form, or in some cases a separate paper. Later, some of the clinics reprinted their clinical history forms to include the screening questions, and some developed a separate form that can be placed in the medical record.

Recommendations and Lessons Learned

The four methods listed on the next page have strengths and weaknesses, ranging from most to least integrated.

Each health program will have to decide what method will work for it, but it may be helpful to review the strengths and weaknesses of four different ways to record the answers to screening questions. It is important to note that for those health programs aiming to integrate a response to gender-based violence into their work, the first method represents the most integrated approach and each option becomes less integrated as one moves down the list. Not all clinics in the IPPF/WHR regional initiative were able to reprint the clinic history form during the initiative, but they all saw that method as the ultimate goal.

Strengths and weaknesses of four ways to document the results of screening

Method of Recording Answers	Strengths, Weaknesses and Other Comments
1. Have the clinical history form reprinted so that it contains a dedicated place for this information. This is the most integrated system.	This approach fully integrates the information gathered through screening into women's medical records and encourages providers to view gender-based violence screening as a standard part of taking a medical history. On the other hand, when routine screening has just begun, a health program may want to wait to see whether it needs to revise the questions before spending money to reprint the forms.
2. Stamp each clinical history form with a table in which providers can record information.	A stamp offers a way to incorporate this information into the medical record, without having to reprint the form (as long as there is extra space available). This was the approach used in several clinics that participated in the IPPF/WHO regional initiative (see the "In Practice" section below for an example).
3. Create a separate form that can be placed into a woman's medical record.	This allows the health program to collect more information than can fit on the clinical history form. However, it works best if these forms are placed in every eligible client's chart, rather than only in the charts of those women who say "yes" to a screening question. Otherwise, it may not be possible to determine who has and has not been asked.
4. Maintain a separate registry or folder where answers to screening questions can be documented. This is the least integrated system.	This approach has been used in some IPPF/WHO clinics. It has the disadvantage of encouraging providers to think of gender-based violence as something that is not integral to women's health, because they do not include it in the woman's medical record, and therefore, in the long run, it may not be the ideal approach. On the other hand, it may be a stop-gap measure if—for any reason—program managers feel that they cannot protect the confidentiality of medical records stored in the normal location.

In Practice

Sample stamp for recording answers to screening questions

Date: The date the screening tool was used with the client.

Accepted Help: Did the client accept a referral?

Ever: Mark if the client has experienced the particular kind of violence at any given point in her life.

The four categories of GBV, defined by the working group based on existing definitions in the literature and on the experience of 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

Date: ____/____/____			
RA: ____	Ri: ____		
Accepted Help? ____			
	Ever	Last 12 months	partner ✓ = yes
PSY			
PHY			
SX			
CSA			

RA: Indicates whether the provider has evaluated the client's current risk.

Ri: Check if the client answers negatively to the following question: "will you be safe when you return home today?"

Partner: Mark if the aggressor of the violence was the client's partner.

Last 12 Months: Mark if the client has experienced the particular form of violence in the last 12 months. This is what IPPF/WHO defines as current experience of violence.

g. Writing a Routine Screening Protocol

The next step in the process that we recommend is to develop a written screening protocol that will clarify the who, when and where of each step of the screening process, so that all staff understand their role. Screening protocols generally vary considerably from clinic to clinic, depending on the client flow, the physical layout, the type of information system used, and available personnel. Therefore, it is difficult to create a standard protocol that would be applicable to all organizations.

Eventually, you may have to consider how often clients should be asked screening questions. When a screening policy is first implemented, this is not an issue because one can assume that clients have not previously been screened. After a screening policy has been in effect for some time, however, health programs will need to develop a specific policy for how often to screen women (for example, at each visit, once a year, etc.).

Recommendations and Lessons Learned

Do not assume that the screening protocol will necessarily be the same in every clinic. Each clinic may need to develop a screening protocol that suits its specific needs based on differences in staff, patient flow, types of services, and clinic resources. There are many different ways to approach screening, and the protocol may need to be adapted for each individual site.

Managers should not try to develop a screening protocol by themselves. Without the participation of health care providers who understand the reality of providing care on a day-to-day basis, it will be difficult to develop a feasible and efficient protocol. Ideally, a health program should find a participatory way to involve providers in identifying what changes need to be made and what kind of screening protocol would work best in their own setting.

Consider whether you need to adjust clinic procedures, such as patient flow. In many cases, a clinic has to adjust patient flow, change information systems, or revise other norms, procedures and policies in the clinic to ensure that providers can implement routine screening in ways that protect women's safety, privacy and confidentiality.

Consider the protocol to be an ongoing work in progress. Over time, managers should expect to revisit the protocol and make changes, either because the original policy did not work as well as expected, or because the situation in a clinic changes. It is important for program managers to gather feedback from providers on a regular basis and to be willing to adjust the protocol as needed.

In Practice

Screening policies used by PLAFAM, PROFAMILIA and INPPARES

At **PLAFAM** (Venezuela), family planning counselors (*orientadoras*) began screening new clients for gender-based violence in 1998 without written screening questions. In 1999, these counselors began using the four-question screening tool developed for IPPF/WHO's regional initiative. According to clinic policy, counselors systematically screened all new clients seen in the central clinic, the clinic in the neighborhood of Petare, and the youth clinic. Other providers, such as doctors and psychologists, were also trained to ask women about gender-based violence; however, they did not necessarily screen women in the same routine way as the *orientadoras*. Recently, however, the screening questions were integrated into the clinical history form used by physicians, a step that has formalized the process of screening in the medical services.

In **PROFAMILIA** (the Dominican Republic), systematic screening began in the youth clinic when it opened in 1999. In PROFAMILIA's two main sexual and reproductive health clinics, Evangelina Rodriguez and Rosa Cisneros, all designated sexual and reproductive health providers (including doctors, midwives and psychologists) began systematic screening of clients in November 2000, though some individual providers had been screening before that. Most clients who are screened are new clients, as screening was incorporated into the client intake process, but PROFAMILIA has recently begun screening returning clients as well. In addition, psychologists in PROFAMILIA's emotional support unit have been asking clients about gender-based violence for several years.

INPPARES (Peru) introduced systematic screening in six sexual and reproductive health clinics in April 2000. Most providers who systematically screen clients are doctors, midwives or psychologists. Until July 2000, providers were only screening new clients. After July 2000, INPPARES changed its policy and began screening new and returning clients.

GUIDELINES FOR WRITING A ROUTINE SCREENING PROTOCOL

IPPF/WHO has developed a seven-step guide for writing a routine screening protocol. The guide describes what each step involves and what decisions a health program needs to make, including:

- How will each step be done? (There are often different but equally useful ways to approach a given step.)
- What category of staff and what specific staff members will be responsible for carrying out that step?
- When and where will each step take place?
- What types of clients will be screened, referred and followed-up?

STEP 1: PREPARATION OF CLIENT CHARTS

Objective: To ensure that medical charts have the necessary paperwork for screening and documentation.

What this step involves: This step varies, depending on what kind of paperwork has been developed for screening. For example:

- If the clinic is using a stamp to record the answers to screening questions, then someone needs to be responsible for stamping all eligible clients' clinical history form.
- If the clinic is using a separate form, then someone needs to place this form in each woman's chart.
- If the screening questions are already written into the clinical history form, or involve a separate registry that is within the control of the screener, then there may not be anything that needs to be done in this phase.

What the health program needs to decide:

- Is the program going to use a stamp? Reprint the clinical history forms? Use a separate form that will be placed in the chart? Create a separate registry?
- What staff member(s) are going to have the responsibility of placing the stamp or including the form? The receptionist? A nurse? Etc.

- When are these staff expected to put the stamp or place the form in the chart? For example, will they stamp the clinical history forms all at once or on the day of the client's appointment?

STEP 2: SCREENING

Objective: Ask a series of direct screening questions to identify whether the client has experienced gender-based violence.

What this step involves:

- Look for indirect indicators of violence, such as wounds, bruises, depression, fear, nervousness, etc.
- Ensure that there is an opportunity to speak with the client in private, without the presence of family members or friends (particularly her partner).
- Introduce the topic of GBV using a standard opening (e.g. "I am asking all my clients about this because it seems to be a problem in our community". . .) during a non-threatening part of the consultation. For example, do not screen a woman for violence during a clinical exam when she is undressed and may feel more vulnerable and exposed.
- Inform the client of any limits to confidentiality of the information that you are asking her to disclose.
- Ask direct questions about her experience with violence using a screening tool.
- Even if a woman says no, the provider can make the client aware of the existence of services to assist women who have experienced gender-based violence.
- If a woman says yes, provide emotional support and assure her that the violence is NOT her fault.
- Evaluate her level of risk using the danger assessment questions the organization has chosen.

GUIDELINES FOR WRITING A ROUTINE SCREENING PROTOCOL *CONT.*

What the health program needs to decide:

- What types of services will implement routine screening. All services? Reproductive health services? (For example, the IPPF associations decided to implement GBV screening in their sexual and reproductive health clinics, but not necessarily their other services.)
- Will staff screen returning clients as well as new clients? (For example, the IPPF associations began by screening new clients, and later changed the policy to include returning clients as well.)
- What kinds of staff and which specific staff members will be responsible for routine screening? In PROFAMILIA, the screening protocol identified physicians as the staff members who had responsibility for screening. In contrast, PLAFAM had a policy that identified the family planning counselors as the staff members with responsibility for routinely screening women. This choice will depend on several factors, including client flow through the clinic, the types of providers who work in the clinic, and the types of attitudes that are common among different groups of staff members. Research suggests that any level of health worker can screen as long as this person is well trained and supported.
- At what point during the consultation will staff members screen women? For example, screening can take place at the beginning of the consultation during the intake process, or it can occur after the clinical exam, when the woman meets with the physician (and is already dressed).
- What screening questions will your providers use?
- What danger assessment questions will your providers use?

STEP 3: DOCUMENT THE RESULTS OF SCREENING

Objective: Ensure that the results of screening are recorded in the client's chart (or other registry).

What this step involves:

- Follow the clinic protocol for recording the client's answers to the screening tool. (For example, in the case of the IPPF associations, their providers initially filled out the stamp in the clinical history forms.)
- If the woman discloses violence, document the information using the woman's own words.
- Document any injury or evidence of violence, using a body map, if needed.

What the health program needs to decide:

- What kind of system are you going to offer to providers so that they can document cases of gender-based violence? There are a number of options. Providers can record the information directly in the client's chart or complete a box stamped onto the clinical history form. Alternatively, providers can record the information on a separate piece of paper or registry that does not remain part of the client's medical record in cases when the clinic does not feel sure that client records are adequately secure. (Note: This is not ideal. It is better to improve the security of client records and overall respect for confidentiality in the clinic rather than have a separate registry for GBV cases. A separate registry defeats the effort to integrate GBV into medical services.)

GUIDELINES FOR WRITING A ROUTINE SCREENING PROTOCOL *CONT.*

STEP 4: PROVIDE SAFETY PLANNING, EMOTIONAL SUPPORT, AND CRISIS INTERVENTION

Objective: To ensure that survivors of violence get immediate emotional support, safety planning and crisis intervention, if needed.

What this step involves:

- If she is living in a situation of risk, help her develop a safety plan or send her immediately to someone in the clinic who can provide this assistance.
- If she appears to be in crisis (including, for example, in extreme emotional distress) either provide her with the necessary emotional support or send her immediately to someone in the clinic who can provide this assistance.
- If she is the victim of sexual assault, offer emergency contraception and other forms of crisis intervention as needed.

What the health program needs to decide:

- Which staff members will be responsible for providing assistance with safety planning, emotional support and crisis intervention? This responsibility can be placed on the same staff who screen, or the clinic can set up a backup support system, including identifying specific members of the staff who are able to step in and help women in crisis.
- What kinds of protocols will be developed to help staff care for women in crisis?

STEP 5. PROVIDE A REFERRAL TO OTHER SERVICES

Objective: To help the client get access to necessary services by referring her to the proper area of care (medical, legal, psychological, shelter, etc.).

What this step involves:

- Explain the types of services that are available either within your institution or in the community.
- Offer to give her written information about those services. (Note: Some women may not want anything in writing for fear that an abusive spouse may see it.)

- If she is interested in receiving additional services from your institution, make any arrangements that are necessary for getting her an appointment.
- If she is interested in receiving services from an organization in the community, provide complete information about the institution, including address, costs of services, etc. This information should be available to the providers in the form of a referral directory. (Note: remind women to hide this information if they feel that their safety will be compromised should someone find it.)
- Document the referral in the clinical history and/or relevant document.
- In a few cases, it may be important to consider accompanying a woman to another agency.

What the health program needs to decide:

- Does the clinic have the resources to provide a referral directory to all providers or will providers have to share?
- Is it possible to print lists of services to hand out to clients? Or alternatively, is it possible to get materials from other organizations in the community to hand out to clients?
- What services within your institution can you provide to women who have experienced gender-based violence? For example, do you have counseling or psychological services? Do you offer support groups for women? Do you have any links to organizations that provide legal advice?
- Can providers who refer women to services within the institution make the appointment for women directly, or does the woman herself have to do it?
- What system are you going to use to document the referral?
- Are there any circumstances under which your staff would be willing to accompany women to an external referral, for example, to lodge a complaint at the local police station in cases of rape?

GUIDELINES FOR WRITING A ROUTINE SCREENING PROTOCOL *CONT.*

STEP 6: ENSURE THAT THE CLIENT RECEIVES THE SERVICES THAT SHE ORIGINALLY REQUESTED

Objective: To ensure that the client will receive the care for which she visited the clinic.

What this step involves:

- Provide the health care originally requested by the client.
- If the client has been identified as a victim of gender-based violence, consider the implications of this experience for her health and care.
- Even if the client has answered “no” to all the screening questions, be aware of indicators of violence, such as wounds, bruises, depression, fear, anxiety, etc. Document any lesions or evidence of violence, using a body map if necessary.
- Inform all women about the availability of emergency contraception (EC). Even if they do not need it at the moment, this information may prove useful in the future.

What the health program needs to decide:

- What documentation system will the clinic encourage providers to use when they see signs of violence, but the woman says that she has not experienced GBV?
- Does the clinic have resources to produce or obtain educational materials about EC?
- Can the clinic explicitly incorporate issues related to GBV into protocols for providing family planning and STI/HIV counseling services (if applicable)?

- Establish a system for allowing staff from different services to share information and provide follow-up for clients who have been referred to another part of the institution. (Note: this is difficult, and the IPPF associations have struggled to do this.)
- Set up a system for following-up clients who have been referred to external organizations.
- Establish a system for monitoring the quality of services that women receive outside the clinic. For example, if the client returns to the clinic, use her visit as an opportunity to ask her questions about the services that she received. Alternatively, staff members can accompany one or more clients to the outside service to see for themselves what the quality of services is.
- If possible (and if the client says that there is a way that it can be done safely), try to stay in contact with women who appear to be at high risk.

What the health program needs to decide:

- What systems for providing follow-up and monitoring are feasible given the resources of the clinic, the types of referral services available, the social context, etc.? Follow-up and monitoring of referral services are extremely challenging. Even after several years of working on the issue of gender-based violence, the IPPF associations continue to struggle with this area.

STEP 7: FOLLOW UP CASES OF GENDER-BASED VIOLENCE

Objective: To monitor the extent to which clients are able to access referral services and be treated well.

What this step involves:

- For internal referrals, set up a system to monitor how many clients actually receive the services to which they have been referred.

h. Addressing Providers' Concerns About Screening

Asking women about gender-based violence can seem daunting to many health care providers. Many might ask: Why would women want to talk to me about their experiences of violence? What can I do to help? Should I open up the topic if I can't deal with the root of the problem? These are just some of the doubts that providers have when they consider incorporating screening and services for victims of violence into their programs.

Changing providers' beliefs, attitudes and knowledge is an essential—and perhaps the most important—component of improving the health sector response to gender-based violence. Routine screening policies will fail if health programs do not build support among staff for this endeavor. Providers' resistance to screening, particularly among physicians, has been reported in many different settings. In some cases, this resistance is based on misconceptions and prejudices. In other cases, their concerns are legitimate and need to be addressed by making changes within health services. In fact, there are many things that program managers can do to overcome resistance and ease providers' concerns.

Recommendations and Lessons Learned

Some providers' concerns need to be addressed through sensitization and training. Some providers' concerns can be addressed by educating providers about the nature of violence and the impact of violence on women's health and wellbeing. For example, many providers oppose screening because they do not recognize gender-based violence as a public health problem, and they may therefore feel that it is a waste of time.

Some providers' concerns need to be addressed by making changes in the clinic. In many cases, health managers can play a role in easing providers' concerns about screening by making sure that staff members have the resources they need to do their job. For example, if staff are concerned that they cannot offer women any assistance, then it is the program manager's responsibility to build links with referral services and consider options such as setting up support groups. Concerns about time constraints are also common among providers. If providers feel that they cannot screen women

for gender-based violence and still see as many clients as they are required to see, then it is the responsibility of program managers to evaluate providers' time constraints and find a manageable approach.

Some providers' concerns disappear when they begin to apply screening in their practice. For example, before providers try screening, it is common for them to believe that women will not answer the screening questions until they have a chance to try it for themselves. In fact, asking providers to screen a handful of clients is often a powerful way to change their preconceptions about gender-based violence in general and about screening in particular.

Some providers will never shed their opposition to screening, and they should not be asked to screen. IPPF/WHR found that even after the initiative had been underway for several years, a small group of providers continued to hold negative attitudes toward victims of physical and sexual abuse, and/or continued to oppose the idea of routinely screening women for violence. The lesson is that some health professionals will not change their views, no matter how many times they receive training. These staff members should not be asked to screen women, because it is unlikely that they will do it well, and their attitudes can place women at risk. In some cases, continued opposition is based on legitimate concerns about their ability to help women. However, when staff members continue to express negative attitudes toward victims of violence, managers have an obligation to consider whether the health program can continue to employ personnel whose beliefs may place women's wellbeing and dignity at risk.

Program managers need to maintain an open dialogue with providers and allow them to give input and actively participate in decisions about when and how to implement routine screening.

Typical providers' concerns about screening and recommended strategies for addressing these concerns

Typical reasons why providers do not want to screen women for gender-based violence	What program managers can do to address providers' concerns
<p>Time constraints. Many providers are under pressure to see many clients in a short amount of time. Providers may be concerned that they do not have time to raise an additional issue with their clients. They may also be concerned that if a woman says “yes” to a screening question, they will have to spend extra time providing emotional support or following up with referrals.</p>	<ul style="list-style-type: none"> • Ensure that screening and referral protocols are as efficient as possible. • Assign screening to staff who won't be overburdened by the responsibility. • Encourage providers to screen some clients. They may find that screening takes less time than expected. In fact, one study found that asking women three brief questions correctly identified the majority of abused women and took an average of just 20 seconds.¹⁰² • Show providers evidence linking violence with repeat visits and increased use of health services. If they understand the extent to which violence is the underlying cause of many chronic health problems, they may recognize the potential of screening to improve the quality of care they provide, as well as to save time in the future. (However, this may not help providers who are paid by the number of consultations they provide.) • Consider training other staff to provide immediate attention that victims may need. For example, if physicians are screening, consider training counselors or nurses to offer safety planning and crisis intervention to women who disclose violence. Having backup support may ease physicians' concerns about time constraints. • Consider ways to ease time pressures on providers more generally.
<p>They do not consider it a health issue. Many providers do not recognize the health consequences of violence, or they believe that other health issues should have higher priority. In many cases, they believe that the issue of violence belongs in the realm of social work or psychology.</p>	<ul style="list-style-type: none"> • Educating staff about the health consequences of violence may change their opinion about whether this is an issue that is worth their time. • Share research that suggests that violence against women is just as prevalent as many common conditions for which providers routinely screen. • Educate providers about the potential role that the health sector can play in addressing gender-based violence.
<p>They believe women will deny it and/or feel ashamed. Providers believe that women do not want to be asked about violence, that they feel it is a private matter, that they will feel ashamed to talk about it with their health care provider, and/or that they will deny it.</p>	<ul style="list-style-type: none"> • Share research that suggests that just the opposite is true. Many women who experience violence (and even those who don't) want to be asked and say that health providers are the people with whom they would like to discuss the issue.^{103, 104} • Encourage providers to screen a few clients. They may be surprised at how readily women disclose experiences of gender-based violence, even sensitive types of violence such as sexual abuse in childhood. • Sensitize providers about their own potential to reinforce the message that violence is not a private matter; it is not the victim's fault; it is not a reason to be ashamed; it is not acceptable; but it is a serious health risk. Women in the IPPF/WHR initiative told evaluators that providers helped them realize that their health was at risk and that they were not at fault.

CONT'D

Typical reasons why providers do not want to screen women for gender-based violence	What program managers can do to address providers' concerns
<p><i>They believe that it does not happen to their clients.</i> Some providers who serve affluent clients believe that gender-based violence only happens to poor or uneducated women.</p>	<ul style="list-style-type: none"> • Share research that indicates that gender-based violence is prevalent among all socio-economic levels. • Encourage providers to screen a handful of clients. They are often surprised at the prevalence levels they find even among affluent clientele.
<p><i>They believe that most of their clients have experienced violence.</i> Depending on the type of screening questions used, providers may have a legitimate concern that so many clients have experienced violence that screening will generate an overwhelming demand for assistance.</p>	<ul style="list-style-type: none"> • Conduct research among the clinic population to find out how prevalent certain kinds of violence are, and share this data with providers. • Ensure that the health program has resources to meet the demand that might be generated by screening. • Develop triage strategies for getting services to women most at risk. • Consider strategies for reducing levels of violence in the wider community, such as education campaigns.
<p><i>They believe that men have the right to discipline their wives and/or to expect sex on demand.</i> In some cases, providers believe that violence is just a normal and acceptable part of life in their community.</p>	<ul style="list-style-type: none"> • Use an evidenced-based approach to increase providers' understanding of gender-based violence as a public health problem and a human rights violation. • When providers continue to express negative attitudes toward victims of violence, do not require or even encourage them to screen. • If some providers' attitudes do not change over time, it may be necessary to ask them to leave the organization. • Consider assessing such attitudes when hiring new staff members.
<p><i>They believe that they cannot do anything to help victims of violence.</i> Many providers feel that they cannot offer women any effective assistance, and therefore feel it would be unethical to screen for gender-based violence. This is a reasonable concern that health programs need to take seriously.</p>	<ul style="list-style-type: none"> • Share evidence that while doctors cannot “solve” the problem of gender-based violence alone, they can provide a critical opportunity for detection and referral. • Build networks with referral systems and give providers referral directories to services outside the clinic. • Consider developing services for victims of gender-based violence within the organization. • Share evidence suggesting that the simple act of asking women about violence in an empathetic manner can let victims know that violence is an important medical problem and that it is not their fault.¹⁰⁵ • Educate providers about how knowing a client's current or past history of violence may help improve the quality of providers' work by improving their ability to accurately diagnose and determine the best course of treatment. • Share what other providers have to say about their experience with screening. For example, Leigh Kimberg, MD, who screens for gender-based violence at a San Francisco public health clinic, says, “since I can't rescue victims, I realize all I need to do is be empathetic and supportive, and this simple intervention can really help empower someone.”¹⁰⁶ • Share information about women's own perspectives regarding the benefits of screening, which in many settings has been quite positive.

CONT'D

Typical reasons why providers do not want to screen women for gender-based violence	What program managers can do to address providers' concerns
<p><i>They believe that they are not trained to determine who is a “real” victim of violence.</i> Some providers think that for some reason, only psychologists are professionally equipped to identify who is a victim of violence and who is not.</p>	<ul style="list-style-type: none"> • Ask providers to screen a handful of women. As soon as they hear their own clients speaking about their experiences of violence, providers tend to forget (almost immediately) any concern about whether someone is “really” a “victim” and what it means for screening data to be “valid” or “reliable.” • In some cases it may be helpful to dispel the misconception that a significant proportion of rape victims lie. This is a common prejudice in some parts of the world, and may contribute to the belief that only a psychologist can reliably identify who is and is not a victim of violence.
<p><i>They feel that it is unethical to screen women because there are no referral services in the community.</i> This is a serious and legitimate concern for which there may not be an easy solution.</p>	<ul style="list-style-type: none"> • However scarce referral services may be in the community, health programs need to make every effort to research what few services may be available. • Health programs can work to increase the types of referral services in the community by lobbying governments, law enforcement agencies, and other nongovernmental organizations. • Health programs can consider setting up services within the health program itself, particularly lower-cost strategies, such as support groups. • At the very least, health programs can ensure that staff are prepared to provide danger assessment, safety planning, counseling and crisis intervention before they begin screening.
<p><i>They are concerned about getting involved in legal proceedings.</i> Providers are sometimes concerned that if they ask about violence, they may end up having to testify in court. They may feel that this can be time consuming and may even put their physical safety at risk.</p>	<ul style="list-style-type: none"> • Research the local situation and ensure that providers have a basic understanding of when courts require medical evidence and what are their legal obligations with regard to victims of violence. • Establish links with legal services for victims of gender-based violence in the community that can assist the health program in this area. • Establish safety protocols to protect providers both while they are in the clinic and off site. Recognize that providers' safety is a serious concern that warrants special policies and monitoring. • Provide ongoing support to providers in case they do become involved in a legal proceeding.

In Practice

Pilot testing a screening tool can allay providers' concerns

Field-testing a screening tool in your own organization or practice can be a powerful catalyst for changing providers' opinions about screening. IPPF/WHR found that the research evidence or even hearing about the experiences of other organizations was not as compelling to staff as seeing the results of the screening tool in their own setting and seeing detection rates climb dramatically. At the level of an individual provider, IPPF/WHR also found that asking a provider to screen a handful of clients was a crucial step in overcoming initial skepticism about the need for or appropriateness of screening.

One of the first major challenges for all three associations involved in the initiative was to agree to implement routine screening for gender-based violence using a standardized screening tool. Resistance came from both managers and individual providers who were skeptical that women would answer direct questions about violence, or that screening could accurately identify cases of violence when done by providers who did not have the specialized training of a psychologist. Without confidence in the effectiveness of screening, the associations were concerned that routine screening would place an undue burden on providers in terms of time and resources.

Even though ample evidence existed in the research literature to address most of their concerns, staff did not find this evidence convincing, especially when the research had been carried out in other settings such as the United States. To explore the issue further and alleviate the concerns of staff, the three organizations decided to field-test a screening tool in PLAFAM, beginning in September 1999.

The field test demonstrated that women would answer direct questions about gender-based violence, even sensitive types of violence such as childhood sexual abuse and rape. "The program has surpassed all expectations and has proven that the questions are neither intimidating nor invasive for the client," said Susana Medina, the Gender-Based Violence Coordinator. "It shows that clients are waiting for someone to ask them these questions."

Once the field test produced encouraging results, all the organizations agreed to implement a routine screening policy in participating clinics. This experience demonstrated that published evidence may be less powerful to providers than the opportunity to try out screening themselves.

i. Offering Emotional Support to Health Care Providers

Why is it important to implement support groups for professionals who work with survivors of gender-based violence?

By Manuel Llorens, technical consultant to PLAFAM, Venezuela

As a starting point, we should consider the idea that as health workers, we are the tools for our work. Although the effectiveness of the treatment we offer is optimized through technical capacity and experience, it is primarily the adequate use of our emotional resources and sensibility that allows us to provide empathetic and warm care to clients. In many cases, this helps give women the hope to believe in being able to establish trusting, healthy and nurturing interpersonal relationships.

Providers who work with victims of gender-based violence are, along with teachers, one of the groups that are most vulnerable to suffering from emotional exhaustion. Among other factors, this vulnerability is due to the experience of listening to testimonies of human pain and suffering on a daily basis. As a result, providers need to use their own emotional resources to face and optimize the intervention with the clients, as well as to protect themselves from the related emotions.

Creating a space for supporting health care providers who work in this area means creating a space for promoting

the care and protection of each staff person's emotional resources and mental health. The consequences of not taking this step include putting staff members' wellbeing at risk through: recurrent physical illnesses; somatic manifestations of anxiety; recurrent thoughts about work or the clients' stories; projecting this anxiety in personal spaces (with partners, family, other work spaces, etc); loss of capacity to enjoy or take pleasure in work; generalized irritability; loss of motivation for work, with the subsequent manifestations of tardiness and missing work days; and expressions of frustration ("I hope that the client does not come today"), among others. Furthermore, another serious potential consequence is that providers can lose sensitivity in their work, which could result in their not behaving in an ethical manner with clients, minimizing their problems, and omitting aspects of intervention. Perhaps most importantly, it could also lead to the loss of a professional who had become a part of the fight against gender-based violence.

Recommendations and Lessons Learned

The following recommendations offer some brief suggestions that may be helpful as health managers think about how to provide emotional support for health care providers who care for victims of gender-based violence on a regular basis.

In Practice

Health workers who screen need ongoing support

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 counseling 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 situations 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.

Consider job candidates' ability to manage stress when hiring staff to provide care to survivors of violence.

Although these characteristics can be difficult to assess during the hiring process, health programs have often found it helpful to consider candidates' ability to handle the challenges of caring for survivors of violence before offering them a job. Candidates who have never experienced hardship may have difficulty listening to painful events. Conversely, job candidates who have not worked through their own experiences of victimization may experience inordinate levels of stress when they begin to discuss abuse with clients. The ability to handle stress and listen to distressing experiences of clients may be particularly important for counselors, psychologists and lawyers who spend a substantial portion of their time talking to women about violence.

Hold a workshop to educate staff about the demands of caring for survivors, including "professional stress syndrome."

This workshop can begin with a presentation on the symptoms of stress that are commonly reported by professionals who care for survivors, and on ways that providers can minimize this emotional toll. Sometimes staff do not realize the extent to which caring for survivors can affect their physical and emotional wellbeing. The workshop should include a participatory discussion that allows staff to discuss the signs and symptoms of stress that they have experienced and to share ideas about how to cope with the emotional toll of this kind of work.

If you have the financial resources, consider obtaining the support of an external professional trained in psychotherapy or group facilitation.

Health programs can look for a professional with experience facilitating groups who is sensitized to the problem of gender-based violence, and who understand the demands on and risks for health providers who care for victims of violence. If possible, it can also be helpful for health programs to give staff opportunities to consult individually with a psychologist, if the emotional toll of caring for survivors begins to affect their wellbeing.

Support groups can also provide an opportunity to get feedback on the clinic's policies and protocols, in light of staff safety and wellbeing.

For example, policies about the optimal number of clients per day or per week (in other words, providers' workloads are too heavy), the scheduling of appointments (including the extent to which appointments are scheduled during lunch, or before or after the work day is supposed to begin or end),

and treatment protocols for women who disclose experiences of sexual and physical violence (including the extent to which these protocols are realistic, feasible, effective, and efficient in the eyes of staff members). One way to reduce stress in the workplace is to ensure that staff have a say in the way a clinic is run.

Health programs can provide emotional support to staff members by giving them time off on a regular basis.

One way to ensure that staff members do not experience "burn-out" is to ensure that staff take vacations on a regular basis and do not spend too many hours in one week providing care to survivors of violence. Some health programs have found that it is helpful to give staff extra afternoons off when the work begins to take a toll.

Health programs have also found it helpful to organize activities outside of work to relieve stress.

For example, some programs have found it helpful to organize outings or retreats, either during working hours or on days off, to build a sense of solidarity among staff and help them feel more like a team.

Health managers should be willing to rotate staff members' job responsibilities when needed.

Some people find that it is not possible to provide care to survivors of violence indefinitely, and health care managers need to protect their staff by rotating job responsibilities when the toll of this kind of work begins to affect their wellbeing.

Hold a separate monthly meeting where providers can discuss specific cases of gender-based violence.

This type of meeting is not the same as an emotional support group for providers; rather it focuses more on the technical and professional aspects of providing adequate care for survivors of violence. One provider should volunteer to do the first presentation of a case, keeping the identity of the client anonymous. The presentation of the case can then be followed by a group discussion about the nature of the case, the way that providers can handle similar situations, the appropriateness of the intervention carried out, the characteristics of the client that were surprising or not surprising, as well as the challenge that the provider faced, etc.

j. Gathering Screening Statistics

Many health programs have implemented routine screening programs, and some have published their efforts to monitor and evaluate those programs.^{107, 108} Typically, health programs collected service statistics on the number and percentage of women screened, or the number and proportion of female clients who answer yes to screening questions, and the number and percent referred to outside services. Even though a lot of information about monitoring routine screening was already available in the published literature when the regional initiative began, IPPF members associations still faced some challenges that are probably not uncommon in developing countries, for example:

Many clinics in developing countries do not have computerized information systems. In the participating IPPF members associations, some clinics did not have enough (or any) computers to collect service statistics. This can make it hard to gather information on basic statistics such as the number of female clients attended who were eligible for screening according to the screening protocol, much less the number of clients who were actually screened.

Even within a single organization, different clinics may use different information systems. Even within one IPPF member association, for example, some clinics had computerized systems while other clinics collected services statistics by hand. As a result, it was difficult for the associations to collect all the data that they would have liked, and even more difficult to collect data that was strictly comparable across all three associations.

In Practice

Gathering comparable screening statistics

While IPPF/WHR made every effort to standardize the collection of screening, detection and service statistics, each association had a different information system and a different patient flow, which made it impossible to collect strictly comparable statistics on the percentage of clients detected as survivors of violence. Measuring the number of women who answered “yes” to a screening question was relatively straightforward, but the associations found it difficult to turn these figures into rates. The ideal denominator—the number of clients attended who were actually asked the screening questions—was surprisingly hard to measure, and only one association managed to computerize this service statistic. Due to these limitations, statistics on detection rates did not precisely measure prevalence among the users of the clinic; rather they were a composite indicator of screening levels (never perfect) combined with reported prevalence of emotional, physical and sexual harm.

Recommendations and Lessons Learned

When collecting routine service statistics in a resource-poor setting, there are a number of points that health managers should consider:

Screening levels are rarely perfect. Even in the best of circumstances, it is difficult to get health care providers to follow the routine screening protocol 100% of the time, nor should this be something that health organizations should necessarily try to achieve. In every organization, there may be some providers who should NOT screen women for violence, because their skills are not adequate or their attitude toward survivors is negative or punitive. Moreover, there may be good reasons why even the most skilled provider may not screen every client.

Measuring screening levels can be more challenging than it appears. Measuring screening levels generally requires a computerized information system and a willingness of providers to systematically record information each time they do NOT screen an eligible client. In the IPPF/WHR initiative, only one member association—the one with the most sophisticated information system—managed to collect data on screening levels. Monthly screening rates can be calculated in the following way:

$$\frac{\text{Number of women screened per month}}{\text{Number of women attended who were eligible* for screening that month}} \times 100 = \text{The monthly screening rate}$$

* Eligible according to the screening protocol. For example, in some clinics, the protocol may be to screen only new clients; to screen all female clients; or to screen at only certain kinds of visits.

In resource-poor settings, measuring the ideal denominator for screening levels can also be a challenge.

Ideally, a health program would be able to determine how many women were screened over a given period of time as a proportion of those who were eligible for screening. However, unless the screening policy is to screen every client at every visit, health programs may not be able to keep track of how many clients were attended at certain kinds of visits, for example, or how many clients were returning clients who were recently screened and therefore not eligible. In that case, health programs may need to measure screening rates by:

$$\frac{\text{Number of women screened per month}}{\text{Number of women attended that month (whether or not they were eligible for screening)}} \times 100 = \text{The monthly screening rate}$$

The following table from INPPARES, Peru illustrates this type of screening data. It is noteworthy that screening rates are much lower among returning clients because many were not eligible to be screened under the screening protocol.

Number of women attended, screened and identified by INPPARES as having experienced any type of gender-based violence, July – December 2002

Clinic and type of client	# of women attended	# of women screened	% of women attended who were screened	# of women detected as survivors (whether or not they were screened)	# of women identified as survivors through screening	# of women identified as survivors who did not pass through screening	Percent of women screened who disclosed violence
	#	#	%	#	#	#	%
Patres clinic							
New clients	4,277	1,942	45%	262	254	8	13%
Return clients	8,446	287	3%	130	130	0	45%
Total	12,723	2,229	18%	392	384	8	17%
Youth Center “Futuro”							
New clients	897	583	65%	143	143	0	25%
Return clients	1,166	55	5%	16	16	0	29%
Total	2,063	638	31%	159	159	0	25%
Peripheral clinics							
New clients	2,119	975	46%	530	511	19	52%
Return clients	1,872	652	35%	256	256	0	39%
Total	3,991	1,627	41%	786	767	19	47%
All clinics							
New clients	7,293	3,500	48%	935	908	27	26%
Return clients	11,484	994	9%	402	402	0	40%
Total	18,777	4,494	24%	1,337	1,310	27	29%

Note: Each clinic had its own screening policy, but in all cases, some but not all returning clients were eligible for screening if they had not been screened within a certain period of time.

If you can't measure how many people were screened, then one alternative is to measure the proportion of all women attended who report violence. This indicator is a composite. It does not measure the prevalence of violence among your patient population, because you don't know exactly how many were actually asked about violence. Instead, it is a combined indicator of the proportion of women who say yes to a screening question combined with the proportion of women actually asked (never 100%). Nonetheless, this indicator can still be helpful, because it gives you an idea of how many women in your patient population may want or need additional services related to gender-based violence, and if measured consistently over time, it may tell you when there are large swings in screening levels.

$$\frac{\text{Number of women who disclose violence}}{\text{Number of female clients attended that month (whether or not they were eligible for screening)}} \times 100 = \text{The monthly detection rate}$$

The following table illustrates the types of detection rates that health programs can collect, even if they cannot accurately measure the precise number of women screened.

Number of women who disclosed violence as a percentage of women attended in the sexual and reproductive health clinics of PLAFAM, INPPARES and PROFAMILA, January – December 2002

	PROFAMILIA (Dominican Republic)		INPPARES (Peru)		PLAFAM (Venezuela)		Total	
Denominator: Number of female clients attended in participating SRH clinics	58,765		97,329		12,075		168,169	
What does this number include?	New clients and returning clients who had not been recently screened		New clients and returning clients.		New clients.		A mix of new and returning clients.	
Were all of these clients eligible for routine screening?	Yes The computer system identifies only those who are eligible.		No It includes returning clients who were recently screened and therefore not eligible.		Yes. All new SRH clients are eligible		No Includes some returning clients in INPPARES who were not eligible.	
Type of GBV	# detected as victims of GBV	% detected as victims of GBV	# detected as victims of GBV	% detected as victims of GBV	# detected as victims of GBV	% detected as victims of GBV	# detected as victims of GBV	% detected as victims of GBV
Family violence (psychological)	6441	11%	5486	6%	1535	13%	13462	8%
Family violence (physical)	3650	6%	2901	3%	870	7%	7421	4%
Sexual violence	2371	4%	1909	2%	440	4%	4720	3%
Sexual abuse in childhood	2157	4%	1698	2%	390	3%	4245	3%
Any type of gender-based violence**	8414	14%	6382	7%	2348	19%	17144	10%

** Clients who experienced at least one type of violence

If you ask about more than one kind of violence, then you cannot calculate the total number of women reporting violence simply by adding up the number of affirmative answers. As illustrated in the previous table, most survivors of violence experience more than one type of violence. Therefore, if you ask women about more than one type of violence, then your information system needs to specifically measure the number of women who experience any type of violence. You cannot simply add the number of those who report psychological violence + those who report physical violence + those who report sexual violence, as these groups will overlap and you will get a wildly inflated number. For example, a clinic may gather the following statistics:

Number of women who report psychological violence: 20
Number of women who report physical family violence: 15
Number of women who report sexual violence: 10

In this case, the total number of women who report any kind of violence could be anywhere between 10 and 45, but it is almost certainly NOT 45 ($20+15+10 = 45$), because this would mean that no survivor experienced more than one type of violence.

Other potentially relevant services statistics include:

- What percentage of cases of violence detected were physical, sexual or emotional.
- What percentage of women identified as victims of violence accepted a referral.
- How many women received each type of specialized service.

The following table illustrates the type of data that health programs can collect on referral rates.

Number of women receiving referrals and services related to violence as a percentage of women who disclosed violence, January 2000 – December, 2002

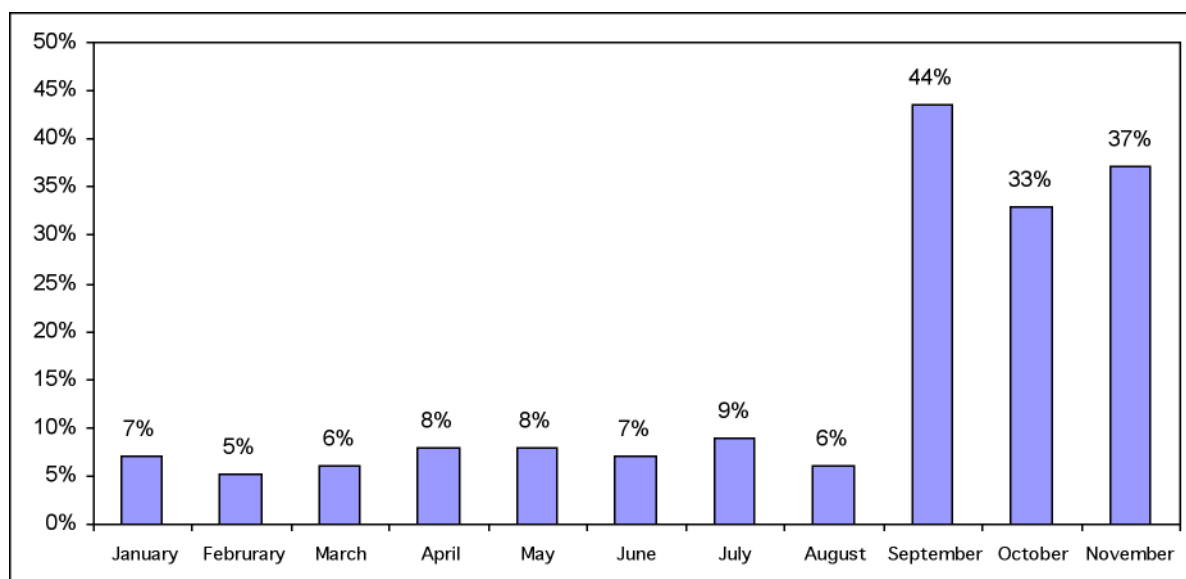
	PROFAMILIA, Dominican Republic*		INPPARES, Peru		PLAFAM, Venezuela	
Women who disclosed gender-based violence	N=8414		N=6382		N=2348	
Type of service or referral	Number	Percent	Number	Percent	Number	Percent
Total referred to an internal service	3439	40.9%	3516	55.1%	1062	45.2%
Medical	21	0.2%	111	1.7%	62	2.6%
Psychological/Counseling	2754	32.7%	3315	51.9%	806	34.3%
Legal	96	1.1%	320	5.0%	202	8.6%
Total referred to an external service	144	1.7%	189	3.0%	154	6.6%
Psychological/Psychiatric	47	0.6%	0	0.0%	35	1.5%
Legal services	64	0.8%	42	0.7%	29	1.2%
Other (including police)	26	0.3%	153	2.4%	106	4.5%
Number who received services**						
Psychological	2406	**	3424	**	1602	**
Legal	197	**	371	**	272	**

* The figures for PROFAMILIA do not contain complete information for the second semester of 2002 due to a technical problem.

** Note: This table does not include percentages for the number who received services, since many of these clients were not included among the original group of women who disclosed gender-based violence. Some recipients of services came directly to the specialized service, rather than being referred from another part of the association.

Monitoring screening statistics can be an important way to provide feedback to staff. IPPF/WHR found it extremely helpful to share screening data with staff as a way to build support for the effort to address violence in the health care setting. For example, when PLAFAM introduced written screening questions in its clinics, it measured a dramatic rise in identification rates. The data presented in the graph below were essential to convincing staff that women would be willing to answer these questions in a health care setting.

Percent of new clients identified as survivors of gender-based violence at PLAFAM's central clinic, January-November 1999 (Written screening questions were introduced in September 1999)



k. Monitoring and Evaluating Routine Screening

Measuring screening identification and documentation rates reveals nothing about the provider/client interaction during screening, much less the potential risks and benefits of a routine screening policy. There are at least two important elements of evaluating routine screening, as summarized below.

	Sample questions to be answered by evaluation (sample indicators)	Means of verification
Process	How prepared are providers to screen and respond to a disclosure of violence? How well was screening carried out? Was it done in a way that was acceptable to women? Did providers follow the screening protocol and respect clinic policies related to confidentiality and privacy? What did clients and providers have to say about their experiences with routine screening? Do clients and providers support the idea of routine screening?	Client exit surveys Provider surveys Role plays Discussion groups with providers and clients
Results/ Outcomes	What benefits does routine screening bring? What risks does it involve? Do the benefits outweigh the risks? Do the benefits justify the resources involved in routine screening?	In-depth interviews with women detected as survivors Discussion groups with survivors Clinic observations Discussion groups with providers Note: Ideally, these questions would also be answered through a formal research design, such as a clinical trial, but that is not feasible for most health programs.

Measuring intermediate objectives, such as improved provider attitudes and knowledge, is fairly straightforward. But how can a health program define success when it comes to helping survivors of violence improve their situation? Even more difficult to determine is how a health program can measure that success. Ultimately, the goal should be to improve the situation of women who experience violence, but it is a struggle to identify what specific benefits and risks health programs can actually measure.

In general, any screening program should be able to demonstrate that the benefits outweigh the risks. Unfortunately, few researchers have been able to gather rigorous quantitative data on the outcomes of screening, including the risks and benefits. Not only does this require long-term, expensive research designs, but researchers have more work to do before they can

adequately define and measure the benefits of screening in quantifiable terms. It is worth noting that in the health care field, there are long running controversies about the benefits and risks of screening for many health issues, including for example, mammography and screening for a number of types of cancer. Gender-based violence is not unique in this respect. Nonetheless, this is an area that requires more work, probably beginning with more qualitative research on the experiences of survivors themselves to better define benefits from their perspectives.

Nonetheless, health programs can do a lot to evaluate the process of screening and they can rely on qualitative methods and client exit interviews to understand what effects a routine screening policy is having in their own clinics, both for providers and clients.

In Practice

Providers' and clients' views about screening

Through surveys, group discussions and in-depth interviews with providers and clients, IPPF/WHR explored the extent to which providers and clients felt comfortable with screening for gender-based violence; whether providers reacted to disclosures in a supportive, non-judgmental, compassionate way; whether providers had the knowledge and skills to respond to women's various needs; and whether the process of asking about and disclosing violence benefited women.

Nearly all women (96%) interviewed during the midterm exit survey said that they felt comfortable/good (*"se sentieron bien"*) when asked screening questions. Nearly all said that health services should/must (*"deben"*) address the issue of violence against women. Not surprisingly, the evaluation found that both women and providers felt more comfortable discussing physical rather than sexual violence, and forced sex (in general) rather than childhood sexual abuse.

In-depth interviews, group discussions and exit surveys found that women were generally positive about their experiences at the clinic. However, when asked about negative experiences with health professionals in general—not necessarily at the participating associations—women mentioned providers who seemed rushed, uninterested, judgmental or skeptical of their story. Women complained about the tendency of some providers to discount the seriousness of the emotional, sexual or physical harm they had experienced. They also described providers who ignored their broader situation, focused only on physical lesions, and then told them to go submit a police report. Women in all three countries (especially victims of sexual violence) complained about the poor treatment received from the forensic physicians, who are notorious for their cold and skeptical attitudes toward victims of violence. Finally, victims of sexual violence mentioned experiencing shame and frustration when asked to repeat their story multiple times. "They ask and ask the same thing," said one adolescent victim of sexual violence, "I felt ashamed after everything that had happened to me."

When asked about the positive experience of discussing violence with health care providers, women consistently mentioned four issues: a) non-judgmental attitudes—"The good thing is that they don't judge you and this enables you to talk"; b) confidentiality, especially if the client was an adolescent—"We feel comfortable because we know that others will not find out." c) being believed—"This was the first time that it felt that I was taken seriously and that they believed my story"; and d) emotional support "When I told my story to the provider, she gave me security, she gave me courage, she gave me strength."¹⁰⁹

Recommendations and Lessons Learned

There are some key research gaps in the area of violence interventions, for example:

- In a health care setting, how and to what extent does screening for violence benefit women? What specific benefits can be measured?
- Do routine screening policies put women at additional risk under certain circumstances? If so, what types of risk? Under what circumstances?
- What would it mean and how can we measure whether a health program has in fact helped women who experienced gender-based violence?

When you cannot identify quantitative indicators of success, qualitative methods offer a valuable alternative.

In evaluating the health service's response to gender-based violence, there is a lack of quantifiable outcomes or indicators for measuring benefits and risks. When it is not possible to measure “benefits” or “risks” in simple, quantitative terms, it is almost always possible to gather qualitative data on the perspectives of health care providers and the women who come for services. The challenge of evaluating certain kinds of objectives should not be used as an excuse to avoid it altogether.

Observing providers during screening raises some ethical problems; role-plays offer an alternative.

IPPF/WHR felt that it would not be possible from an ethical standpoint to observe provider/client interactions directly. In place of direct observation, providers were asked to carry out a role-play to demonstrate how they would ask female clients about gender-based violence and how they would respond to a disclosure. Obviously, a role-play is an artificial situation, and may not accurately reflect a provider's behavior in real life interactions with clients. However, role-plays can demonstrate whether or not providers know how they should handle these situations and whether or not they are willing or able to apply that knowledge in their practice.

Any evaluation should include an effort to gather information from women directly. Health programs can learn about women's perspectives and experiences through client exit surveys, individual interviews, and group discussions. These data can be gathered among women in general, or among survivors of violence in particular. However, any effort to gather information among survivors should conform to the ethical guidelines developed by the World Health Organization.¹¹⁰

V. Providing Specialized Services

a. Overview

A major challenge for health programs in developing countries is the lack of adequate referral services in the community for victims of gender-based violence, including shelters, legal advice and other kinds of social services for survivors. Given this situation, what are the most important services that victims of violence need? And, given limited resources, what services should receive most priority when a health program considers setting up some services within its organization?

From the beginning, IPPF/WHO initiative planners struggled to understand how a health care organization

could help women who experience violence get the kinds of services they need. The initiative addressed gender-based violence survivors' service needs in various ways. For one, associations reached out to existing social, emotional support, and legal services in their communities, and when such services did not exist, they established in-house services. The challenge of sustaining such services now faces all three organizations, but this approach allowed them to test various strategies and document lessons learned.

In Practice

Routine screening can generate a high demand for specialized services

When the IPPF member associations began routinely screening women using written questions, the results wiped away concerns that women would refuse to answer questions, that women would take offense, or that women's answers might somehow be "invalid" or "unreliable". In fact, the screening tool identified so many women as having experienced violence, that the organizations were concerned that they would be overwhelmed with women needing assistance.

"We have had some results that we weren't prepared for," noted Susanna Medina (Gender-Based Violence Coordinator from PLAFAM, Venezuela), "as the available hours of psychological counseling could not meet the demand of the cases detected... In some cases, we have had to make external referrals for psychological counseling."

Throughout the process, PLAFAM tried to keep its staff from feeling overwhelmed by carrying out sensitization activities both before and after the screening began, and by providing information and feedback to the staff on the results of the initiative on a regular basis. Ultimately, it began organizing support groups for women, which proved to be a low-cost way to provide services to many women at once. Qualitative evaluation studies suggest that women found these groups to be extremely beneficial, and sometimes preferable to individual counseling.

Nonetheless, this example suggests that health programs need to be prepared for the possibility that screening will greatly increase the number of women wanting specialized services from the organization.

Recommendations and Lessons Learned

The experience of IPPF/WHR highlighted the need to ensure that health workers know how to assess risk, help women create safety plans, provide crisis intervention, and refer women to whatever internal and external services do exist. Other key lessons learned were:

Avoid an over-reliance on individual psychotherapy as the primary service for survivors. There are many reasons why health programs may turn to psychological services as the primary service for victims of gender-based violence. First, many victims of gender-based violence need emotional support to cope with their situation, to face the challenges ahead, and to recover from past trauma. Second, psychologists often have greater awareness of and experience with gender-based violence than other health professionals. Indeed, in all three associations that participated in the IPPF/WHR initiative, staff members with psychological training were at the forefront of the effort to address gender-based violence.

However, there are several reasons why an over-reliance on psychotherapy can be problematic. First, individual psychotherapy is a relatively high-cost intervention, and in developing country settings, it may not be a feasible or cost-effective approach. When women cannot pay the fees of a professional psychologist, it is generally not possible for health programs to subsidize long-term individual therapy for large numbers of women. Second, some victims of violence have needs that are more urgent than psychological therapy—especially if they are at risk of further abuse. These needs might include legal advice, police intervention, economic support, housing, employment, health care, and other social services. For these women, focusing on psychological counseling to the exclusion of other services could actually put some women at additional risk. Third, from a human rights and gender perspective, a strategy that relies solely on psychotherapy locates responsibility for the violence on the woman herself—and specifically on her mental and emotional health. The underlying cause of violence is the perpetrator's behavior, not the victim's emotional state. In fact, the midterm evaluation found that many women perceive a stigma associated with psychological services precisely because they felt that it was suggested that responsibility for the violence (as well as for stopping it) lay with the woman herself rather than with the perpetrator.

"I am not crazy, he is the one who needs psychological help."

Survivor of intimate partner violence from Peru.

A case management approach can be helpful. One important service that health programs can provide for women currently living in situations of violence is a kind of case management approach. This approach is similar to an approach often used in social work, but the IPPF/WHR experience suggests that it can be helpful even when used by staff members without professional training. The important thing is that the staff member knows how to help women solve practical problems and how to help them access a range of services in the community. For example, there are staff in all three associations who know the local referral services personally and can talk to women about their legal and social service options with firsthand experience.

At one organization in Los Angeles, a staff member is trained to help women plan ways to escape from violent relationships. For example, she knows exactly what couriers do the best job at delivering orders of protection to men who are deliberately trying to avoid receiving the police order. This kind of practical knowledge can be essential for women who are trying to solve difficult problems related to violent relationships.

Support groups offer a relatively low-cost alternative to long-term, individual psychotherapy. When the associations began routine gender-based violence screening, they quickly found that they could not provide individual psychotherapy to the high number of women identified as survivors. They therefore began pilot-testing the use of support groups facilitated by trained professionals. The qualitative midterm evaluation found that the support groups had many advantages. They offered a low-cost way to bring services to more women, while making use of women's ability to serve as a resource for one another. All three associations eventually began running support groups. To encourage empowerment and promote self-esteem and knowledge of rights, the support groups emphasized: 1) recognizing gender-based violence as a violation of human rights; 2) understanding social inequities based on gender; and 3) valuing women's sexual and reproductive rights.

The greatest demand for legal services may not necessarily involve assistance with criminal prosecution, but rather with divorce, child custody, economic support and division of property. When the IPPF/WHR initiative began, the planners assumed that most legal issues would deal with prosecution of men who perpetrated violence. In fact, however, most women who sought in-house legal advice wanted to know about their rights regarding divorce, property disputes and child custody—in other words, the tools that would make it possible to leave a violent partner and still support themselves and their children. This is an important example of how important it is to listen to women’s own perspectives about their needs rather than rely on well-intentioned assumptions.

Do not overlook or underestimate women’s ability to help each other. The success of the support groups suggests that there is a great, largely untapped potential for women to help each other. Women who have experienced violence of all kinds can be a great resource to one another, both in terms of emotional support and in terms of helping other women to address the practical, legal and economic issues that they face in the attempt to protect themselves and their children from further violence. This suggests that perhaps in the future, health programs in developing countries should explore new ways—in addition to support groups—that survivors of violence can help other women in that situation.

b. Counseling, Emotional Support, and Psychological Services

Many IPPF associations in the Latin American region had begun to offer in-house psychological, counseling and emotional support services long before this initiative began. This allowed the associations involved in the IPPF/WHR initiative to offer counseling to survivors of violence without having to add a whole new service. For those organizations that offer counseling and emotional support services, there are a number of important guidelines to follow that emerged both from the research literature and from the IPPF/WHR experience.

Recommendations and Lessons Learned

Do not assume that professional psychologists or other professional counselors have adequate training in gender-based violence. A health program has an important obligation to ensure that the counselors who provide emotional support services to women have undergone adequate sensitization and training specifically related to gender-based violence. While some mental health professionals have received extensive training in the area of gender-based violence during their academic training, health programs should not assume that all psychologists or counselors have this expertise.

To address any gaps, mental health professionals can find short courses or continuing education opportunities in many settings. For example, the IPPF member associations arranged for a number of their mental health staff members to participate in courses offered by local universities and non-governmental organizations specifically focused on gender-based violence. In some cases, staff members participated in programs offered in other countries in the region. To supplement this, the IPPF/WHR Regional Office arranged for consultants within the region to provide additional workshops for staff within the associations.

Mental health professionals may share the prejudices of the broader society that blame victims. Health programs should not assume that all trained psychologists (or other counselors) are immune to the prejudices of the broader society, including the tendency to blame victims of violence for the suffering that they experience. In fact, in some cases, mental health professionals use the

language of psychology to blame the victims in medicalized terms. IPPF/WHR staff found that it was not uncommon to hear psychologists identify the root of violence as some mental or emotional pathology of the victim, saying, for example, that a woman has a “persecution” or “masochistic” complex. This experience suggests that programs need to monitor the attitudes, knowledge and beliefs of mental health counselors as much as (if not more than) those of other health care providers.

Do not allow staff to conduct couple counseling for women living in an abusive relationship. Evidence indicates that couple counseling is not advisable in situations of domestic violence and can actually put women at greater risk of additional abuse by a violent partner if a victim is “too honest” in therapy.¹¹¹ Additionally, couples therapy may send the erroneous message that gender-based violence is caused by a relationship or communication problem and that both parties are equally responsible. One of the principles of working in the area of gender-based violence is that the violence (and its cessation) is always the responsibility of the aggressor.

Consider ways to provide emotional support outside the psychological or psychiatric framework. While some women certainly need the help of a professional psychologist for recovery from past abuse, there may be ways to provide emotional support outside a psychiatric framework. Indeed, the midterm evaluation found that many women preferred services called “emotional support” over those called “psychological services.” It may be possible to train other kinds of professionals in counseling techniques—particularly crisis intervention—when fully qualified psychologists are not available. In addition, group sessions are another way to provide emotional support.

Long-term individual psychotherapy is not necessarily feasible or cost-effective in developing country settings. Before setting up long-term, individual psychotherapy services for survivors of violence, it is important to understand the limits of psychotherapy. While it may help women cope or recover, it cannot necessarily stop violence perpetrated by someone else. Services such as legal advice, shelters, job placement, and law

enforcement may be more effective in helping a woman escape from a situation that is dangerous for herself and her children. Moreover, individual psychotherapy is extremely expensive, and is simply too costly for most women living in poverty and for most NGOs to subsidize on a large scale. One approach is to offer a limited number of individual sessions before referring women to a support group. Any organization that subsidizes emotional support services will have to decide how many sessions per woman it can afford to offer.

In Practice

When are psychologists prepared to care for victims of violence?

At the beginning of the regional initiative, IPPF/WHR found that many health care providers believed sexual and physical violence to be a problem best addressed by psychologists rather than by medical professionals. These providers assumed that psychologists had the training and skills to care for victims of violence. However, the baseline study found that the ten psychologists working in the three associations were not necessarily knowledgeable about intimate partner violence or sexual abuse, and a number of these staff members expressed negative attitudes toward victims. At baseline, some believed that violence against women was the result of “masochistic” tendencies of women’s personalities, and four out of ten psychologists said they did not feel sufficiently prepared to talk about violence with their clients.

As part of the regional initiative, the associations invested resources in strengthening the knowledge, skills and awareness of their psychologists by providing training in house and by sending some staff members to courses offered by other organizations. These efforts appeared to be beneficial. By the time of the follow-up evaluation, all psychologists reported feeling “sufficiently” prepared to discuss violence with clients, and many reported that their views had changed substantially over the previous three years. For example, one psychologist explained that she had previously held the belief that “only strangers could be perpetrators of sexual violence.” Another described realizing for the first time that “anyone can be raped.” Another psychologist explained that over the course of the initiative, she had to learn to adopt a more empathetic approach toward victims and to shed the “neutral” stance toward victims of violence that had been part of her professional training.

c. Legal Services

In many developing countries (and some developed countries), legal systems have serious limitations in their ability to protect women from physical and sexual violence. Many legal systems fail to respond to violence within the family as a crime, either in theory or in practice. In some settings, laws do not recognize marital rape or statutory rape, or even the ability to prosecute sexual violence as a criminal rather than a civil offense.¹¹² Furthermore, laws governing divorce are often written or enforced in ways that make it difficult for women to leave a violent relationship.

Even when comprehensive laws against gender-based violence exist, procedures for enforcing the laws are often grossly inadequate. For example, all three countries where the IPPF/WHO initiative was carried out have fairly strong legislation to protect women from sexual and physical violence; however, the enforcement of those laws is often inconsistent and fraught with risk for victims of violence.¹¹³ Police often treat women poorly and conservative judges often violate mandatory minimum

sentences proscribed by law.¹¹⁴ As a result, many victims of violence find the law enforcement system to be inaccessible, unaffordable, ineffective or downright abusive. If health care providers simply tell victims to go to the police without providing additional information or support, they may put their clients at additional risk. On the other hand, ignoring the legal system altogether can deprive clients of their rights, and, in some cases of rape and incest, may deprive their clients of the opportunity to seek a safe and legal abortion when allowed by law.

Helping women get affordable legal advice is an important but challenging task for health programs in resource-poor settings where affordable services are often unavailable and legal systems are often weak. Furthermore, the legal issues related to gender-based violence are often complex. Even when women do have access to inexpensive legal services, there is no guarantee that those legal professionals will be adequately informed about the laws related to violence against women.

In Practice

Example of strategies for working with a flawed legal sector

At PROFAMILIA, in the Dominican Republic, the in-house lawyer began to take responsibility for reporting cases of sexual violence against children and adolescents to the authorities, as well as for following-up cases as they moved through the judicial system. Her legal knowledge and experience allowed her to navigate a complex and flawed process. Health care providers in that association said that this mechanism made it much easier for them to report cases of sexual abuse without being concerned that they would get involuntarily bogged down in a difficult legal proceeding.

Another example of how to work with a flawed legal system is cited in a report by the Human Rights Watch about a case in Pakistan. In that setting, experienced non-governmental organization activists who provide assistance to victims of sexual violence told Human Rights Watch that because of the endemic corruption of police, they take their clients directly before a magistrate to obtain an order instructing the police to register a complaint. However, the report notes that this is only possible when legal aid workers have ongoing relationships with magistrates.¹¹⁵

Recommendations and Lessons Learned

Do not assume that prosecuting aggressors will be the most common reason why women seek legal advice.

IPPF/WHR found that the greatest demand for legal assistance among clients related to issues such as divorce, division of property, and child custody—all the legal tools that could make it possible for women to consider leaving a violent partner and still be able to support herself and her children.

Knowledge and attitudes about violence are just as important among legal professionals as they are among health professionals.

Legal professionals can inflict as much harm on women who experience violence as health professionals if they express negative attitudes toward victims of violence or are uninformed about the dynamics and consequences of physical and sexual abuse. Health programs should not assume that lawyers necessarily have adequate knowledge and attitudes. A gender and human rights perspective among legal staff is essential for protecting women's safety and wellbeing.

STRATEGIES FOR INCREASING WOMEN'S ACCESS TO LEGAL SERVICES

Health programs can use many different strategies to increase women's access to legal advice and law enforcement services, depending on the services available in the community and the financial resources of the institution. For example, the IPPF/WHR experience found that the following strategies could be helpful:

Establish cooperative agreements with organizations that provide low-cost legal assistance to women. In some countries—including the Dominican Republic and Peru—there are organizations that provide legal assistance to victims of violence at low cost, which allowed IPPF member associations to arrange referrals for women to legal services offered by local institutions. Health programs can reimburse those institutions directly, negotiate special rates to be paid by women themselves, or simply make the referral. This approach is not possible, however, if affordable legal services are not available, as is the case in most rural areas or even in many cities in developing countries.

Hire an in-house lawyer to provide legal advice to victims and to the whole institution. This strategy provides the most direct access for women, and it can be an effective way to increase the institution's ability to contribute to national debates and advocacy surrounding legal reform. This can be expensive in resource-poor settings where the majority of clients cannot afford to pay legal fees, but it may make sense for large organizations, particularly those that want to contribute to wider policy debates and legal advocacy.

Contract a part-time lawyer to advise the organization about legal dimensions of violence and to assist with a select number of cases. Health programs that cannot afford to hire a full-time lawyer can consider contracting a lawyer to provide occasional or part-time advice. This type of arrangement can allow a lawyer to educate staff members about the legal dimensions of violence, the laws and regulations that affect the health service response to violence, and any ongoing national or local debates on legal issues. In addition, health programs can use a part-time contract with a lawyer to provide legal advice for a select number of clients whose situations appear to be particularly in need of assistance.

Train a few staff members to have a more in-depth knowledge about the legal dimensions of violence. When no affordable legal services are available in the community and the program has no funds to hire a legal professional, another option is for health programs to educate their staff in basic legal issues. For example, some women can be helped simply by letting them know basic information about their rights, such as: whether and how they can obtain a divorce; whether the police can issue or enforce orders of protection; and whether there is anything they can do to ensure economic support from the father of their children. Health programs may also want to train a select number of staff in a more in-depth understanding of the legal situation so that they can better inform women about their legal rights. The “legal guide” in this manual (Chapter III.f) can help managers identify key issues that staff may need to know. However, we strongly recommend that health programs seek professional advice, at least initially. For example, most developing countries have at least one or more nongovernmental organizations working on legal advocacy related to women rights. These organizations can often serve as a low-cost resource for health programs on the legal dimensions of violence and health.

Whatever strategies they choose, health programs need to select legal professionals with care. To be effective, health organizations need to work with lawyers who have certain essential qualifications. First, they need enough experience to address the challenging area of gender-based violence. Some organizations may be tempted to find a new law graduate with little experience as a way to save funds, but the IPPF/WHR experience suggests that this can be a waste of money given how challenging the area of gender-based violence can be when the laws are not adequately written or enforced. Lawyers who work with health programs have the potential to be much more than service providers to clients because they can contribute to the broader policy debate with the backing of the health sector. It is important to find professionals who can speak as strong advocates for legal reform in public settings. The second important qualification is that—as already noted—it is essential that legal professionals have a gender and human rights perspective, are informed about the nature and consequences of violence against women, and do not have negative attitudes or prejudices against victims.

d. Women's Support Groups

Adapted from an article written by Lolimar Moreno, Adriana Ramírez and María Alejandra Ramírez. With help from Idhaly Guzmán, Susana Medina, Iliana París, Fabiola Romero and Esther Sánchez

My life [has] changed completely, first of all because I feel that I am in charge of my life, and I can make decisions . . . I don't recognize myself because for many years I lived with a man tolerating things that now I don't tolerate. A lot of people have noticed this change. Now my family and my co-workers are amazed because they see how I changed from being very passive to taking charge of my life.

SURVIVOR OF VIOLENCE SPEAKING ABOUT THE WAYS
IN WHICH A SUPPORT GROUP CHANGED HER LIFE.

When PLAFAM, the IPPF member association in Venezuela, began to screen women for gender-based violence, providers identified so many women as victims of violence that PLAFAM could not meet the resulting demand for long-term individual counseling. Moreover, providers felt that women needed an opportunity not only to confront their personal situations, but also to move beyond them. PLAFAM decided to start emotional support groups for women in order to address both of these issues. To address the needs of women in different situations, PLAFAM decided to form three types of gender-based violence support groups—one for victims of domestic violence, one for victims of adult sexual abuse/violence, and one for victims of childhood sexual abuse.

By handling some aspects of care in a group setting, PLAFAM could reach more women with fewer resources, thereby improving the efficiency of clinic services. The support groups also created an opportunity for staff to learn more about violence, including its causes and consequences, surrounding myths and beliefs, its cycles, and ways to break the cycles. But the support groups did much more than solve these practical needs. The social context of the group setting offered women the chance to see that they were not alone and to build upon the solidarity they felt with other women confronting similar circumstances.

PLAFAM hoped that participating in the support groups would help women understand gender-based violence as a public health issue and recognize its relationship to gender inequity. This understanding would be the springboard for participants to begin the process of empowerment, improving their self-esteem, self-knowledge, and knowledge of their rights. With these objectives in mind, PLAFAM structured the support groups upon three key perspectives:

- 1) Recognizing gender-based violence as a violation of human rights;
- 2) Addressing the social inequities that are based on gender; and
- 3) Valuing and encouraging the exercise of women's sexual and reproductive rights.

In Practice

Implementing support groups

The first women's support group at PLAFAM was for survivors of domestic violence. It started with seven women, of whom five completed what was called the "first phase," consisting of 16 weekly sessions. Although the facilitators had worked with other types of groups in the past, this first group functioned as a pilot for the whole program. The facilitators used the experience of these first 16 sessions to develop a structure for each session that would be used with subsequent groups. That said, the structure for each session was not rigid, in order to allow the individual women in each group, who have different personalities and have gone through different circumstances, to bring a new dynamic to the process.

The first sessions were structured to build rapport, to provide information about gender-based violence, to educate women about a gender perspective, and to strengthen their self-esteem. In the beginning, the themes were biased toward the staff's own interests and not those of the participants; this reflected staff's anxiety about involving themselves in a group process on gender-based violence. The women asked facilitators to add a discussion about childrearing and to provide information on legal issues and sexuality. Similarly, the participants asked the facilitators to deepen and expand the scope of particular discussions beyond what had been planned. By taking a flexible approach and allowing the process to unfold, the group sessions better met the needs of the women. The facilitators encouraged the active participation of women in discussing their own situations and in working through the stories of the other women.

PLAFAM staff members identified at least two important stages in the process of developing support groups. The first consists of providing information using different materials and discussion guides. During this stage, the participants establish their voice within the group, ask for information, develop strategies to interact compassionately, and find meaning in being part of the group. In the second stage, participants take ownership of the content of the sessions and begin to apply what is discussed to their own lives.

Since the participants in the pilot group were so motivated, they asked for a "second phase," in addition to the first 16 sessions, wherein they would become peer educators, providing information to others. They would also co-facilitate new support groups in order to help strengthen other women by being examples of the process of recovery. As was the case in the first phase, the women from the pilot group are establishing precedents in the conceptualization of support groups, which will be useful in future actions.

According to the midterm evaluation and additional case studies, many women have found the support groups beneficial. The group setting allowed women to see that they are not alone, and they built solidarity among women who confronted similar circumstances. According to participants, the support groups have allowed many of them to do the following:

- Feel empowered, as manifested through improved self-esteem, actions of personal courage, and actions for the benefit of other women
- Feel safer, more self-confident, and less fearful
- Provide emotional support to other women outside the group, particularly in denying the common justifications for violence
- Recognize the strengths and weaknesses of the participants and the groups
- Change their attitude from negative and pessimistic to positive and optimistic

Recommendations and Lessons Learned

The staff at PLAFAM offer the following recommendations about forming support groups for women:

Designing the overall approach:

- Establish a protocol for recruiting participants to the group. For example, referring women after one or two individual counseling sessions.
- Establish the number of participants in each group, so that there are not too few or too many participants, taking into account that all groups lose some members over time.
- Consider the possibility of providing additional individual support sessions for some women who may need them.

Planning the sessions:

- Review the recent literature, including reviewing descriptions of similar experiences in other places.
- Recognize that the women will progressively take ownership of the sessions with regard to the topics discussed, strategies for development and techniques of interaction with each other.
- Be flexible in planning the sessions, recognizing that, as time goes by, sessions tend to become less structured in order to accommodate the emerging needs of the women.

Facilitating the Sessions:

- Maintain a gender perspective and defend human rights, women's rights, and sexual and reproductive rights as the banners of the organization's work.
- Maintain a compassionate and supportive attitude toward the participants, avoiding judgment or criticism of their actions.
- Promote an empathetic and unconditional relationship between the facilitators and the participants, which permits the development of an environment of trust and harmony necessary for the group.
- Recognize that the work of facilitators is not to conduct or dominate, but to accompany and facilitate a process.
- Employ different mechanisms for empowering women, such as techniques for self-assertion, video forums, group exercises, role-playing, written exercises and relaxation techniques, among others.

Monitoring and evaluating the groups:

- Evaluate the group work periodically and establish a feedback loop to keep the sessions relevant and productive.

SUGGESTIONS FOR FACILITATING WOMEN'S SUPPORT GROUPS

Content of group sessions. The support groups at PLAFAM address various aspects of gender-based violence, from identifying violence as a public health problem to helping women understand that they have the resources to adapt and thrive in their environments. Other topics include:

- Discussing the cultural myths and realities with regard to gender-based violence
- Defining “gender” and differentiating gender from “sex”
- Addressing stereotypes of feminine and masculine roles
- Exploring the history and construction of gender inequity, in which the justification and/or naturalization of violence predominates.
- Teaching about the cycle of violence, its causes and consequences, and using this knowledge to develop a plan for personal safety.
- Providing legal information on the rights of women in violent situations, where legal services can be obtained, and general information on the Venezuelan Law of Women and the Family.

To help empower women and build their confidence, the facilitators also explore feelings of desperation, guilt, grief, and anger, among others. To boost self-esteem, the facilitators lead women to identify strengths, resources, and mechanisms to overcome violent situations and the feelings that these provoke. Moreover, the facilitators propose alternative strategies for talking with children who have been witnesses or victims of domestic violence who might otherwise display hostility, become isolated or develop other emotional problems. Finally, staff members give women a framework for establishing short- and medium-term plans, emphasizing the support the women's survivor group can provide.

Styles and strategies for facilitating the group. At PLAFAM, the facilitators orient, encourage, guide, and support the group and the individual participants. The facilitators—all women—are responsible for calling the group together, coordinating efforts to structure the sessions, and creating good group dynamics. As women are encouraged to participate and share their experiences, the group begins to take increasing responsibility for itself; at the same time, the facilitators remain mindful of the group's process and assess its development. As facilitators of the women's support groups, staff members generally feel that the women themselves should set the guidelines, which is to say that they should be the ones who establish the rhythm of the work while keeping an eye on accomplishing the objective of each session. PLAFAM has used a variety of styles, from more assertive and directed at the beginning, to more open and flexible when the group has advanced or when the circumstances or the women themselves require it. The facilitators tend to be more directed when providing information, clarifying a point, or answering questions, and more flexible when dealing with decisions the group may face, such as modifying the contours of the conversation.

Some roles of the facilitator include:

- Supporting the participants in recognizing their situation to enable them to take appropriate actions;
- Encouraging them to recognize the changes that are necessary to escape gender-based violence and to claim their human, sexual and reproductive rights;
- Analyzing the experiences the women share
- Leading the group in such a way as to convert intentions into results; acting as guides; and emphasizing the abilities, energies and talents of each participant
- Structuring the goals of the session, applying appropriate materials and recording the results

e. Monitoring and Evaluating Specialized Services

Health programs that provide specialized services such as counseling, psychotherapy, legal services and women's support groups need to find ways to monitor and evaluate those services. The IPPF/WHR initiative did not develop standardized instruments or tools for this purpose since each member association took a slightly different approach to providing services for women who experienced violence. Nonetheless, a number of lessons learned did emerge from the individual experiences of the associations, as described below.

Recommendations and Lessons Learned

Health programs should consider using a variety of informal methods for evaluating pilot projects. When health programs begin to offer new services, such as legal advice, counseling or support groups, it is essential to have information as soon as possible about how well those services have been designed. So rather than wait until a long time has passed to do a formal evaluation, health programs may want to use methods such as informal group discussions and interviews with staff and clients during the beginning stages of designing and implementing new services. The member associations found that these methods could correct problems early, and eventually could be used to write up their findings to share with other clinics and organizations.

Case studies and qualitative methods can be important ways to evaluate specialized services. The Annexes of this manual contain a brief description of qualitative methods that can be used to gather the perspectives of providers and clients on the quality, benefits and risks of services for survivors of violence. These techniques can be helpful for evaluating specialized services, including legal, psychological, and emotional support services.

Each service will need its own objectives, indicators and methods of monitoring and evaluation, but the table below outlines some common elements.

Possible objectives of specialized services	Key questions to ask to determine whether the objective was achieved
To increase access to affordable services for women who experience violence	<p>How many women have received each type of service during different periods of time?</p> <p>Were the services provided as planned?</p> <p>How much did it cost to serve each woman, and is this sustainable?</p> <p>Is the current model the best way to increase access to services for women or is there a better, more cost-effective way (such as offering in-house services versus referring women to an outside organization)?</p>
To increase the quality of specialized services that women receive	<p>Were any changes made to the original program design and why?</p> <p>How feasible and appropriate is the current program design (for example, the number of individual sessions offered to women before they are referred to a support group)?</p> <p>What is known about the knowledge, attitudes and skills of service providers? Have they changed since the baseline assessment?</p> <p>What do clients think about how the services are offered (for example, the space, the number of sessions, the attitudes and skills of providers, etc.)?</p> <p>What do clients think about the quality of the services?</p>
To improve the situation of women who have experienced violence	<p>What benefits did these services bring to women? For example, did women feel that these services were beneficial? In what ways? What proportion of cases was resolved in a positive way, from the perspective of clients and providers?</p> <p>What risks were involved in receiving these services? For example, did any clients experience negative consequences as a result of the services, such as additional acts of violence, emotional distress, or any kind of material loss that could be linked in any way to the specialized services?</p>

VI. Beyond the Clinic: Building Networks, Legal Advocacy, and Community Education

a. Overview

There are at least two factors that make it essential for health organizations to look beyond their clinics when working on the issue of gender-based violence:

1. First, survivors of violence may have many needs that go beyond health care, including the need for legal advice, police protection, housing, economic support and other social services. These needs may be as or more important than their need for health care, and no organization can single-handedly address the range of services that survivors may need.
2. The second reason why clinics need to look beyond their walls is to contribute to the broader policy debate and the effort to change attitudes toward women's rights and gender-based violence at the community, regional and national levels. Through legal advocacy and community education efforts, health organizations have an important role to play in challenging the social norms that perpetuate violence against women.

Building alliances with other organizations takes time and effort, and health programs often find it challenging to work with other sectors, particularly when staff members are overextended and resources are limited. Nonetheless, these efforts can lead to important gains, both for the institutions involved and, more importantly, for women living in situations of violence.

Recommendations and Lessons Learned

The participants in the IPPF/WHR initiative undertook several strategies in order to identify potential allies and to create or strengthen networks. PROFAMILIA, for instance, established partnerships with the public sector that enabled it to carry out sensitizations and trainings among law enforcement agents and judges. PLAFAM took on the responsibility of coordinating the National Network for the Prevention of Sexual Violence in Childhood and Adolescence and carried out various advocacy efforts to raise awareness about this type of violence. Their experiences produced a number of recommended steps:

Identify potential partners. Even in resource-poor settings, there will likely be a few organizations or individuals who are also working to address gender-based violence. The first step to working in a coordinated manner is to identify potential partners and to establish an initial contact to express your interest in collaborative efforts.

Use a human rights framework. Because each organization may prioritize different aspects of the issue of violence (research, legal protection, emotional support, etc.), it may be important to establish a common ground. A human rights framework can provide groups with a clear set of principles and help establish a common agenda for the group.

Ensure that networks hold members accountable. Networks can serve as an important mechanism to ensure that survivors have access to the different services they may need. In order for referral networks to be effective, however, organizations should not think that by making a referral they are 'washing their hands of the problem', but should instead create mechanisms that allow for following up cases and for monitoring how individual organizations and the network are working.

Look at societal factors that contribute to violence. In addition to providing the specific services that survivors may need, networks should also seek to have an impact on those factors that contribute to the occurrence of violence. This could include working to change cultural norms, as well as working to have an impact on issues, such as poverty or unemployment, that may ultimately lead many survivors to remain in violent relationships. To this end, it is important to look to other organizations whose work may not focus specifically on violence, but that may offer great potential for collaboration (for instance, organizations working in the area of HIV/AIDS, equal opportunities, micro-credit, etc.).

Use networks as a space for reflection and dissemination of lessons learned. The lack of opportunities for collaboration among organizations within the region or within the same country often leads to a waste of precious resources and time. A network can also function as an important space for exchanging information and for jointly reflecting upon lessons learned. This may be particularly important if both government and civil society organizations are involved in the network since it may allow for lessons learned through pilot initiatives led by NGOs to be transferred to the public sector, where a greater number of survivors of violence could be reached.

b. Building Alliances With Other Organizations

The struggle to prevent violence, raise public awareness, and advocate for better legislation cannot be won by the health sector alone, much less a single institution. For all of these reasons, health programs have a responsibility to reach out to other organizations working in the area of violence. This may include individual organizations as well as networks of organizations. For example:

Social Action/Advocacy Networks: Groups of organizations that come together to carry out targeted actions such as changing policies, monitoring governments' compliance with international agreements, or carrying out mass media campaigns.

Referral Networks: Groups of organizations that set up formal or informal agreements and procedures to facilitate survivors' access to different services through referrals and counter-referrals.

Groups of organizations that join efforts for a specific timeframe around a specific objective. For instance, they may come together to organize events around commemorative days such as November 25, the International Day Against Violence Against Women, or they may join efforts to draft nationwide guidelines and protocols for addressing violence within the health system.

In some settings, such networks do not exist, or are not as active or effective as they could be. In that case, health programs may want to help build or revitalize local networks. In other cases, these networks do exist, and health programs simply need to do more research to find out how they can participate. Some health programs are surprised to find out how much other organizations have already done in the area of gender-based violence once they invest the time to research the situation in their area.

In Practice

Building alliances with other organizations

All three IPPF member associations joined networks and built alliances with other organizations working on gender-based violence at the local and national level. For example:

PROFAMILIA, in the Dominican Republic, has been active for years in a network of nongovernmental organizations working on issues related to gender-based violence. Because of its participation in efforts to raise awareness of the need to address violence against women, PROFAMILIA succeeded in getting the four questions from its screening tool incorporated into the National Guidelines for the Health Care of Victims of Family Violence.

Another example comes from PLAFAM, which has been involved in a national network for prevention and care of sexual violence against adolescents and children in Venezuela for several years. In 2002, it served as the coordinating agency for that network.

INPPARES has helped strengthen local referral networks in the peripheral communities of Lima, Peru.

Recommendations and Lessons Learned

Joining networks of organizations can benefit health programs and allow them to contribute to a broader effort to combat gender-based violence. In the long run, collaborating with other organizations not only benefits the health program, but also offers a chance for health care organizations to participate in the broader policy debate by raising awareness of gender-based violence as a public health issue.

In some settings, health care organizations may need to establish or revitalize networks. In some settings, formal social action or referral networks do not exist, or are not as active or effective as they could be. In that case, health organizations may need to build new networks or work to revitalize existing ones. The first step in the process is to identify a list of institutions that already work on issues related to violence against women. Depending on the level of resources available, a health program may want to start with informal collaboration with a small number of organizations, or it may want to try to organize a more formal collaboration with a large network of organizations.

To encourage other organizations to collaborate, it may be necessary to raise their awareness of gender-based violence as a public health problem. To encourage other organizations to collaborate in referral or social action networks, it may be necessary for a health program to sensitize others about the magnitude of the problem and the need to address it in an integrated way.

To organize formal networks against violence, the Pan American Health Organization (PAHO) suggests a five step approach,¹¹⁶ roughly paraphrased as follows:

1. Familiarize yourself with the institutions in the local area that offer services that could be helpful for women who experience gender-based violence.
2. Identify a core group to develop a democratic process for ensuring the participation of key organizations.
3. Develop a process for raising awareness about the problem of gender-based violence.
4. Develop a strategic plan to address the problem based on a model of integral care agreed upon by the participating organizations.
5. Establish mechanisms of operation, for example, conferences, meetings, agreements, tasks and responsibilities.

c. Legal Advocacy and Community Education

Throughout this manual, we have emphasized the importance of addressing gender violence within a human rights framework because it provides a clear set of principles for understanding the wider context of gender-based violence and because it ensures a commitment to survivors' dignity and rights. The health sector can make an important contribution to increasing respect for human rights by advocating for better legal protection for women and by carrying out education efforts among the broader population and among key groups of professionals.

In many settings, women find that family members, religious leaders, health workers, social service providers, police, the judiciary, the media, and/or other service providers often minimize or even justify the suffering caused by physical, sexual and emotional abuse of women. In other settings, the broader society recognizes gender-based violence as a serious problem, but the legal system is so weak that it cannot prosecute offenders or ensure that women can exercise their rights with regard to divorce and other legal matters.

Health organizations have an important role to play in the effort to advocate for better legal protection for women and to change the widespread attitudes that work to perpetuate gender violence. Specifically, health professionals have the ability to reframe gender-based violence as a public health problem as well as a violation of human rights—and these types of arguments often have the power to change opinion, even among more conservative sectors of society.

Recommendations and Lessons Learned

Each member association involved in the IPPF/WHR initiative carried out different activities related to legal advocacy and community education, so it was not possible to produce standardized or comparable findings in this area. However, their experiences suggest a number of general recommendations about the role that health care organizations can take to educate the wider community and to increase women's legal protection.

Use data to inform and to change opinions. Health organizations can systematically collect and disseminate data to highlight both the widespread nature of violence and its consequences. Such data can be internal—such as rates of women identified as victims of violence at clinics and services—or it can be community-based. PROFAMILIA in the Dominican Republic, for instance, joined efforts with other organizations to carry out a study documenting the number, patterns and circumstances surrounding femicides (homicide of women by their current or former partner) in the country. By publishing and widely disseminating this information, it was able to raise awareness and mobilize public opinion around this issue.

Monitor and strengthen existing legislation. Two associations involved in the IPPF/WHR initiative joined efforts with other local organizations to lobby for legislation addressing gender-based violence within their countries. Advocacy does not necessarily end once a law is passed. Health organizations can help to monitor how well the law is being enforced and highlight areas that need improvement. Health organizations can also help to protect new legislation that experiences a backlash from conservative groups. For example, in the case of the Dominican Republic, when conservative groups tried to weaken the violence legislation, PROFAMILIA joined efforts to lobby against those changes.

Try to improve the implementation of the law. Health organizations can also work to improve the way laws are applied by educating law enforcement agents and judges about the nature of gender-based violence and its impact. For instance, law enforcement agents may dismiss gender-based violence as a private matter, or conversely, they may feel frustrated when they see women returning to a violent partner. Educating officials about the complex nature of intimate partner violence and the risks inherent in the decision to leave a violent relationship may improve the quality of the assistance provided to women. PROFAMILIA has developed good relationships with a number of law enforcement agencies and has carried out training of law enforcement staff at different levels.

Educate the community about its rights. Health organizations can work to inform the public about its rights according to existing legislation. PROFAMILIA, for instance, published three different versions of the violence legislation to reach publics with varying degrees of literacy.

VII. Bibliography and References

IPPF/WHR found a number of publications to be essential during the process of planning the regional initiative. This manual would not have been possible without the work done by such organizations as the Family Violence Prevention Fund, the World Health Organization, CHANGE (the Center for Health and Gender Equity) and others. We strongly recommend that this manual be used in conjunction with the following resources:

For comprehensive literature reviews on violence against women and the role of the health sector:

Heise L, Ellsberg M, Gottemoeller M, “Ending violence against women,” *Population Reports* 27.4 (1999). (*The entire text is available online at: www.jhuccp.org/pr/l11edsum.shtml*)

Shane B, Ellsberg M, “Violence Against women: Effects on Reproductive Health,” *Outlook* 20. Program for Appropriate Technology in Health (PATH), (2002).

World Health Organization *World Report on Violence and Health* (Geneva: World Health Organization 2002).

For tools and guidelines for individual health professionals from a developed country perspective:

The Family Violence Prevention Fund has published a comprehensive set of guidelines and training materials for individual health care professionals. The information is largely based on research and clinical experiences from the United States, but it is a tremendous resource on caring for victims of violence. (*Both manuals can be ordered online at: www.endabuse.org*)

Warshaw C, Ganley AL, *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care providers* (Family Violence Prevention Fund: San Francisco 1998).

Ganley AL, *Improving the Health Care Response to Domestic Violence: A Trainer's Manual for Health Care Providers* (Family Violence Prevention Fund: San Francisco 1998).

For diagnostic and treatment guidelines for various kinds of violence and abuse:

The American Medical Association has published the following guidelines in English, which IPPF/WHR translated, adapted and published in Spanish. The full text of these publications is available in English from the American Medical Association (www.ama-assoc.com) and in Spanish from IPPF/WHR (www.ippfwhr.org).

- Diagnostic and Treatment Guidelines on Child Physical Abuse and Neglect
- Diagnostic and Treatment Guidelines on Child Sexual Abuse
- Diagnostic and Treatment Guidelines on Domestic Violence
- Mental Health Effects of Family Violence
- Strategies for the Treatment and Prevention of Sexual Assault

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VIII. Annexes: Monitoring and Evaluation Tools

a. Sample Logical Framework

GOAL	OPERATIONAL DEFINITIONS/INDICATORS	MEANS OF VERIFICATION
Contribute to improving the situation of victims of gender-based violence in [specify the location]	<p>Improving the situation of victims of GBV implies:</p> <p>(1) Strengthening services for victims of GBV. (2) Increasing awareness of GBV as a public health problem and human rights violation. (3) Improving legal protection for victims of GBV. (4) Increasing knowledge about effective GBV interventions.</p> <ul style="list-style-type: none"> As measured through changes in the results indicators for each of the four objectives 	<ul style="list-style-type: none"> Methods listed below
PURPOSE	OPERATIONAL DEFINITIONS/INDICATORS	MEANS OF VERIFICATION
Improve the situation of victims of gender-based violence in [specify the location].	<ul style="list-style-type: none"> As measured through changes in the results indicators for each of the four objectives 	<ul style="list-style-type: none"> Service Statistics Surveys In-depth interviews Focus groups discussions Organization records Case Studies
OBJECTIVES	RESULTS INDICATORS	MEANS OF VERIFICATION
1. Strengthen the institutional capacity of [specify organization] to offer services to victims of gender-based violence within existing sexual and reproductive health services.	<ul style="list-style-type: none"> Changes in knowledge, attitudes and practices of health care providers regarding GBV Changes in the physical infrastructure, policies and written resources in the clinics Percent of providers with ability to identify victims of GBV and make the appropriate referral (internal and external) by type of personnel Number and percent of clients identified as victims by type of GBV and by site Number of referrals made to GBV services Number of women who receive services related to GBV by type of service Client perceptions about the services provided by the organization 	<ul style="list-style-type: none"> KAP survey among providers Observation guide of clinics Service statistics Focus group discussions with staff Random record reviews Client exit survey In-depth interviews with clients
2. Contribute to increasing awareness of gender-based violence as a public health problem and a human rights violation in [specify the location].	<ul style="list-style-type: none"> Changes in knowledge, beliefs and attitudes about GBV among participants in IEC and/or advocacy activities 	<ul style="list-style-type: none"> In-depth interviews Surveys of knowledge and attitudes Pre- and post-questionnaires among participants in IEC activities
3. Improve the legal protection of women who are victims of GBV by (a) contributing to changes in policies or legislation; (b) improving the application of the law; and/or (c) increasing awareness of the law.	<ul style="list-style-type: none"> Changes in policies or legislation Changes in the application of laws 	<ul style="list-style-type: none"> Analysis of policy and legislation Case studies relating to legal procedures
4. Increase knowledge among reproductive health service providers about effective interventions that address the problem of GBV.	<ul style="list-style-type: none"> Guides, tools and protocols produced, field-tested and implemented Lessons learned, documented and disseminated 	<ul style="list-style-type: none"> Organization records

b. Provider Knowledge, Attitudes and Practices Survey Questionnaire



SURVEY ON THE PERSPECTIVES (KNOWLEDGE, ATTITUDES AND PRACTICES) OF HEALTH PROVIDERS REGARDING GENDER-BASED VIOLENCE

IPPF/WHR

(Only for personnel who provide services to women 12 years old or older)

PURPOSE OF THIS SURVEY: We are collecting information about the experiences and perspectives of health providers regarding women who have experienced violence. Although both women and men can be victims of violence, this survey focuses on violence against women. Even if you have not cared for victims of violence in your own practice, your responses will be very helpful to us. The findings from this survey will be used to develop capacity-building materials to improve health services.

INSTRUCTIONS: Completing this survey should take less than 30 minutes. Please complete the survey and return it to us.

Please do not write your name on the questionnaire.

It is important to note that the purpose of this survey is not to evaluate your performance; for this reason we ask you to answer as honestly as possible. Your answers will be completely confidential and will not affect your work or your position in any way. The information in all the surveys will be analyzed as a whole (not individually).

In this survey, gender-based violence can include the following:

- Domestic violence (physical, sexual or psychological)
- Sexual abuse or rape
- History of sexual abuse during childhood

GENERAL INFORMATION:

City _____

Country _____

Clinic/Health Center _____

1. What is your sex?

- ☐ 1. Male
☐ 2. Female

2. What is your job within the organization? (**Choose only one option**):

- | | |
|--------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> 1. Nurse | <input type="checkbox"/> 5. Psychologist, emotional support staff |
| <input type="checkbox"/> 2. Medical doctor | <input type="checkbox"/> 6. Midwife |
| <input type="checkbox"/> 3. Counselor | <input type="checkbox"/> 7. Manager / Administrator |
| <input type="checkbox"/> 4. Social worker | <input type="checkbox"/> 8. Other (Please specify) _____ |

3. How long have you been working in the organization?

- ☐ 1. Less than 1 year
☐ 2. Between 1 and 3 years
☐ 3. Between 4 and 6 years
☐ 4. 7 years or longer

4. What is your age group?

- ☐ 1. Less than 25 years old
☐ 2. 25-34 years old
☐ 3. 35-44 years old
☐ 4. 45-54 years old
☐ 5. 55 years old or older

5. During a regular week, how many women 12 years old or older do you see?

- ☐ 1. None → **SKIP TO QUESTION 18**
☐ 2. 1-10 women
☐ 3. 11-20 women
☐ 4. 21-30 women
☐ 5. More than 30 women

INFORMATION ABOUT SERVICES:

In this survey, gender-based violence can include the following:

- Domestic violence (physical, sexual or psychological)
- Sexual abuse or rape
- History of sexual abuse during childhood

6. Out of every 10 women (12 years old or older) that you see in your practice, approximately how many of them do you suspect have been victims of gender-based violence at least once in their lives?

(Circle one option between 0 and 10 for each type of violence)

a. Physical abuse by her partner?	0	Less than 1	1	2	3	4	5	6	7	8	9	10
b. Sexual abuse or rape?	0	Less than 1	1	2	3	4	5	6	7	8	9	10
c. Sexual abuse during childhood?	0	Less than 1	1	2	3	4	5	6	7	8	9	10

Some health providers ask women **direct and specific** questions about whether they have experienced violence, while others ask **indirectly or only when the client brings up the subject**.

Examples of direct and specific questions regarding violence:

“Has your partner ever physically hurt you?”

“Have you ever felt forced to have sexual relations with someone?”

7. In the past year, have you ever asked a woman whether she has been abused or mistreated?
(Choose only one option)
- ☐ 1. Yes, I have asked a **direct and specific** question at least once.
- ☐ 2. I have not asked a direct question, but I have asked **indirectly or when a woman has brought up the subject**.
- ☐ 3. No, I have not asked any questions about violence in the past year. → **SKIP TO QUESTION 12**

In the past year, under **which** of the following circumstances did you ask a **direct question** about gender-based violence? (*Select one answer for each of the following circumstances.*)

8a. Did you ask because a client presented bruises or other signs of violence?

- ☐ 1. Yes
☐ 2. No

8b. How often in the past year did you ask about violence under this circumstance?

- ☐ 1. *Once* ☐ 2. *Several times* ☐ 3. *Often*

9a. Did you ask because a client said something that made you suspect violence?

- ☐ 1. Yes
☐ 2. No

9b. How often in the past year did you ask about violence under this circumstance?

- ☐ 1. *Once* ☐ 2. *Several times* ☐ 3. *Often*

10a. Did you ask as a matter of routine (for example, as part of the clinical history)?

- ☐ 1. Yes
☐ 2. No

10b. How often in the past year did you ask about violence under this circumstance?

- ☐ 1. *Once* ☐ 2. *Several times* ☐ 3. *Often*

11a. Did you ever ask for any other reason?

- ☐ 1. Yes
☐ 2. No

11b. How often in the past year did you ask about violence under this circumstance?

(*Please specify*) _____

- ☐ 1. *Once* ☐ 2. *Several times* ☐ 3. *Often*

12. Please circle the number that best reflects the level of your agreement or disagreement with each of the following statements: (*Circle the option that best reflects your opinion when you can't decide between two options.*)

	<i>Strongly disagree</i>	<i>Disagree</i>	<i>Agree</i>	<i>Strongly agree</i>
a. I feel uncomfortable asking women about DOMESTIC VIOLENCE .	1	2	3	4
b. I feel uncomfortable asking women about RAPE .	1	2	3	4
c. I feel uncomfortable asking women about SEXUAL ABUSE DURING CHILDHOOD .	1	2	3	4

13. There may be many barriers that make it difficult to ask women about violence. **In your own experience**, to what degree do the following barriers make it difficult for you to ask women about gender-based violence? (***Circle a number for each of the following statements.***)

<i>Sometimes it is difficult to ask because:</i>	<i>Disagree (this is not a barrier)</i>	<i>Partially agree (sometimes this is a barrier)</i>	<i>Agree (this is a serious barrier)</i>
a. I have time limitations.	1	2	3
b. There is a lack of private space in the clinic.	1	2	3
c. There are few opportunities to speak with women on a one-to-one basis (without the presence of family, partners, children or friends who accompany them).	1	2	3
d. I feel there is little I can do to help them.	1	2	3
e. There are few resources in the community where I could refer women who are victims of violence.	1	2	3
f. I could offend women if I asked them a direct question about violence.	1	2	3
g. Differences in cultural beliefs and values make it difficult to talk about violence.	1	2	3
h. I need to focus my attention on other health problems that have a higher priority.	1	2	3
i. Getting involved in cases of violence means that I would have to participate in police proceedings.	1	2	3
j. I could provoke retaliation from the abuser.	1	2	3
k. I have not received enough training to address the issue of violence.	1	2	3

14. In your own experience, what other barriers make it difficult to ask direct questions about violence?

- a. _____
- b. _____
- c. _____

15. Has a client ever told you that she had been a victim of:

- a. Physical violence by her partner? ☐ 1. Yes ☐ 2. No
- b. Sexual violence? ☐ 1. Yes ☐ 2. No
- c. Sexual abuse during childhood? ☐ 1. Yes ☐ 2. No
- d. Some other type of violence? ☐ 1. Yes ☐ 2. No
(Please specify) _____

16. Health providers can respond to victims of violence in many different ways. In the past year, how often did you do each of the following? (*Circle a number for each of the following statements.*)

	<i>Never</i>	<i>Once</i>	<i>Several times</i>	<i>Many times</i>
a. I identified or suspected that a client had been harmed or abused.	1	2	3	4
b. I listened to and provided emotional support to a victim of violence.	1	2	3	4
c. I documented information about a case of violence.	1	2	3	4
d. I informed a client about her rights with respect to violence.	1	2	3	4
e. I informed a client about referral services for COUNSELING .	1	2	3	4
f. I informed a client about referral services for PSYCHOLOGICAL SERVICES .	1	2	3	4
g. I informed a client about referral services for LEGAL ASSISTANCE .	1	2	3	4
h. I informed a client about referral services for MEDICAL SERVICES .	1	2	3	4
i. I informed a client about referral services for OTHER SERVICES IN THE COMMUNITY (Please specify) _____	1	2	3	4
j. I assessed the level of danger that a client was facing.	1	2	3	4
k. I helped a client in a dangerous situation establish a safety plan.	1	2	3	4
l. I informed a client about the effects of violence on health and about the risk that she faced.	1	2	3	4
m. Other (<i>Please specify</i>): _____ _____	1	2	3	4

17. How well trained or prepared do you feel to ...

	<i>Not adequately trained or prepared</i>	<i>More or less trained or prepared</i>	<i>Sufficiently trained or prepared</i>
a. Talk with women about gender-based violence?	1	2	3
b. Detect cases of physical domestic violence?	1	2	3
c. Detect cases of psychological violence?	1	2	3
d. Detect cases of sexual violence?	1	2	3
e. Identify clients with a history of sexual abuse during childhood?	1	2	3
f. Provide care to victims of gender-based violence?	1	2	3
g. Assess the level of danger of a women living in a violent situation?	1	2	3
h. Help a client create a safety plan?	1	2	3
i. Document cases of violence?	1	2	3
j. Record details about a case of violence in a clinical history form?	1	2	3
k. Provide information to an affected client?	1	2	3
l. Provide referrals to victims of gender-based violence?	1	2	3
m. Counsel women about emergency contraception?	1	2	3
n. Address the reproductive health needs of women who have suffered sexual violence?	1	2	3

RESOURCES IN THE CLINIC AND IN THE COMMUNITY

18a. Can you name two organizations that offer specialized services to women who are living in violent situations or who have experienced violence in the past?

- ☐ 1. Yes → 18b. What are they? 1. _____
☐ 2. No 2. _____

19. In your clinic, is there a directory or written list of local organizations or other community resources to which you can refer women victims of violence?

- ☐ 1. Yes → 19a. In the past year, how often have you used that directory?
☐ 2. No (Circle one of the following)
☐ 3. Don't know

Never **Once** **Sometimes** **Often**
 0 1 2 3

→ 19b. If you never used the directory, why not?

20a. Is there a mechanism in your clinic that enables health personnel to find out what happens to a client after she has been referred to another organization for services?

- ☐ 1. Yes → 20b. What is it? _____
☐ 2. No _____

21. In your opinion, how adequate is the system that your clinic uses to follow up individual cases of violence that have been detected?

- ☐ 1. Adequate
☐ 2. More or less adequate
☐ 3. Inadequate
☐ 4. Don't know / No opinion

22. In your opinion, how adequate is the feedback given to health personnel regarding the detection and care of victims of gender-based violence within the clinic?

- ☐ 1. Adequate
☐ 2. More or less adequate
☐ 3. Inadequate
☐ 4. Don't know / No opinion

23. In your organization, is there a written policy that prohibits sexual harassment by personnel?

- ☐ 1. Yes
☐ 2. No
☐ 3. Don't know

ATTITUDES AND KNOWLEDGE:

24. Please circle the number that indicates whether you agree or disagree with each of the following statements: *(Circle the option that best reflects your opinion when you can't decide between two options.)*

	<i>Strongly disagree</i>	<i>Disagree</i>	<i>Neither agree nor disagree</i>	<i>Agree</i>	<i>Strongly agree</i>
a. Women would feel offended if I were to ask them directly about violence.	1	2	3	4	5
b. DOMESTIC VIOLENCE is a private matter, and outsiders should not interfere.	1	2	3	4	5
c. Health providers have a responsibility to ask about DOMESTIC VIOLENCE .	1	2	3	4	5
d. Health providers have a responsibility to ask about SEXUAL VIOLENCE .	1	2	3	4	5
e. Health providers have a responsibility to ask about CHILDHOOD SEXUAL ABUSE .	1	2	3	4	5
f. The majority of victims will deny that they have been abused if asked.	1	2	3	4	5
g. Health providers have as much responsibility to ask about violence as they do to ask about other health problems.	1	2	3	4	5
h. If the woman does not want to respond or to talk about her situation, she should not be pressured to respond immediately.	1	2	3	4	5
i. Domestic violence is a problem that results from poverty and lack of education.	1	2	3	4	5
j. Alcoholism and drugs are the causes of violent behavior.	1	2	3	4	5
k. Some women are to blame for domestic violence because their inappropriate behavior provokes their partners' aggression.	1	2	3	4	5
l. Women don't leave their violent partners because on some level they like to be mistreated.	1	2	3	4	5
m. Many girls and adolescents who report sexual abuse in reality have only fantasized about having had sexual contact with adults.	1	2	3	4	5

	<i>Strongly disagree</i>	<i>Disagree</i>	<i>Neither agree nor disagree</i>	<i>Agree</i>	<i>Strongly agree</i>
n. Some adolescents are to blame for having been sexually abused because they provoked the abuse with their inappropriate sexual behavior.	1	2	3	4	5
o. Men cannot control their sexual behavior.	1	2	3	4	5
p. Men have a responsibility to control their own sexual behavior.	1	2	3	4	5
q. Mothers are to blame for sexual abuse against their daughters, because they failed to protect them adequately.	1	2	3	4	5
r. Men who commit incest do it because their wives do not give them sexual satisfaction.	1	2	3	4	5
s. Men who abuse their partners are often mentally ill.	1	2	3	4	5
t. Forced sexual relations within marriage is rape.	1	2	3	4	5
u. In most cases, if a woman defends herself, she can avoid being raped.	1	2	3	4	5

25. Sometimes, husbands get upset about things that their wives do. Do you think it is okay for a man to hit his wife in the following situations?

	<i>Yes, it is okay</i>	<i>It is okay in some cases</i>	<i>No, it is never okay</i>
a. If she refuses to have sex with him?	1	2	3
b. If she disobeys him?	1	2	3
c. If she fails to perform her domestic duties?	1	2	3
d. If he suspects that she is being unfaithful?	1	2	3
e. If she is unfaithful?	1	2	3
f. In any other situation? (<i>Please specify</i>)	1	2	3

26. Are there any laws in your country that address domestic violence?

- ☐ 1. Yes
☐ 2. No
☐ 3. Don't know

27a. According to the law in your country, do health providers have any legal obligations with regard to victims of **DOMESTIC VIOLENCE**?

- ☐ 1. Yes
☐ 2. No
☐ 3. Don't know

27b. If so, what are the legal obligations of health providers?

(Please specify)

28a. According to the law in your country, do health providers have any legal obligations with regard to victims of **SEXUAL VIOLENCE**?

- ☐ 1. Yes
☐ 2. No
☐ 3. Don't know

28b. If so, what are the legal obligations of health providers?

(Please specify)

29. Please circle the letter that indicates whether you think that the following statements are true or false. If you don't know the answer, please circle the letters for "Don't know."

	<i>True</i>	<i>False</i>	<i>Don't know</i>
a. Victims of violence tend to use health services more often than women who have not experienced violence.	T	F	DK
b. Children can be seriously harmed by domestic violence, even if they themselves were not direct victims of the violence.	T	F	DK
c. Violence within a couple tends to decrease with time.	T	F	DK
d. Suicide attempts are much more common among women who are victims of aggression than among other women.	T	F	DK
e. Generally, a male abuser stops abusing his partner once she gets pregnant.	T	F	DK
f. Domestic violence is a problem that mostly affects poor women.	T	F	DK
g. The majority of rapes of women are committed by strangers.	T	F	DK
h. Boys who are exposed to domestic violence are more likely to repeat this type of behavior as adults.	T	F	DK
i. The woman will finally be out of danger once she has left the abusive partner.	T	F	DK
j. The most dangerous time for a woman is when she decides to leave a violent partner.	T	F	DK

		<i>True</i>	<i>False</i>	<i>Don't know</i>
k.	Women are more likely to suffer violence at the hands of men they know.	T	F	DK
l.	Violence against pregnant women is as common as toxemia and gestational diabetes.	T	F	DK

30. Which of the following effects are related to gender-based violence?

		<i>True</i>	<i>False</i>	<i>Don't Know</i>
a.	Unprotected sex	T	F	DK
b.	Pelvic inflammation	T	F	DK
c.	Low birth weight	T	F	DK
d.	Difficulty getting access to health services	T	F	DK
e.	Isolation from friends and family	T	F	DK
f.	Depression	T	F	DK
g.	Difficulty working	T	F	DK

TRAINING ON GENDER-BASED VIOLENCE

31. **In the past three years**, how many times have you participated in sensitization or training sessions regarding gender-based violence? (**Select one option**):

- ☐ 0 —————→ **SKIP TO QUESTION 35**
☐ 1
☐ 2
☐ 3 or more times

Regarding these sensitization or training activities,

a. Which organization provided it?	b. In what year?	c. How long did it last?	d. What topics did it cover?
32. _____	_____	Hours _____ Days _____ Weeks _____	_____ _____ _____
33. _____	_____	Hours _____ Days _____ Weeks _____	_____ _____ _____
34. _____	_____	Hours _____ Days _____ Weeks _____	_____ _____ _____

35. On which of the following topics related to gender-based violence would you like to receive training? (**Indicate all the applicable options by writing an "X" in the appropriate boxes.**)

_____ <input type="checkbox"/> 1. Indicators of violence	_____ <input type="checkbox"/> 6. Health effects
_____ <input type="checkbox"/> 2. How to ask about violence	_____ <input type="checkbox"/> 7. Legal issues
_____ <input type="checkbox"/> 3. How to conduct a clinical exam	_____ <input type="checkbox"/> 8. Other (<i>please specify</i>) _____
_____ <input type="checkbox"/> 4. How to provide services to victims	_____ <input type="checkbox"/> 9. None
_____ <input type="checkbox"/> 5. Referral options	

(After marking the boxes with Xs, please go back to the question and number your selections in order of priority)

36a. Do you think that health professionals should ask women clients routinely about violence?

- ☐ 1. Yes
☐ 2. No

36b. Why? (*Please explain*) _____

37. What suggestions do you have for improving services for victims of gender-based violence in your clinic?

Thank you for your time and participation!

c. Clinic Observation Guide

OBSERVATION GUIDE INSTRUCTIONS

It is recommended that this instrument be applied by a person from outside the organization to ensure an objective evaluation.

This observation guide consists of two parts:

→ **Section I** – This section should be completed based on a group INTERVIEW with a small number of clinic personnel. If possible, we recommend that this small group of staff members include the director of the clinic, a doctor and a counselor or psychologist (depending on clinic staffing). The questions in this section address general information about the clinic and the materials and forms available to health providers in the clinic. To complete this section, the observer must have access to the clinic's written materials. This process will take approximately 30 minutes.

→ **Section II** – This section should be completed based on OBSERVATION of the clinic environment. This process will take approximately half an hour, during which the evaluator should observe the environment and physical layout of the clinic and complete the form accordingly.

It is recommended that this observation guide be applied in each of the organization's clinics that will be participating in the gender-based violence initiative, at baseline and follow-up. Before conducting the observation, the observer should review the tool by following these instructions to ensure that the process is clear.

Abbreviations used in the observation guide:

GBV = Gender-based violence

Guide – Section I: INTERVIEW

Questions	Instructions
#1 - 6	These questions are straightforward. Fill out your name, the date and time the interview begins, the name of the persons being interviewed and their positions, the name of the clinic, and the country and city where the clinic is located.
#7 - 11	These questions should be answered by the professionals being interviewed based on existing data/statistics for each clinic.
#12 - 18	These questions should be answered by the professionals being interviewed based on their own experience and knowledge. Both parts of the questions must be answered; that is: <u>In the first part of each question</u> , mark YES when the respondents say that the document exists in the clinic.
#12a-19a	<u>In the second part of each question</u> , mark YES only after you have seen the document.
#19b	Write down the last date the directory was updated. In other words, when was the last time that the information in the directory was revised?
# 20a	In the space provided, write the names of the organizations with which the clinic has a cooperation agreement that facilitates the referral process. Please note that this can be a formal or informal agreement. It might be useful to jot down such details in the margin.

- #21 a-d Mark only one option for each of the four questions in the following manner: Mark “1” if the respondents say that the material is available in the clinic and you have seen it personally. Mark “2” if the respondents say that the material is available in the clinic but you have not been able to see it personally. Mark “3” if the respondents say that the material is NOT available in the clinic.
- #22a-b In the first part of this question, write down whether or not emergency contraceptives (EC) are available in the clinic according to the respondents. If the answer is “yes”, ask Question 22a and write down the type of EC. In Question 22b, indicate whether or not you were able to see the emergency contraceptives personally.
- #22c-d In Question 22c, indicate whether or not clinic staff say that the clinic has a copy of the dosage protocol or other instructions for using EC. In Question 22d indicate whether or not you saw the document personally.
- #23 - 25 These questions have three parts each. First, mark the respondents' answers regarding whether they receive feedback (1) never; (2) sometimes; or (3) routinely. If they say never (1), then skip to the following question.
- #23a-25a Indicate the frequency of feedback, according to the respondents.
- #23b-25b Write down how the feedback is given, according to the respondents.
- #26 Write down the respondents' suggestions for improving feedback.
- #27 In the first part of Question 27, mark “YES” if the respondents say that the institution has a written policy on sexual harassment. In the second part of this question (27a), mark YES only after you have had the opportunity to see the document.
- #28 Write down the time when you complete the interview.

Guide – Section II: OBSERVATION

- | Questions | Instructions |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| #29 | Write down the time when you begin the observation. |
| #30 - 33 | This part of the observation guide consists of questions about the characteristics of the physical layout and environment in different areas of the clinic that are used to perform specific functions, namely: medical consultations, counseling/orientation, psychological services/emotional support and childcare. Please note that the same area can sometimes be used for two different purposes, for example, for medical consultations and counseling. |
| #30a - 32a | Find out whether a client or provider can be heard from outside each area of the clinic mentioned, including: (30a) medical consultations; (31a) counseling/orientation; and (32a) psychological services /emotional support. If you can hear noise from outside these areas, mark "yes." If you cannot hear anything from outside, mark "no." |
| #30b - 32b | Find out whether you can see the client or the provider from outside each area mentioned, including: (30b) medical consultations; (31b) counseling /orientation; and (32b) psychological services/emotional support. If you can see the client or the provider from outside, mark "yes." If you cannot see anything from outside, mark "no." |
| #30c - 32c | Observe whether there are any interruptions during each type of consultation mentioned, including: (30c) medical consultations; (31c) counseling/orientation; and (32c) |

psychological services/emotional support. If there are interruptions, mark "yes." If there are no interruptions, mark "no."

#30d Indicate whether or not there is a separation (such as a wall or a screen) between the desk and the examination table. If the desk and the examination table are in separate rooms, then you can indicate that "yes," there is a separation.

There is extra space after Question 32 for additional comments regarding privacy in the three types of areas under observation.

#31d Some clinics do not provide individual counseling or orientation, only group sessions. For this question, mark "no" if counseling sessions are done in groups rather than individually. Note any additional details in the margin.

#33 Indicate whether or not there is any place within the clinic for childcare during the mother's medical appointment.

#34 - 42 This part of the observation guide addresses the availability of IEC materials in the clinic. This requires observing all the areas in the clinic and noting down the types of different materials available. For each topic on the list, indicate whether there are IEC materials on that topic in the clinic. Please note that some IEC materials address more than one topic simultaneously. In such cases, identify and indicate the main topic of the material.

In the appropriate boxes, include the code for the surrounding where the material is located. The codes are as follows:

Coding:

Reception	RE
Waiting Room	WR
Medical Consultation	MC
Psychological Consultation	PS
Counseling/Orientation	CO
Hallway	H
Other	O

For example, if there is a poster in the waiting room, mark the box under "posters," and add the code "WR."

#43 In this space, you can write additional comments about the content of the observed IEC materials.

#44 Write down the time when you have completed the observation.

OBSERVATION GUIDE – SECTION I

This section includes a brief interview with a small group of clinic personnel regarding general information about the clinic as well as materials and forms available to health providers in the clinic. If possible, it would be ideal to interview a small group of staff members that includes the director of the clinic, a doctor and a counselor. This process will take approximately 30 minutes.

GENERAL INFORMATION

1. Name of the interviewer _____
2. Date of the interview _____
3. Interview starting time _____
4. Names and titles of the persons interviewed:

<i>Name</i>	<i>Title</i>
_____	_____
_____	_____
_____	_____

5. Name of the clinic _____
6. Country and city _____, _____
7. Size of the clinic (average number of clients per week) _____
8. Operating hours of the clinic _____
9. Types of services offered by the clinic:
 - ☐ a. Medical services
 - ☐ b. Psychological services or emotional support
 - ☐ c. Legal assistance to victims of gender-based violence (GBV)
 - ☐ d. Other specialized services related to GBV (***Please specify***):

10. Total number of persons who work in the clinic _____

11. Number of health personnel (who have direct contact with clients), by type of service.
(Temporary volunteers, administrative and support staff, and the directorate should not be included if they do not provide direct services.)

	Number
a. Medical services	_____
b. Psychological services and emotional support	_____
c. Legal assistance to victims of gender-based violence	_____
d. Other specialized services related to GBV	_____

RESOURCES, MATERIALS AND PROTOCOLS

12. Are there written policies and procedures (a protocol) in this clinic to identify victims of gender-based violence?

Yes 1. ☐ **→** 12a. May I see a copy? Yes 1. ☐
No 2. ☐ No 2. ☐

13. In this clinic, are there written questions that can be used to detect cases of gender-based violence?

Yes 1. ☐ **→** 13a. May I see a copy? Yes 1. ☐
No 2. ☐ No 2. ☐

13b. Where are they written?

1. ☐ Printed in the clinical case-history form?
2. ☐ Stamped on the clinical case-history form?
3. ☐ Written in a different place? (**Specify:**) _____

13c. Is there a space on the clinical case-history form to document the answers?

Yes 1. ☐
No 2. ☐

14. Does this clinic have a mechanism to verify in the case-history form that the questions were asked, even when the answers were negative?

Yes 1. ☐ **→** 14a. What is the mechanism?
No 2. ☐ _____

14b. May I see an example? Yes 1. ☐
No 2. ☐

15. Does this clinic have a mechanism to document information about a case of gender-based violence?

Yes 1. ☐ → 15a. May I see a copy?
No 2. ☐

Yes 1. ☐
No 2. ☐

16. Does this clinic have written policies and procedures (a protocol) to provide services to victims of gender-based violence?

Yes 1. ☐ → 16a. May I see a copy?
No 2. ☐

Yes 1. ☐
No 2. ☐

17. Does this clinic have written questions that are used to evaluate the level of danger of clients who live in a violent situation?

Yes 1. ☐ → 17a. May I see a copy?
No 2. ☐

Yes 1. ☐
No 2. ☐

18. Does this clinic have written policies and procedures (a protocol) to provide services to women who are in a dangerous situation?

Yes 1. ☐ → 18a. May I see a copy?
No 2. ☐

Yes 1. ☐
No 2. ☐

19. Does this clinic have a directory or printed list of local agencies and other resources on gender-based violence to which you could refer women living in violent situations?

Yes 1. ☐ → 19a. May I see a copy?
No 2. ☐

Yes 1. ☐
No 2. ☐

19b. When was the directory/list last updated?

20. Are there any cooperation agreements between your institution and other institutions that offer services to victims of gender-based violence, to facilitate the referral process?

Yes 1. ☐ → 20a. With which institutions? _____
No 2. ☐ _____

21. When you provide referrals to clients to services outside your organization, do you use any of the following? **(Circle the answer.)**

	Yes, and they showed me a copy	Yes, but they were unable to show me a copy	No
a. Brochures, cards or other printed materials with information about resources available in the community?	1	2	3
b. A mechanism to document the referral?	1	2	3
c. A mechanism to check whether the client went for her appointment?	1	2	3
d. A counter-referral mechanism?	1	2	3

22. Does this clinic offer emergency contraception?

Yes 1. ☐
No 2. ☐



22a. What type of emergency contraceptive do you offer?
(Write down the type)

22b. May I see a sample?

Yes 1. ☐
No 2. ☐

22c. Does this clinic have a dosage protocol or other written instructions on how to use them?

Yes 1. ☐
No 2. ☐

22.d May I see a copy?

Yes 1. ☐
No 2. ☐

In this clinic, is there feedback regarding cases of gender-based violence . . .

	Never 1	Sometimes 2	Routinely 3
23. Among the clinic's health professionals?	↓	↓	↓ 23a. How frequently? _____ 23b. How is the feedback given? _____
24. From the statistical service to clinic staff?	↓	↓	↓ 24a. How frequently? _____ 24b. How is the feedback given? _____
25. From management or the GBV initiative leader to the clinic staff?	↓	↓	↓ 25a. How frequently? _____ 25b. How is the feedback given? _____

26. What suggestions do you have to improve feedback?

27. Does this institution have a written policy on sexual harassment?

Yes 1. ☐ No 2. ☐ → 27a. May I see a copy?

Yes 1. ☐
No 2. ☐

28. Interview ending time: _____

OBSERVATION GUIDE – SECTION II

This section includes an observation of the physical aspects of the clinic. This process will take approximately half an hour to complete, during which time the observer will visit the different areas and then complete the form.

29. Observation starting time: _____

SITE CHARACTERISTICS

Ob-gyn medical consultations

	Yes	No
30. Is there a specific area devoted to ob-gyn medical consultations ?	1	2
30a. Can conversations be heard from outside?	1	2
30b. Can clients be seen from outside?	1	2
30c. Are there interruptions during consultations?	1	2
30d. Is there a separation (e.g., a screen) between the desk and the examination table?	1	2

Counseling/orientation

	Yes	No
31. Is there a specific area devoted to counseling/orientation ?	1	2
31a. Can conversations be heard from outside?	1	2
31b. Can clients be seen from outside?	1	2
31c. Are there interruptions during counseling sessions?	1	2
31d. Are counseling sessions one-on-one?	1	2

Psychological consultations / emotional support

	Yes	No
32. Is there a specific area devoted to psychological consultations or emotional support ?	1	2
32a. Can conversations be heard from outside?	1	2
32b. Can clients be seen from outside?	1	2
32c. Are there interruptions during consultations?	1	2

	Yes	No
33. Is there a place for childcare (formal or informal) during the mother's visit to the clinic?	1	2

Notes or observations on privacy:

BROCHURES, POSTERS AND OTHER IEC MATERIALS ON GENDER-BASED VIOLENCE

For each of the topics listed below, indicate whether there are any IEC materials on the topic in the clinic. In the boxes, include the code for the area where the material is located. For example, if there is a poster on clients' rights in the waiting room, check the box under "posters" and write "WR."

Coding:	Reception	RE	Counseling / Orientation	CO
	Waiting Room	WR	Hallway	H
	Medical consultation area	MC	Other	O
	Psychological consultation area	PS		

	Posters	Brochures or Flyers	Videos	Other Material (Please specify)
34. Clients' rights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Domestic or family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Sexual abuse or rape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Psychological services or emotional support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Legal assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Other services for victims of GBV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Laws on violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Prices of services offered in the clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Other topics related to GBV (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

43. Comments regarding the content of the materials (optional):

44. Observation ending time: _____

d. Client Exit Survey Questionnaire

EXIT INTERVIEW GUIDE

INSTRUCTIONS FOR THE SURVEY COORDINATOR

This questionnaire explores clients' perspectives about the services provided in a health center where providers have begun to screen clients for gender-based violence on a routine basis. If at least 5% of clients interviewed answer negatively to any of the questions (indicating dissatisfaction), the area of quality represented by the question will be considered an area that needs improvement. Consequently, the health service should consider developing and implementing actions to address these areas.

Sample Size

To obtain an adequate sample size to evaluate the quality of screening, it is important to interview at least 80 women who have been asked about gender-based violence by providers at the clinic. This number represents a compromise between statistical precision and the feasibility of conducting the survey within a reasonable period of time.¹

However, it must be noted that not all clients interviewed will have been screened for gender-based violence, either because they are repeat clients or because the provider simply did not ask the screening questions for some reason. This means that the sample size for this survey will have to be greater than 80, although the actual number will depend on the proportion of women who have been screened. In other words, to interview at least 80 women who have been screened for gender-based violence (during this visit or on a prior visit) in a clinic where the proportion of clients who have been screened is 80%, then 100 women must be interviewed. The total number of women who should be interviewed would vary depending on the screening level in each site. For example:

Proportion of clinic clients who have been screened	Required subsample size of women who have been screened	Total sample size
80%	80	100
50%	80	160

In a small association where the client flow is not large enough to interview 80 clients who have been screened within a reasonable period of time, the sample size can be smaller. However, it is important to remember that this will affect the confidence level of the results. If fewer than 73 interviews are conducted, the results will not be statistically reliable; however, they can still be useful. If it is not possible to interview 80 clients who have been screened during a period of a week, it is preferable to extend the period of the evaluation than to decrease the sample size.

We recommend interviewing all clients during a period of one week, thereby ensuring that clients will be selected from each day of the week on which the center provides services. If the association has clinics in different sites with clients whose sociodemographic characteristics vary

¹ The actual calculation of the sample size for the estimated proportions can be smaller or larger, depending on the desired level of precision and the assumptions regarding the estimated proportion of the population who are dissatisfied. This sample size could be small, 73, or large, such as 243. These parameters have been used widely in the evaluation of health services, including IPPF/WHR client satisfaction surveys. 1 Williams T, Cuca Y and Schutt-Ainé J, *Client Satisfaction Survey for Improved Family Planning Services*, IPPF/WHR: April 1998.

greatly, it is recommended that the survey be conducted with a sample of 80 women who have been screened in each of the sites (or groups of clinics).

Selection Criteria

The purpose of this survey is to understand women's perspectives about health care providers' effort to identify women who have experienced violence. Therefore, the primary selection criterion is that the client must have received services in a part of clinic where health providers have begun to routinely screening women for gender-based violence as a matter of clinic policy.

This questionnaire is not designed to measure the quality of specialized services for victims of violence; rather, it is designed to measure the quality of care in health services where routine screening is done.

Before photocopying the questionnaire, it is important to list the services or parts of the clinics in which providers do and do not routinely screen women for gender-based violence. These should be listed under Question 6, so that the interviewers will know which clients are eligible to be interviewed and which clients are not.

Sample Selection

The interviews should be conducted every day of the week in which the health center offers services. The sample selection procedures may vary depending on the size of the health center and the desired sample size. In health centers with relatively low client volumes, particularly centers that serve fewer than 73 clients per week, the *census* method should be used, which means that all clients should be interviewed within a particular period of time (one or more weeks). The census method reduces sampling error and biases related to the selection of participants.

The number of weeks needed to reach a sufficiently large sample to ensure a subsample of 80 or more clients who have been screened should be calculated based on the volume of clients. The period should be established in whole-week increments, even if this results in a sample size that is larger than desired.

In large health centers (serving more than 100 clients per week), different methods could be used. One option is to use the census method for a period of one week, ensuring that each day of service is covered. The second option is to determine the appropriate sample size and employ systematic sampling to choose participants (see below for an explanation). The following table summarizes these options:

Size of the health center	Suggested sampling method	Minimum sample size	Time required
Fewer than 100 clients per week	Census*	100	≥ 2 weeks
More than 100 clients per week	Census* or systematic sampling	100	1 week

* In the census method, all clients who visit the health center seeking sexual and reproductive health services during the period of the evaluation should be interviewed.

The following is an example of systematic sampling. Paz Hospital sees approximately 300 clients per five-day week. To obtain a sample size of 100, 20 clients should be interviewed every day during the period of a week.

$$\frac{100 \text{ interviews}}{5 \text{ service days during the week}} = 20 \text{ interviews per day}$$

The Paz Hospital serves about 60 clients per day, so to select 20 clients per day, the sampling interval should be 3:

$$\frac{60 \text{ clients per day}}{20 \text{ interviews per day}} = 3$$

An interval of 3 means that every third client who comes out the clinic's door should be interviewed. If there is more than one door, an interviewer should be located at each exit plus one or two substitute interviewers to prevent missing potential cases. If the sampling is done using the census method, there should be enough interviewers available to ensure that all clients are interviewed.

To determine who will be selected for the interviews, first choose a random number between 1 and 3 (the sampling interval) to determine the *random starting number*.² In this example, suppose the number 1 is the random starting number. Because the sampling interval is 3 and the random starting number is 1, the interviews will begin with the first client, and the subsequently selected clients should be every third client. If a client refuses to participate or has come for a service that is not eligible,³ simply choose the following client who arrives. Use the same random starting number every day.

Selection of Interviewers

It is recommended that the exit interviews be conducted by competent, experienced interviewers who are not permanent staff members of the organization. Some of the questions are sensitive, which will require experienced interviewers who can obtain answers without making the clients feel uncomfortable. Because the focus of this survey is gender-based violence, it is recommended that all the interviewers be women.

The number of interviewers hired will depend on the number of women who will be interviewed and the duration of the survey. Approximately one interviewer will be needed for every four clients seen at the center per hour. Although the interview takes only 10 to 15 minutes to complete, there is a limit to how many interviews an interviewer can complete every hour. Based on this information, the evaluation expert in the team should calculate the number of interviewers needed to conduct

2 To pick a random number, write each number on a small piece of paper and place the pieces of paper in a container. Write down numbers beginning with 1 up to the interval number (from 1 to 3 for an interval of 3, from 1 to 8 for an interval of 8, etc.). Pick a piece of paper from the container, and use that number to choose the first client to be interviewed.

3 If there are several interviewers, but only one arrival point (reception area/entrance) for clients, then the interviewers should follow the same random selection scheme. For example, the first interviewer chooses client number 3, the second interviewer chooses client number 6, etc. If the interviewers are at a different arrival point (for example, if the center has two arrival points or reception areas where clients to be surveyed can be picked), then each interviewer should choose and follow a different random starting number.

the interviews efficiently and effectively. Nevertheless, it is suggested that no more than four interviewers be used in order to minimize the risk of bias.

Preparation of Interviewers

The interviewers should familiarize themselves with the questionnaire before conducting an interview. The coordinator and the evaluation officer should hold a training session specifically for the interviewers who will conduct the exit interviews. The training should consist of a question-by-question review of the instrument, including the statement of informed consent, the specific aspects that are being investigated, and examples.

The interviewers should practice by interviewing one another until each interviewer has conducted a practice interview at least once, supervised by the evaluation specialist and the coordinator of the gender-based violence initiative. Finally, the evaluation specialist should emphasize the importance of following the sampling procedures to ensure that the instrument is applied correctly. A pilot test of the instrument is recommended, consisting of at least two interviews in the center, in order to improve knowledge of the interview and to practice in the field. Interviewers can be given visible ID cards to identify them to the clients.

Interviewers should offer information on gender-based violence and the services available in the clinic to those clients who say that they have not received such services. However, it is important that the interviewers emphasize to the client that, if she is living in a violent situation, she should take precautions to make sure that the abuser does not find these materials, since they could increase her risk of violence.

Choosing a place to conduct the interviews

Privacy is important to obtain good results with the exit interviews. The clients should feel certain that their answers will not be heard or shared with health center personnel, other clients, or anyone else. The interviewer should try to maintain a cordial and welcoming environment so that the client will feel comfortable answering the questions. The interviewer should show interest in what the client has to say. Specific spaces should be made available to conduct the interviews for the duration of the survey.

Minimizing bias

It is recommended that this survey be presented to the health providers as a general survey on gender-based violence and not as a survey to measure client satisfaction regarding services they have received. This will help minimize the possibility that providers will act in a different manner because they think that the quality of their work is being evaluated. Each association and its executive director should determine the best way to present the survey.

GENERAL INSTRUCTIONS FOR THE INTERVIEWERS

Coordinate with the health center personnel. Each health center has a different structure. It will be useful to find out where clients go and whom they talk to before leaving the health center, and coordinate with this person so that s/he escorts the clients to the interviewers.

Approach the client. When the client is about to leave the health center (or when she has concluded her counseling session or clinical visit), invite her to participate in the survey.

Read her the informed consent statement. Respond to her questions or doubts. If she does not want to participate, thank her for her time.

Determine the client's eligibility. Use the attached form titled "Selection Criteria for the Exit Survey" to determine whether a client is eligible to participate in the survey. This survey is meant only for clients who have received services in parts of the clinics where providers are routinely screening women for gender-based violence.

Read the questions exactly as written. It is important that all interviewers ask the same questions in the same manner. In this questionnaire, all bold text should be read aloud. The rest of the text is meant to guide the interviewer. The only exception is as follows: if a client has a hard time responding to a question, you may read her the available options to help her respond.

Vocabulary used in this questionnaire:

Gender-based violence can include:

- Domestic violence, including physical, emotional and sexual violence
- Sexual abuse or rape
- A history of sexual abuse during childhood

Gender-based violence screening

Is when a provider routinely asks clients whether they have suffered abuse or violence.

Specific instructions for each question

- | | |
|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Questions 1 - 5 | Write the name of the interviewer, the name of the health center, the country and city or town where the health center is located, and the date and time of the interview. |
| Informed Consent Statement: | Read the informed consent statement. Respond to the clients questions or doubts. If the client does not want to participate, thank her for her time and stop immediately. Do not discard the form. |
| Question 6 | Ask the client what type of service she used today, and check the appropriate box. If she mentions a service where routine gender-based violence screening is not done, then she is not eligible to participate in the survey. In this case, simply write down the type of service she indicates in the space provided for "other" and thank her for her time. Stop the interview at this point.

Do not discard the form. All questionnaires have to be reviewed to ensure that the appropriate women have been interviewed. |
| Question 7 | If the client is eligible, ask her whether this is her first visit to the health service. This information can be used to determine how many new and returning clients are interviewed during the survey. |

Client Exit Survey

The questionnaire is divided into three sections: general information, acceptability of services and acceptability of screening.

General Information

- | | |
|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Question 1 | Write the client's age. |
| Question 2 | First ask the client what educational level she reached, primary, secondary, university or higher. Then, ask her what was the last year she completed. Try to obtain answers for both parts: educational level and exact year completed. |

Acceptability of Services

- | | |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Question 3 | If the client says that the time of service was NOT convenient, ask her what day(s) and time(s) would be more convenient (Question 3a). If she says that the time WAS convenient, you may go directly to Question 4. |
| Question 3a | Ask this question only if the client says that the service schedule is NOT convenient. Record the day and time that she mentions. If she provides more than two answers, record everything she says. |

- Question 4 After asking the question, wait for the client to respond. If she answers that she does not know, read her the answer options so that she can choose the category that most closely reflects the amount of time she had to wait.
- Question 5 If the client responds that the consultation room was NOT comfortable, ask her why not, and write down everything she says.
- Question 6 If the client says that she prefers to be seen by a man or a woman, ask her why and write down everything she says. If she has no preference, go on to Question 7.

Acceptability of Screening

- Question 7a-e The purpose of this question is to find out whether a provider asked the client about gender-based violence during the visit. You must ask the question "Were you asked about _____?" five times, each time ending the question with each of the following types of violence on the list, a-e, one by one.
- If the client responds NO to all the options -- that is, if she says that she was not asked about any type of abuse or violence today, then ask Question 8 to find out whether she was ever asked in the past.
- If she responds YES to any of the options, then skip to Question 9 after asking about all five types of violence.
- Question 8 If the client responds NO to all the options in Question 7, ask her if she has ever been asked in this clinic in the past about violence or abuse.
- If she responds NO, skip ahead to Question 21 toward the end of the questionnaire.
- If she responds YES, continue with Question 8a, which asks how long ago. And then go to Question 9.
- Question 9 Ask the question and read the list of types of providers one by one until the client responds YES. You may check more than one option, but every time the client responds YES to a type of provider, ask Questions 10 and 11 (about the sex of the provider and how the client felt) before proceeding with the following provider type. You must return to the list of provider types in Question 9 after asking Questions 10 and 11.
- Question 10 After indicating whether the provider was a man or a woman (by circling the appropriate number), go to Question 11 before returning to the list of provider types in Question 9.

- Question 11 Indicate how the client felt when the provider asked her about abuse or violence. If she says that she did not feel comfortable (or if she gives any other negative answer), go to Question 12 and ask her why.
- Question 12 Write down everything she says.
- Question 13 Ask this question only if the provider who asked the client about violence was a doctor. The purpose of this question is to determine at what point during the visit the provider asked the screening questions: before, during or after the examination.
- Question 14 and 14a If the client says NO, that no one was present, skip directly to Question 15.
- If the client says YES, that someone was present, ask her who was present (Question 14a). If she says that she doesn't remember, circle "other person" and write "doesn't remember" on the line that reads "please specify." If more than one person was present, write down all that apply.
- Question 15 You must ask the question "To what extent would you say the provider . . .?" three times, each time substituting one of the options: "was respectful," "listened with attention," and "seem interested in providing support."
- Circle the number that corresponds to the answer and move on to the next point until you reach the end of the question.
- Question 16 If the client says that she did feel that she could NOT trust the provider AT ALL, continue with Question 16a, "Why," and write down everything the client says.
- On the other hand, if the client says that she trusted the provider SOMEWHAT or A LOT, skip directly to Question 17.
- Question 17 and 17a If the client says that there was NOT enough time, ask her to explain (Question 17a) and write down everything she says.
- If she says that Yes, she did have enough time, go directly to Question 18.
- Question 18 and 18a If the client says that she did NOT feel comfortable, ask her to explain (Question 18a) and write down everything she says.
- If she says that she DID feel comfortable, go directly to Question 19.
- Question 19, 19a-b If the client responds that she did NOT receive information about the services provided by the organization, ask her if she would like the information (Question 19a). If so, give her copies of the information or referral materials. **(Your supervisor must provide you with these materials before the survey begins.)** When you give the client the information, emphasize that women living in a violent situation should take precautions to ensure that the abuser will not find these materials because this could increase the danger of violence. In addition, be aware that we do

not know whether the client wants the information for herself or for another woman. Afterward, skip directly to Question 20.

If the client says that YES, she has already received information, ask her about which types of services (Question 19b).

Question 20, 20a-b If the client responds that she did NOT receive information about EXTERNAL services, ask her whether she would like this information (Question 20a). If she does, give her copies of the information or referral materials. **(Your supervisor must provide you with these materials before the survey begins.)** When you give her the information, emphasize that women living in a violent situation should take precautions to ensure that the abuser will not find these materials because they could increase the danger of violence. In addition, be aware that we do not know whether the client wants the information for herself or for another woman. Afterward, skip directly to Question 21.

If the client says that YES, she has already received information, ask her about which types of services (Question 20b).

Question 21 After answering YES or NO, ask the client why or why not (Questions 21a and 21b) and write down her complete answer, in her own words. Probe by asking, "Would you like to add anything else?"

Question 22 Write down everything the client says.

Question 23 Write down everything the client says.

Question 24 Write down everything the client says.

Thank the client for participating in the survey.

EXIT SURVEY CONSENT AND SELECTION FORM

1. Name of the Interviewer _____
2. Name of the Health Center: _____
3. Country and City (location): _____
4. Date of Interview: ____ / ____ / ____ (day/month/year)
5. Interview Starting Time: _____

Informed Consent Statement

We are conducting a study to understand what clients' think about the services they have received in this health center. This information will be used to improve the quality of care in this health center.

We hope you can collaborate with us by letting us interview you today. If you wish to participate and you meet the requirements to participate, the interview will take between 10 and 15 minutes.

This questionnaire includes several questions related to sexual and reproductive health services. Some health providers in this center are making an effort to help clients who have suffered violence. They are integrating this topic into the services they provide. So we are asking clients what they think about this effort, and what their experience was like in the clinic today.

I would not have to know your name, and your answers would be completely confidential and anonymous. Your individual answers will not be shared with your health provider.

Whether or not you participate in this study will not affect in any way the level of service you will receive from now on.

Would you be interested in being interviewed?

No → **Thank you for your time. (End of the interview)**

Yes → **Continue with the interview.**

To make sure that you meet the requirements to participate in this study, I am going to ask you several questions about what type of service you came for today.

6. What type of visit did you come for today?

(BEFORE PHOTOCOPYING THE QUESTIONNAIRES, REVISE THE FOLLOWING LIST TO ENSURE THAT IT INCLUDES ALL SERVICES IN WHICH PROVIDERS ARE CONDUCTING ROUTINE SCREENING)

- ☐ 1. Family Planning
- ☐ 2. STIs/HIV/AIDS
- ☐ 3. Gynecological visit different from FP
- ☐ 4. Another service or counseling related to sexual and reproductive health

→ ELIGIBLE

- ☐ 5. A service in this clinic in which providers are not conducting routine GBV screening, including the following:

→ NOT ELIGIBLE

(BEFORE PHOTOCOPYING THE QUESTIONNAIRES, LIST THE SERVICES IN WHICH PROVIDERS ARE NOT CONDUCTING ROUTINE SCREENING ON THE FOLLOWING LINES)

(If the service is not one in which providers are conducting routine GBV screening, then this client would not be eligible.)

“Thank you for your time.”
(End of the interview)

7. Is this your first visit to the center?

No 1. ☐

Yes 2. ☐

CLIENT EXIT SURVEY

General Information

1. How old are you? _____

2. What was the highest level of education that you reached, primary school, secondary school, university or higher? (Mark the level and write down the year or degree.)

What was highest grade or degree that you completed?

Did not attend school

1. ☐

Primary school, incomplete

2. ☐

Primary school, completed

3. ☐

Secondary school, incomplete

4. ☐

Secondary school, completed

5. ☐

University or higher

6. ☐

Grade or degree

Acceptability of Services

3. Are the clinic hours at this health center convenient or inconvenient for you?

Not convenient

1. ☐ →

Convenient

2. ☐

3a. What day(s) and/or hour(s) would be more convenient for you?

Day(s): _____

Hour(s): _____

4. Approximately how long did you have to wait to be seen from the time that you arrived at the center?

Less than 15 minutes

1. ☐

Between 15 and 30 minutes

2. ☐

Between 30 minutes and 1 hour

3. ☐

More than 1 hour

4. ☐

5. During the consultation, did you find the consultation room to be comfortable?

No

1. ☐ → 5a. Why not? _____

Yes

2. ☐

6. Would you prefer to be seen by a man or a woman?

Man

1. ☐ → 6a. Why? _____

Woman

2. ☐ → 6b. Why? _____

No preference

3. ☐

Acceptability of the Screening

As I mentioned earlier, in this clinic, some providers are asking clients about violence or abuse. We would like to understand what clients think about these questions and about the care given by these providers. We ask you to respond as honestly as possible, because your answers can help other clients and improve services.

7. Today during your visit, were you asked about: *(Read all the options and circle the applicable answers)*

	No	Yes
a. emotional/psychological abuse?	1	2
b. physical abuse?	1	2
c. sexual abuse?	1	2
d. childhood sexual abuse?	1	2
e. any other type of violence or abuse?	1	2



(Go on to Question 8 only if she answered NO to all questions 7a-e)

8. Before today, have you ever been asked in this clinic about violence or abuse?

No 1. ☐ → SKIP TO QUESTION 21

Yes 2. ☐ → 8a. How long ago?

- 1. ☐ 1-6 days
- 2. ☐ 1-4 week(s)
- 3. ☐ 1-12 month(s)
- 4. ☐ more than 1 year

Regarding the provider who asked you about abuse or violence . . .

9. What type of provider was it?
(Read all of the options and mark all that apply)

10. Was it a man or a woman?

11. How did you feel speaking with him/her? That is, would you say that you felt uncomfortable, indifferent or comfortable speaking with him/her?

		Man	Woman		Uncomfortable	Indifferent	Comfortable
a. Counselor?	<input type="checkbox"/> →	1	2	→	1	2	3
b. Doctor?	<input type="checkbox"/> →	1	2	→	1	2	3
c. Midwife?	<input type="checkbox"/> →	1	2	→	1	2	3
d. Psychologist?	<input type="checkbox"/> →	1	2	→	1	2	3
e. Other or don't know?	<input type="checkbox"/> →	1	2	→	1	2	3

Please specify:



(Ask Question 12 only if she responded "Uncomfortable" to one of questions 11a-e)
12. Why didn't you feel comfortable?

13. (Ask only if the provider was a doctor) In relation to the physical exam, when did the doctor ask you about abuse or violence? (Read the choices)

- | | |
|-------------------------------------------|-----------------------------|
| before starting the physical exam? | 1. <input type="checkbox"/> |
| during the physical exam? | 2. <input type="checkbox"/> |
| after the physical exam? | 3. <input type="checkbox"/> |
| there was no physical exam? | 4. <input type="checkbox"/> |
| or, does not remember | 5. <input type="checkbox"/> |

14. Was anyone else present when the provider asked you about abuse or violence?

No 1. ☐

Yes 2. ☐ → 14a. **Who was present?**

- | | |
|----------------------|-----------------------------|
| Another staff member | 1. <input type="checkbox"/> |
| Partner | 2. <input type="checkbox"/> |
| Child/Children | 3. <input type="checkbox"/> |
| Family/Friend | 4. <input type="checkbox"/> |
| Other | 5. <input type="checkbox"/> |

(please specify): _____

15. **We would like to know about the provider's attitude when s/he asked you about abuse or violence. To what extent would you say s/he ... (read each of the following options):**

	Not at all	Very little	Somewhat	A lot	Don't know/don't remember
a. was respectful?	1	2	3	4	DR
b. listened attentively?	1	2	3	4	DR
c. demonstrated interest in helping you?	1	2	3	4	DR

16. **To what extent did you feel that you could trust her/him when you were talking to her/him about this subject? Not at all, somewhat or alot?**

Not at all 1. ☐ → 16a. Why not? _____
Somewhat 2. ☐
A lot 3. ☐

17. **Did you have enough time to ask questions and clarify your concerns about the issue of violence?**

No 1. ☐ → 17a. Could you tell me more? _____
Yes 2. ☐

18. **Did you feel comfortable asking the provider questions and clarifying your concerns?**

No 1. ☐ → 18a. Could you tell me more? _____
Yes 2. ☐

19. **Did you receive information about the organization's services related to abuse or violence?**

No 1. ☐ → 19a. **Would you like this information?**

No 1. ☐

Yes 2. ☐ → Give her the information or referrals. Emphasize that women living in a violent situation should take precautions to ensure that the abuser doesn't find these materials, since this could increase the danger of violence.

Yes 2. ☐ → 19b. **What types of services?** (Check all that apply)

Health services 1. ☐
Psychology/counseling 2. ☐
Support groups 3. ☐
Legal services 4. ☐
Other 5. ☐ (please specify) _____

20. Did you receive information about services **OUTSIDE** the association that could be helpful to women who have suffered violence?

No 1. ☐ → 20a. **Would you like this information?**

No 1. ☐

Yes 2. ☐ → Give her the information or referrals. Emphasize that women living in a violent situation should take precautions to ensure that the abuser doesn't find these materials, since they could increase her risk of violence.

Yes 2. ☐ → 20b. **What types of services?** (Check all that apply)

Health services 1. ☐

Psychology/counseling 2. ☐

Legal services/police 3. ☐

Other 4. ☐ (please specify) _____

21. Do you think that providers should routinely ask female clients whether they have experienced violence or abuse?

No 1. ☐ → 21a. **Why not?** _____

Yes 2. ☐ → 21b. **Why yes?** _____

22. What suggestions do you have to improve the services in this health center for women who have suffered violence? _____

23. Was there anything that you particularly liked about the services today?

24. Was there anything in particular that you did not like about the service today?

“THANK YOU FOR YOUR PARTICIPATION”

e. Sample Protocol for Qualitative Evaluation

Statement of problem

One of the difficulties in evaluating interventions related to gender-based violence in the context of health services is the lack of theory or evidence to support concrete definitions and indicators for measuring “success” or “failure”, risk or benefit.

To address this issue, the IPPF/WHO mid-term methodology was designed to be qualitative and participatory. Rather than approach the evaluation with pre-determined definitions of success, the exercise was designed to elicit the definitions and perspectives of women who had experienced gender-based violence, service providers, project managers and external informants.

In a sense, this study had two components: on the one hand, it attempted to evaluate components of the project. On the other hand, it attempted to shed light on what it means for these interventions to succeed or fail, to benefit women or to put women at risk. Thus, this evaluation was partly a practical exercise to give information to donors and the participating associations, and partly an attempt to address a gap in the research literature.

General objective:

The overarching goal of the study was: *To identify the ways in which the three associations can improve their work in order to benefit women who have experienced gender-based violence.*

Specific objective:

The evaluation was designed to address three specific objectives / research questions:

1. How do women who have experienced gender-based violence define “success” or “failure”, benefit and risk in the context of their own lives? After GBV survivors receive services from an institution, what are their views about the milestones and outcomes that they have experienced?
2. To what extent have the various interventions achieved success or failure, or resulted in benefits and risks, from the perspectives of women themselves, project managers, service providers and external key informants.
3. To what extent has the integration of GBV into sexual and reproductive health services had an impact on: a) the sexual and reproductive health of women who have experienced violence b) the structure and quality of SRH care c) the attitudes and priorities of service providers.

Methodology:

The evaluation primarily involved qualitative research methods, triangulating different sources of qualitative information to complement the quantitative findings of a client exit interview. The evaluation explored the perspectives of women who had experienced GBV, providers of health care services, decision makers at the associations, and external informants who have participated in the network of organizations working on GBV.

The fieldwork was carried out between August and November 2001. Specifically, it involved:

- a) A review and analysis of documents used by the project and the project coordinators
- b) 14 in-depth interviews with women who have experienced violence
- c) “*Talleres de reflexión*” —“reflection workshops”—participatory group discussion/interview, including:

- i) 6 with service providers
 - ii) 8 with women who have experienced violence and received services
 - iii) 2 with external informants involved in organizations that address GBV
- d) 14 structured interviews with key informants from within and outside the organizations
- e) Three efforts to document or “systematize” experiences (called “*sistematizaciones*”) of specific pilot interventions, including:
 - i) Support groups for women who have experienced violence (Venezuela and Peru)
 - ii) Networks, specifically “a multi-sectoral round table network” (Peru)
 - iii) Case study exploring examples of “success” and “failure”, as defined by the project team (Venezuela)
- g) 691 exit interview with women who received SRH services at the participant clinics and who gave consent to participate in the study.

In addition to structured and unstructured interview/discussion guides, evaluators used a number of techniques to gather information in an open-ended, participatory way, including the following:

1. Pathways taken (*El camino recorrido*): a chronological history

This method was used both during individual interviews and group discussions.

During group discussions, the evaluator asked service providers to describe the chronological history of the project and to identify key events over the previous two years. Their comments were recorded in chronological order along a timeline. Participants were asked to rate these events from 1 to 10 for positive developments and –10 to 0 for negative events/developments.

During individual interviews, women were asked to describe the key events in terms of how they dealt with their experience related to GBV. They were also asked to rate these events, not numerically, but in terms of whether they were positive or negative, not important, important or very important.

2. Achievements / benefits (Group discussions only)

Participants were asked to fill out cards (as many as they wished) to answer the question: for you, what have been the principal achievements that you have seen or experienced since:

- a) The beginning of the project (service providers);
- b) Since you received services from the institution (women); or
- c) Since the establishment of the network (external informants).

The facilitator organized the cards on the wall, according to topic. When two cards contained the same idea, the facilitator pinned one on top of the other. If any major topic had no cards, the facilitator asked for a second round with cards of another color.

Once the cards were up on the wall, the facilitator asked the participants which themes were mentioned most and why, and how widespread or important each of the ideas on the cards were in their opinion.

One element of this exercise was to compare the perspectives of women who had experienced violence and received services with the perspectives of the service providers.

3. Who helps women?

This exercise is a rapid situation analysis of the community resources available to help women who experience violence—from different perspectives. Given an example of a case (e.g. Maria is living with a violent partner), participants were asked, “who helps her?” Participants were given cards of different colors and sizes to record their answers. Specifically colors represented the following:

- a) During group discussions with women and external informants, one color for individuals (such as family members, neighbors, etc.) and another color for organizations (public and private).
- b) During group discussions with service providers, one color represented services available within the institution, another color represented services external to the organization, and a third color represented individuals in the woman's life.

Small, medium and large cards represented small, medium or large importance. Participants were asked to put up the cards closer or farther away from Maria, depending on the degree to which they thought these resources were accessible.

4) Incomplete history of Rosita

The facilitator presents the group with a hypothetical case of a woman living in a violent situation who is asked about violence during a visit to the health clinic. The group is then asked:

- a) To describe the factors that might facilitate or prevent her from improving her situation.
- b) To identify what they think may be the impact on her sexual and reproductive health
- c) To answer a series of questions about what the woman and her health care provider might do, say or feel when she is asked about violence.

The Table below illustrates the number and type of interviews and group discussions held as part of the IPPF/WHR qualitative midterm study:

Instrument	Venezuela (PLAFAM)	The Dominican Republic (PROFAMILIA)	Peru (INPPARES)
In-depth interviews with women who have experienced GBV	5 interviews	4 interviews	5 interviews
Group discussions with providers	2 groups	2 groups	2 groups
Group discussions with women who have experienced GBV and received services	2 groups	3 groups	3 groups
Group discussions and interviews with key informants from outside the institution	1 group	3 interviews	1 group
Structured interviews with key informants from within the institution	3 interviews	4 interviews	4 interviews
Efforts to document experiences of specific interventions	2 (support groups and a case study of “success” and “failure”)	NA	2 (support groups and a district network)
Client exit interview	180 interviews	201 interviews	310 interviews

f. Random Record Review Protocol

Objective: The general objective of this random record review is to evaluate the **completeness** of record keeping with regard to screening for gender-based violence (GBV). This protocol was designed for clinics that have a routine screening policy that requires certain providers to ask female clients a set of standardized written questions about gender-based violence. These written screening questions are referred to as the “screening tool.”

The specific objectives are:

- a) To verify how well providers are using and recording answers to the screening tool in clients' medical records.
- b) To identify parts of the clinic in which providers are having difficulty applying the screening tool or documenting the results.

Conceptual Framework:

Documenting information is a key component of GBV screening. The key question is, when the client returns for a follow-up visit, will the provider be able to determine from the client's file whether or not she was screened? And from the records, will the provider be able to determine what the results of the screening were?

It is important to note that the process of documenting screening consists of two parts: (a) in each clinic there are GBV screening policies and a protocol or system for documenting the screening process; and (b) in each clinic there is a certain proportion of providers who follow the policies at least some of the time.

If both parts work properly, then the documentation of GBV screening will be relatively complete. If either of these two parts does not work properly, it is possible that there will not be complete documentation.

What do we mean by "complete"? The definition of complete documentation will depend on the policies of the clinic. However, at a minimum it should include the following:

- a) The written screening questions are stamped or printed on the clinical history or on a separate sheet of paper (unless the clinic uses another system).
- b) An answer is recorded for each of the questions in the screening tool regarding violence.
- c) If the client answered yes to any of the screening questions, then:
 - i) the record should indicate that the provider carried out a danger assessment.
 - ii) there should be some details recorded regarding the case.
 - iii) there should be information about whether or not a referral was (or was not) made.

Documentation of GBV screening data can be done in several places, including:

- a) The clinical history form
- b) A separate sheet kept in the client's medical file
- c) Some other place, such as a notebook or separate registry dedicated to information about gender-based violence THAT IS ACCESSIBLE TO PROVIDERS AT THE TIME OF THE FOLLOW-UP VISIT.

- d) Some other place that IS NOT ACCESSIBLE TO PROVIDERS AT THE TIME OF THE FOLLOW-UP VISIT.

Sample selection criteria:

To collect these data, a group of records that meet certain criteria have to be selected. For the GBV initiative, IPPF/WHR used the following criteria to select medical records to review.

The records had to meet the following criteria:

- a) They belonged to NEW clients of sexual and reproductive health services. (This criteria allowed us to ensure that the clients were eligible for screening according to the policies of each participating clinic.)
- b) They belonged to clients who received these services during two selected months that were six months apart.

Sample size:

[**Note:** The CDC (Centers for Disease Control and Prevention) has developed a methodology to randomly review vaccination records. We followed the CDC's recommendations to adapt the methodology, including the size of the sample.]

The following is the minimum sample size; it is acceptable for associations to use a larger sample size if they wish.

INPPARES:	Patres: 50 Youth (optional): 30 Los Olivos: 30 Comas: 30 San Juan de Lurigancho: 30 Ate Vitarte: 30
Profamilia:	Rosa Cisneros: 50 Evangelina Rodríguez: 50
PLAFAM	Headquarters: 50 Petare: 50

Procedure for selecting a random sample to prevent bias:

1. First, prepare a list of all the records of new SRH clients who visited the clinic during the chosen time period (N).
2. Calculate a sampling interval (SI) by dividing the total number of records (N) by the desired number of records in the sample (n): $SI = N/n$.
3. Choose a random starting number (RS). The random starting number is any number between 1 and the SI. It can be chosen using any random number selection procedure, for example, choosing from the serial numbers on a bill (peso, sol, dollar, etc.).
4. The RS determines the first record to be picked. Continue adding the SI to obtain the next record number until the list of records has been exhausted.

Data collection

The data collection sheets are attached. They include four general questions about the information system in the clinic. Then, they include a tabulation sheet for collecting the data from the record review. This data sheet was developed for the specific screening tool used by the participating clinics in the IPPF/WHO GBV initiative. Other organizations would need to adapt this form depending on the specific screening questions that they use.

1	Record Number	Number used by the clinic to identify the SRH client's record (archive/file).
2	Type of service (Optional)	This depends on the needs of the clinic and the association. All clients must be clients of eligible services, but in some cases the association might wish to distinguish between different types of services.
3	Provider (Optional)	This depends on the needs of the clinic and the association. This could be the last name of the provider.
4	Screening tool (or stamp) included?	Mark YES if the tool or stamp is in the appropriate place according to clinic policy. For clinics that include the screening questions in the clinical history form, the answer to this question will always be YES.
5	Questions asked?	If there is an indication in the record that any of the screening questions were asked, then check YES and continue with the review. If there is no indication that the questions were asked, check NO and end the review.
6	Answers recorded?	To answer "YES, all" you must verify that there is an answer to each and every one of the questions in the screening tool (e.g. psychological, physical and sexual violence and abuse during childhood). If one or some answers are recorded but not all, then mark "Yes, but not all". If none of the answer is provided, mark "No" and continue onto the next item 7.
7	Which answers are complete or incomplete?	If an answer to a question is missing, check "I" (incomplete) in the box that corresponds to that question. For each question that has an answer, check "C" (complete).
8	Any affirmative answer?	If at least one answer is affirmative for any type of violence, check YES. If all the answers were negative (or left blank), mark NO and end the review.
9	Danger assessment?	Only if there was an affirmative answer: If there is documentation that a danger assessment was done, check YES. If there is not written indication that a danger assessment was done, then mark NO.
10	Details about the case?	Only if there was an affirmative answer: In this column, check whether or not there is some detail in the record about the case.
11	Was any referral made?	Only if there was an affirmative answer: In this column, indicate whether or not there is documentation that a referral was done (it can be any type: external, internal, etc.)
12	Other notes	Space for other pertinent information.

DATA COLLECTION SHEET:

Name of the Association: _____

Name of the Clinic: _____

Monitoring Dates: _____

Reviewed by: _____

Information Systems:

1) How are the screening questions incorporated into clients' medical records?

- ☐ 1. They are printed directly on the clinical history form.
- ☐ 2. They are stamped on the clinical history form.
- ☐ 3. They are printed or stamped on a separate sheet.
- ☐ 4. There is another system. Please specify: _____
- ☐ 5. There are no written screening questions included in the medical records.

2) Where are the answers to the screening questions recorded?

- ☐ 1. Directly on the clinical history form.
- ☐ 2. On a separate sheet of paper placed in the medical file along with the clinical history.
- ☐ 3. In a separate file or registry.
- ☐ 4. Elsewhere. Please specify: _____

2.a) Are the answers to previously asked screening questions accessible to the provider at the time of a follow-up visit to the clinic?

- ☐ 1. Yes
- ☐ 2. No

3. Where are referrals to other services recorded?

- ☐ 1. Directly on the clinical history form.
- ☐ 2. On a separate sheet of paper placed in the medical file, along with the clinical history.
- ☐ 3. In a separate file or registry.
- ☐ 4. Elsewhere. Please specify: _____

4. How are records from different services stored? For example:

- ☐ 1. Medical records are kept in the same file as records for services such as emotional support, psychological services and /or legal services.
- ☐ 2. Separate records kept for services such as medical care, emotional support, psychological services and legal services, but a summary of these other records are added to the medical record,
- ☐ 3. Separate records are kept for emotional support, psychological services and legal services, and there is usually no information in the medical clinical history form about these other services.

Name of the Clinic: _____

Date of records: (MM/YY):

[illegible]

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A Resource Manual for Health Care Professionals in Developing Countries



 **IPPF** International
Planned Parenthood
Federation
Western Hemisphere Region

International Planned Parenthood Federation,
Western Hemisphere Region
120 Wall Street, 9th Floor, New York, NY 10005
Tel: (212) 248-6400 Fax: (212) 248-4221
info@ippfwhr.org
www.ippfwhr.org