

Multi-sectoral response to GBV

An effective and coordinated way
to protect and empower GBV victims/survivors



2015

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Published by the UNFPA Regional Office for Eastern Europe and Central Asia (UNFPA EECARO), 2015.

The views expressed in this publication are those of the authors, and do not necessarily represent the views of UNFPA, the United Nations or any of its affiliated organizations.

Design & printing: Image Studio s.r.l.

ISBN 978-973-87875-3-7

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What this document is

The challenges raised by the gender-based violence (GBV) phenomenon are insurmountable through isolated approaches, when different actors act alone and not connected to the others. The special need of the response to GBV have already established concepts, principles and norms that stipulates cooperative behaviours and attitudes which integrate and organize the specific actions in an solution generating framework which is intended to be an exhaustive one.

This document explores the concept of multi-sectoral response to GBV with the aim to support the inter-institutional and multi-disciplinary intervention and referral actions by establishing a common methodological framework for the relevant actors, especially for professionals who work directly with GBV victims/survivors. Not limited to this, the document represents a guide for policy makers, stakeholders and service providers in developing or strengthening the existing programmes or initiatives that address GBV.

This document is complementary to standards, procedures and guidelines that are in place which regulates the activities that address GBV and effective coordination mechanisms.

What this document is not

The document does not provide comprehensive, detailed technical information for multi-sectoral response to GBV. The key sectors' specific operational procedures are additionally developed and presented as part of the package. Finally, this document does not cover the specific needs/actions for addressing GBV within the context of conflict, post-conflict, emergencies, disasters, and humanitarian situations due to them.

What is the multi-sectoral response to GBV

The traditional model of addressing GBV deals with isolated providers (multiple uncoordinated entry points for GBV victims/survivors), allocating a set of uncomprehensive services, unable to meet the complex needs of the GBV victims/survivors. At systemic level, the absence of an integrated approach deals with a width range of problems which cumber the intervention and impermissibly distort the accuracy of statistics regarding the GBV phenomenon. There are differences between procedures of different institutions for identification, registration and reporting of a GBV cases.

The disadvantages of uncoordinated response to GBV are:

- victim/survivor deprivation of integrated social support and information;
- tangle situation for the victim/survivor and delays in offering of concrete intervention/support;
- multiple and repeated visits of victim/survivor to service providers, "following" an unclear inter-institutional itinerary;
- usage of various terms and definitions of GBV;
- collection of different data/indicators about GBV cases;
- usage of different rules of recording, counting, transmission and aggregation of data.

A multi-sectoral response to GBV represents a holistic and coordinated approach aimed at harmonizing and correlating programmes and actions developed and implemented by a variety of institutions (but not limited to these) in the areas of psychosocial welfare, law enforcement (police, prosecutors and justice departments) and health. A multi-sectoral response to GBV is based on inter-institutional partnership and cooperation, requires a common philosophy for addressing GBV and follows the principles and standards determined by the partners involved.

Why a multi-sectoral response to GBV

A multi-sectoral response to GBV leads to increased level safety and support for GBV victims/survivors through an effective, immediate and consistent services network.

A coordinated activity between relevant institutions/organizations improves the quality of services provided to GBV victims/survivors by facilitating the access to training programmes of multi-sectoral team members. A network of well-trained service providers, with necessary skills and adequate behaviours, will offer a sensitive and efficient support adapted to victim/survivor's needs and will reduce the risk of re-victimisation.

A network of effective and qualitative services will increase the trust of victims/survivors in the capabilities of and the addressability to mandated institutions/organizations.

The multi-sectoral response to GBV brings durable and sustainable changes and help to create an institutional and community culture that GBV is not acceptable and tolerable.

Council of Europe Convention on preventing and combating violence against women and domestic violence (called the Istanbul Convention), adopted in 11 May 2011, entered into force in 1 August 2014 (in EECA the Convention was ratified by Albania, the Former Yugoslav Republic of Macedonia, Serbia and Turkey; and signed by Georgia, Romania and Ukraine). The Istanbul Convention is the first legally binding instrument in Europe to create a comprehensive legal framework to protect women from acts of violence as well as prevent, prosecute and eliminate all forms of violence against women. The Istanbul Convention focuses on four major themes: prevention, protection, prosecution, and monitoring. It defines different forms of violence against women (VAW), including forced marriage, female genital mutilation, violence, and stalking, sexual violence, and also establishes a specific monitoring mechanism in order to ensure effective implementation of its provisions by the Parties. The Article 18 make references to appropriate mechanisms to provide for effective co-operation between all relevant state agencies, including the judiciary, public prosecutors, law enforcement agencies, local and regional authorities as well as non-governmental organisations and other relevant organisations and entities, in protecting and supporting victims/survivors and witnesses of all forms of violence covered by the scope of the Convention.

Objectives of multi-sectoral response to GBV

The multi-sectoral intervention and referral represents a comprehensive response to GBV and have the following objectives:

1. Ensure and facilitate the access to support services for GBV victims/survivors.
2. Integrate and mainstream intervention throughout all programmes by using agreed inter-institutional working rules and tools.
3. Ensure accountability at all levels and all involved institutions.
4. Ensure coordinated actions for addressing to and prevention of GBV.
5. Ensure more accurate data regarding the GBV cases and the intervention and referral history.

Guiding principles of multi-sectoral response to GBV

The generic model is developed based on the principles that ensure protection of victim/survivors' rights and multi-sectoral case management coordination.

The following set of principles represent the foundation on which was built the present model.

- 1. Victim/survivor-centred approach.** All service providers engaged in multi-sectoral response to GBV prioritize the rights, needs and wishes of victim/survivor.
- 2. Partnership.** The multi-sectoral response to GBV implies good cooperation and coordination of involved institutions/organizations.
- 3. Participative management.** The rules regarding the multi-sectoral intervention and referral, the strategies and action plans, including planning, implementing, monitoring and evaluating programmes should be done in a participatory manner, including the input of beneficiaries (if applicable).
- 4. Strategic planning.** The policies that address GBV phenomenon should be translated in inter-institutional common strategies, with specific objectives and activities.
- 5. Integrated services.** The procedures for intervention and referral as well as the protection measures require a multi-disciplinary approach based on unified work methodology.
- 6. Prevention.** An effective integrated approach sets as a priority also the prevention of GBV.
- 7. Accountability.** All interventions/organizations have to ensure the accountability (and measures of it) for staff to implement and respect the agreed programs/rules and to follow these guiding principles in their work.
- 8. Sustainability.** Despite the political changes or staff turnover/demotivation, once the multi-sectoral response to GBV is assumed, the institutions/organizations should ensure all conditions to implement and sustain this approach.

The institutions/organizations that convene to be part of a multi-sectoral mechanism to address GBV have to adhere, without exception, to a set of principles that represent the foundation for their interventions/assistance, referral, attitudes, and behaviour in addressing GBV.

Usually, the institution/organization who leads coordination of multi-sectoral response to GBV is responsible for principles agreement and must therefore ensure that all institutions/organization follows them. The personal biases or attitudes of involved institutions/organizations must not affect these guiding principles.

Functions of multi-sectoral response to GBV

Understanding and elaborating efficient solutions for decreasing a complex phenomenon like GBV requests a systematic approach. This requires the commitments of institutions involved in managing this phenomenon and the persons involved to constitute an open system. In order to achieve this, the institutions mandated to respond to GBV have to be in a dynamic interaction with the phenomenon and with the other institutions which are part of the system.

Addressing GBV effectively is not possible in a closed system, a system in which the institutions involved develop programs and offer services without interacting with other service providers and being connected to them, without knowing the complex data of the problem and without having a clear image of the result of the activities undertaken (feedback). Such a working style will not facilitate the evaluation of effectiveness of provided services. As a result, the evaluation of GBV case might be wrong and the correcting interventions might be inadequate.

An effective GBV integrated approach should include both prevention and response strategies. Prevention consists of reducing or eliminating the root causes of GBV and the situation-specific factors that contribute to, perpetuate, or increase the risk of GBV. Response activities target the consequences or outcomes of incidents of GBV.

The multi-sectoral response to GBV may be a formal mechanism or not, implemented at country or local level. Synonyms may include "integrated approach", "multi-sectoral", "multi-disciplinary", "inter-sectoral", "inter-institutional". It is not limited to multi-sectoral coordination mechanism or referral of GBV cases, to which is often confounded.

An effective multi-sectoral response to GBV requires more than a sign partnership and communication between involved institutions. It is a complex mechanism of intervention and collaboration with a clear methodology that gives a unitary framework for all actors, which can be built by implementing the following 6 functions:

1. Intervention/services.
2. Reporting and referral system.
3. Training programmes.
4. Documentation, reporting, transmitting and data analysis systems.
5. Prevention and awareness raising activities.
6. Coordination.

1. Intervention/services

The multi-sectoral intervention to GBV implies an assemblage of comprehensive services for GBV victims/survivors that reduce the effects and consequences of harmful experiences, and prevent further trauma, including re-victimisation. Also, offer the chance to identify the immediate needs of GBV victims/survivors, and to develop, implement and monitor the individualized intervention plan, according to identified needs and available resources. All intervention actions must be victim/survivor's needs focused, implemented in a multi-sectoral and holistic manner, adaptable, and sustainable.

Because in most of the cases GBV remains undisclosed, one of the advantages of the multi-sectoral response to GBV is that it can influence the victim/survivor's opinion about the effectiveness and appropriateness of available services, and can change public policies related to service delivery, in the community benefit.

However, help cannot be given until an incident has been reported and the victim/survivor has requested assistance. Response, therefore, begins with establishing assistance services and building confidence amongst community members that appropriate and compassionate care and support are available.

Procedures

The multi-sectoral intervention and referral on GBV actions aims to protect the victim/survivor; to support and protect other family members, especially the witnesses (where is the case); and to make accountable the perpetrator.

The services provided to GBV victims/survivors are based on the principles of safety, privacy, confidentiality, informed choice, respect and non-discrimination.

Any intervention must prioritize the **safety** of GBV victims/survivors and their children as the highest concern. This means first, that service providers need to refrain from any action, even well-intentioned, that might put victims/survivors at risk of experiencing further violence. A safe and caring environment will be ensured. When is possible or needed, accompany the victims/survivors to other services. Additionally, service providers should help GBV victims/survivors in assessing potential safety risks and developing a safety plan.

Conditions should be created to ensure **privacy** for people who have experienced GBV. Only professionals involved in case management should be present during the intervention steps, except the situation when could be a person accompanying the victim/survivor at her/his request.

The victims/survivors should be convinced about the strict **confidentiality** before they are willing to access services. The blame, shame and social stigma which often accompany GBV, especially in small communities, underline the hidden nature of the situation and the need of building a sense of trust in the services that are confidential. Service providers should discuss about GBV cases with other providers when strictly necessary. All written information about GBV victims/survivors must be maintained in secure, locked files.

Service providers should not share any information regarding a GBV case without victim/survivor's **informed consent** (the legal limitations or mandatory reporting should be addressed). If agreed or requested, obtain the informed consent prior referring to other GBV specialized services. Share only pertinent and relevant information with others for the purpose of helping the victim/survivor.

Respect the wishes, choices, rights, and dignity of the victim/survivor. Service providers should address the basic need and wishes of the victim/survivor prior any interview or examination. Being respectful with a GBV victim/survivor implies a non-judgmental manner of interaction. The interaction with the GBV victims/survivors should take place in private rooms or settings. In case of female victims/survivors and children, the interaction with female professionals is advisable.

In all interactions with GBV victims/survivor and in all services, the **non-discrimination** should be ensured (on any grounds, including race, sex, colour, nationality, ethnicity or social origin). For example, providers should not deny or limit the type or extent of provided services to GBV victims/survivors belonging to a particular ethnic group.

The immediate needs are assessed and, linked to these, clear and correct information about possible ways of actions and available services are provided.

Specific services for which the victim/survivor could address the institution are provided.

Service providers should inform the victim/survivor about the assistance they offer and clearly relate what cannot be provided, to avoid creating false expectations.

The GBV intervention consists in a case management process which involves four steps, undertaken in the limits of legal and ethical framework of each country. It is important to note that the GBV case management is not linear or one-way process. The case assessment or intervention plan evaluation can occur/be repeated in any moment of the process.

- 1. Identification.** First step in responding to GBV is to recognize/identify the victim/survivor and the reasons to initiate the intervention. This can be done by facilitating the self-disclosure as a GBV victim/survivor, or by finding out due to referral or reporting (mandatory or not). The victim/survivor's autonomy and confidentiality are subsequent to victim/survivor's security.
- 2. Evaluation.** A correct and complete evaluation of the potential/existing risk factors, needs and resources is necessary, to understand the social, familial and individual context that affect the victim/survivor's situation. Types of violence, relations with family members, social integration in the community of the victim/survivor, victim/survivor's mechanism of understanding and problem solving, economic implications, all have to be evaluated. This step have to include obtaining informed consent for case management services if appropriate or for referral to other service providers.
- 3. Service provision/Intervention.** The intervention plan will be developed tailored on the expectations and changes needed or desired in order to protect the GBV victim/survivor or for making the perpetrator accountable. It contains the outcomes, plan of actions, methods and timeline, and also determines the type of services and resources needed in order to address the established goals or desired outcomes. This is the moment when needed referral are planned. The implementation and coordination of intervention plan (the service provision itself) consists in translating the intervention plan in actions. In a multi-sectoral manner of the case management, different service providers could implement part of the intervention plan actions and one service provider, designated to be the case manager, will do the coordination of the intervention plan and the implementation of actions. The coordination function consists in a deliberate organization/coordination of victim/survivor's support services delivered by two or more service providers (with the victim/survivor involvement in the decision making process) to facilitate the access to appropriate and effective services. Coordinating the delivery of support services will facilitate judicious involvement of professionals and use of other resources needed to carry out all required intervention actions. This can be ensured through regular exchange of information among service providers involved in intervention plan implementation.
- 4. Follow-up and closure.** The outcomes status is evaluated and intervention plan adjustments are made if needed. The intervention ends either when the best possible outcome has been attained, or the needs/desires of the victim/survivor changed.

Whenever to which institutions the victim/survivor addresses, there is a minimal intervention package to be undertaken in order to ensure victim/survivor's safety. The minimal intervention package should be followed either when the institution's mandate to address GBV is limited or when the victim/survivor's choice is limiting the intervention. The service providers should keep in mind that if the victim/survivor discloses a GBV incident and there is no service available or at least a minimal support is not provided in a timely, compassionate and confidential manner, the trust in the service provider could be lost and this will prevent the victim/survivor to disclose the situation once more to someone else.

Roles and responsibilities of service providers

This section presents briefly the roles of key sectors which provide services to GBV victims/survivors. Clarifying the responsibilities will provide a better understanding of mandates and limits of institutions and service providers and also will serve as a base for developing an effective referral system.

The key s that can play a crucial role in multi-sectoral intervention and referral to GBV are health care services, psycho-social services, and law enforcement institutions which include police and justice.

In a multi-sectoral response to GBV, service providers will intervene following the procedures described above and will provide services specific to each institution/organization. Regardless the type, all services should be victim/survivor's needs focused, offered in a multi-sectoral and holistic approach, adaptable to the victim/survivor's needs and available resources, and in a sustainable manner.

Each service provider should have specific detailed intervention protocols and standard operating procedures (SOPs) that outline the roles and responsibilities in prevention of and response to GBV. The development of SOPs for intervention and referral is a process which should involve consultations with key stakeholders and service providers who will implement them. SOPs are important in the development and implementation of a response programme because they set the guiding principles, ethical standards, and coordinated multi-sectoral service provision.

All institutions/organizations engaged in multi-sectoral response to GBV should follow the agreed guiding principles and should ensure adequate resources to provide appropriate services to any victim/survivor. Considering this, capacity building of service providers is an essential component of an effective programme that addresses GBV.

Health care services

The health intervention could be necessary in acute phase, when a victim/survivor could address to emergency units for immediate health care, or could manage the health consequences of GBV.

A comprehensive medical service provision to GBV victims/survivors includes the following:

- First-line support
- Medical history and examination
- Clinical care of injuries and urgent medical issues
- Psychological/mental health assessment and management
- Collecting evidence
- Risk assessment and management

The following list summarizes key elements of the role of health care staff in responding to GBV.

- Understand the signs and symptoms of GBV. Some behaviours may be indicators of exposure to GBV.
- Ask questions about GBV in case of clinical symptoms that indicate possible experience of GBV (screen patients for GBV). A number of minimum requirements should be in place when asking about GBV: an intervention guideline, skilled and trained health care providers on how to interact with GBV victims/survivors, ensured confidentiality and victim/survivor's safety and privacy, a system for referral.
- Decide on the next steps to be followed (evaluation, service provision, collection of evidence, documenting GBV and referral), according to the resources, skills and mandate.
- Provide the patient with information on GBV and its consequences on health.
- Create a friendly and confidential environment, listen to the patient and give her validating messages.
- Obtain consent for services that will be provided. An informed consent should be signed by the adult victim/survivor or by the parent or caregiver for children or person with limited discernment.
- Specify if there is any legal mandatory reporting of other institutions of a GBV incident/case.
- Collect the patient's medical history and undertake a medical examination.
- According to legislation and regulations, collect evidence following the protocols, after explaining the purpose of the manoeuvre and obtain consent.
- Provide appropriate medical care. Besides investigating and treating the health conditions for which the victim/survivor addressed the health facility, treatment of injuries in case of physical violence or medications for the pain relief, anxiety or insomnia should be provided. In case of sexual violence, the health care provider should provide prophylactic treatment for sexually-transmitted infections; investigate for ongoing pregnancy and prevent unwanted pregnancy by offering or prescribing emergency contraception; reduce

the risk of contracting HIV by administering post-exposure prophylaxis; and inoculate for Hepatitis B and tetanus.

- Respond to the immediate psychological needs of GBV victim/survivor.
- Document the health evidence on GBV consequences.
- Provide the patient with information about the possibility to be referred to other service providers, as requested and/or needed (such as specialized medical, women's shelter, crisis centre).
- Make referral according to the victim/survivor's choice.
- Assist the patient in safety planning.
- Plan and provide follow-up medical care, as required.

Psycho-social services

All service providers who have direct contact with GBV victims/survivors should be aware about the guiding principles and be able use them in practice. To listen carefully the victims/survivors and give complete and clear information is the responsibility of all service providers; at a lower level of complexity, each professional who meet a GBV victim/survivor should provide a minimal psycho-social support to GBV victims/survivors, including:

- provision of safety measurement for the victim/survivor
- active listening of the victim/survivor and, for initial evaluation, relevant and non-judgmental questions could be asked. The communication limits imposed by the victim/survivor should be respected.
- provide basic emotional support to the victim/survivor, in an comfortable and confidential place
- remind the victim/survivor that is not her/his fault, the entire responsibility for GBV acts is to the perpetrator
- offer clear and complete information about available services that can be accessed
- draw a minimal safety plan, especially when the victim/survivor is not prepared to take any action to stop GBV or to cope with GBV trauma
- help the victim/survivor to make informed decisions, without telling what to do or where to go.

The psycho-social providers are acting usually as case managers, coordinating all service delivery by all service providers. The main objective of the psycho-social services is to help victim/survivor to regain self-esteem and the control of their one life.

A brief description of psycho-social support refers to victim/survivor's empowerment to keep them safe, to develop intervention plan based on needs assessment, to implement and coordinate the intervention plan, to refer and accompany the victim/survivor to other service providers, to provide follow-up to evaluate if the intervention plan objectives are meet.

The key elements of psycho-social services are:

- Crisis counselling
- Safe accommodation
- Long-term psycho-social support and counselling
- Other support services
- Risk assessment and management

One important component of psycho-social support is security/safety provision. Offering interim alternative accommodation, pending long term solutions, providing financial support and transport to the safe location whenever possible are the actions to be taken for ensuring the victim/survivor's security. The assessment of risks and ongoing monitoring of protection measurement are integrative part of the safety provision. Special attention should be paid to security of victims/survivors of trafficking, cases in which the traffickers may seek where the victim/survivor is, situation that can put the victim/survivor in a major danger.

The success of response to GBV is a long-term effort and service providers may evaluate this success from a different perspective. What is important to remember is that each step in helping the victim/survivor to end the GBV situation and cope with trauma is a success in itself.

The service providers who offer support to GBV victims/survivors on a daily basis must protect themselves by the psychological and emotional impact of their work. For this purpose, the service providers should undertake a supervision process, which consists in usage of the services of another counsellor to review the work with victims/survivors, the professional development, and often the personal development as well. Moreover, service providers may need to confront during supervision issues of abuse that they are struggling with personally. The supervisor acts as a consultant, not as a “boss”.

Law enforcement

Law enforcement institutions are responsible to investigate and prosecute GBV cases that constitute offences under the national laws.

Police is often the first law enforcement institution where GBV victim/survivor disclose their situation. The way in which police officers responds to GBV situation and address victim/survivor’s needs can have a significant impact on further actions undertaken by the victim/survivor. Adequate methods for interviewing a GBV victim/survivor may facilitate better elicit the details of what happened. Interviewing GBV perpetrators requires police officers knowledge about the responsibility of violent actions, and ability to anticipate the reaction of perpetrator during investigation.

Investigation and evidence collection is critical in GBV cases. Due to the fact that most of the GBV forms happens behind closed doors and rarely reported, the victim/survivor’s testimony is sometimes the only evidence of violent behaviour. A correct and complete investigation can provide additional evidence for prosecutors to support the victim/survivor’s testimony. In some countries, police or justice have the legal mandate to issue and enforce restraining or protection orders.

The interaction with the GBV victim/survivor should take place in private place and should be conducted by an officer of the same sex or as preferred by the victim/survivor. The forensic report which will constitute strong evidence should be requested in all cases when is necessary. During the investigation, the police should provide protection to victims/survivors, if necessary. When applicable, the police officer will visit the scene where the GBV took place and gather evidence. The collected evidence will be constituted in a case file which will be submitted to judicial institutions for a criminal lawsuit; in some cases, this can be done only having an official complain of the victims/survivors.

Once the case file is submitted by the police to the judicial institutions, a criminal lawsuit is initiated. Given the sensitive character of sexual violence forms, judicial response should be different from other types of violence; the hearings should take place in private places and during separate sessions. Extra protection and security measures are put in place during the hearing to ensure the safety of the victim/survivor. The judicial service providers should provide free-of-charge or low-cost counselling about all aspects of the legal process and court representation. The victim/survivor should be treated in a manner that eliminates further victimization and the confrontation with the perpetrator should be avoided.

The victim/survivor has the right to decide to initiate a civil lawsuit for different reasons: divorce, separation of assets, children custody, and compensation for damages suffered by the victim/survivor as a result of GBV (e.g. re-victimisation by professionals by treating victims/survivors in an insensitive or hurtful manner).

2. Reporting and referral

Reporting

A victim/survivor has the right to choose not to report the GBV case to another service provider; this choice should be respected and the victim/survivor should still be supported in any way possible. The exceptions from this rule are when the victim/survivor is a person under the age of legal consent or without discernment capacity OR if there is an evident and immediate safety and security risk for the victim/survivor OR when reporting is mandatory.

If a victim/survivor does not want to inform someone about the incident, adequate support cannot be provided.

In some countries, the legislation obliges individuals or service providers to report (usually to the police or legal system) any disclosed GBV incident or suspicions. Mandatory reporting applies primarily to child abuse and maltreatment of minors, but there are countries where it has been extended to the reporting of intimate partner violence as well. Still, it is not recommended that providers be required to report GBV cases to the police.

When mandatory reporting laws and/or policies exist and certain individuals or service providers are required to report GBV cases, those requirements can create a conflict with the guiding principles - respect for confidentiality and respect for autonomy of the victim/survivor. In this situation, the service provider must obtain and understand all information about the mandatory reporting requirements, including reporting mechanisms and investigation procedures. The victim/survivor should be informed about the mandatory reporting of certain GBV incidents in accordance to laws and what can happen after reporting. Even if the reporting procedure is mandatory, it should ensure the safety, dignity, and comfort of the victim/survivor.

Referral

Referral system's goal is to address the immediate and multiple needs of the victim/survivor in a manner that will ensure the safest and most effective way of reporting and in accordance with victim/survivor's preferences for care and treatment. Also, referral is about a coordinated approach to service delivery.

In addition, it is very important that the victim/survivor is able to access various entry points for care according to her own wishes/needs; in establishing a referral system there should not be a designated first point of contact from which the referral system proceeds. All service providers should be aware of the system and able to activate referrals whether or not they are the first point of contact for a victim/survivor. A referral system can function effectively if information/details about institutions/organizations, specific service providers (professionals) and contact details are systematized and shared between all relevant institutions.

If the victim/survivor wants to access other support service or to undertake any legal process, every time a risk of GBV is detected or a GBV case is identified, service providers should ensure that all appropriate support services are available and accessible.

A clear referral procedure should be established from the first stage of development of multi-sectoral response to GBV, so the victim can receive assistance in a timely manner. Clear referral procedures between services facilitate multi-sectoral response to GBV, and better meet victim's needs and wishes.

There are two types of entry points which need to refer a GBV victim/survivor: entry points which provide specific intervention and entry points which are not mandated/trained/skilled to provide specific intervention. Regardless of the mandate/capacity, all entry points should observe the same standard 5 steps of referral:

- 1. Information.** The victim/survivor should be informed about possible referrals for services.
- 2. Agreement and informed consent.** Prior any other step of referral victim/survivor's agreement should be obtained, as well as the informed consent for information sharing should be undertaken. The victim/survivor has the right to choose to which service will be referred and to ask for limitations on the shared information.
- 3. Complete information and decision.** The referral itself will be made according to the victim/survivor's choice and should be preceded by complete and correct information about service providers, following the 3W scheme described below:

WHO – which institution/organization provide services to GBV victims/survivors, adding contact information of a person (name, telephone number) that can be reached as an entry point to that service

WHAT – what sort of assistance they can expect to receive from a specific service provider, adding cost information related to that service

WHERE – where exactly is the place (the exact address) of the indicated services
- 4. Referral itself.** The referral should be accompanied by a short written report and a telephone discussion with the other service provider, as a method for avoiding the situation when the victim/survivor has to repeat the story and answering the same questions during multiple interviews, passing again through the psychological trauma caused by the GBV incident. At this stage is important to encourage the autonomy, empowering the victim/survivor to do the referral by itself.
- 5. Accompany the victim/survivor** to the referred service provider, if needed and possible.

3. Training programmes

Training programmes for all service providers, from all sectors, at all levels is essential to improve the systemization and functioning of GBV-related services network; capacity building of institutions/organizations to develop and implement programmes that address GBV, including specialized services; and develop a culture of partnership and social solidarity, and accountability of service providers towards GBV.

The training programmes addressing multi-disciplinary teams should cover GBV in theory and legal framework, as well as the practical aspects of intervention and referral of GBV cases, multi-sectoral response to GBV and the role, tasks and responsibilities of various institutions and organizations in addressing GBV.

High-quality training programmes should be available for all institutions/organizations part of multi-sectoral response to GBV. The training should be provided to police workers, social workers, psychologists, legal counsellors, health care providers, forensics, and any other relevant service providers.

Even if we are talking about university curriculum, post-graduate education or continuous professional education, the training should not only provided information about GBV, but give participants the opportunity to explore their own attitudes and to develop the skills necessary to communicate with and respond to the needs of victims/survivors. For this purpose, the training programme should provide an adequate explanation and understanding of GBV and the link with gender perspective, the complexity of phenomenon, and the dynamics of the relation between victim/survivor and perpetrator.

It is necessary for trained service providers to learn and use an unique definition of GBV, to know the importance of intentionality aspect of GBV, to recognize all types of GBV, to assess the risk of victimization, to know patterns and dynamics of GBV, to develop/strengthen the communication skills and empathy, to learn the principles of intervention and how to develop a safety plan.

Continuous training for service providers represents a quality standard in response to GBV. Training programmes is an investment in human resources with direct impact on the quality of intervention.

4. Documentation, reporting, transmitting and data analysis

Each GBV case should be documented by all service providers to which the case was reported; the documentation provides at least a comprehensive summary of the most relevant information about an individual GBV incident, if not the case history. The documentation of a GBV case could be made using standardized forms, hand notes, charts, photos, paper registries, etc. Collecting relevant data about each GBV case and gathering them in a data base will a) generate data for monitoring and evaluating GBV cases progress, b) offer a clear view on the disclosed cases in a specific area, and c) help to evaluate the functioning of multi-sectoral response to GBV.

The objective of the documentation and data analysis is to generate data for making decisions at different levels (institution/organization, local, country) in order to:

- support the operational functioning of response to GBV at all levels
- monitor and control the functioning of response to GBV at different levels
- plan the activity

GBV incident: an event with clear time limits and space, involving different GBV forms.

GBV case: an individual who can be during her/his lifetime a victim of one or multiple GBV incidents that were reported/disclosed to one or multiple institutions/organizations. In terms of time variable, new cases, former cases or inactive cases could be included in a documentation system.

If an agreed common set of indicators is enclosed in each institution/organization form, as a means of collecting consistent data in all services that respond to GBV, this could enable comparison of GBV data across programs, services, and institutions/organizations. The common set should include indicators that provide information regarding the extent of the phenomenon, helps to avoid duplications when counting the cases, and, if possible, are already collected routinely. Some common indicators could be (but not necessarily all of them and not limited to them): type of violence, type of services provided, who made the referral, legal steps initiated or undertaken, relation between victim/survivor and perpetrator, victim/survivor's and perpetrator's profile, space where violence took place (home, workplace, public space, other).

It must be mentioned that the documentation/information sharing system is not a research study performed at a certain moment in time, but a modality to continuously get data referring to GBV in a systematic and dynamic manner, starting from the institutions that receive and record the GBV events or cases, to those that aggregate them at the local level and centralize them at country level. Such a system is the only way in which local or country level institutions that play a role in addressing GBV can report and have access at any moment in time to a real and up-to-date situation of the phenomenon.

The monitoring and evaluation in this context of GBV cases is different by the monitoring and evaluation of the progress of agreed strategies among institutions/organizations involves in multi-sectoral to GBV.

The monitoring report should include quantitative data about reported GBV incidents and/or case collected by using the agreed set of indicators, as well as qualitative data gathered by service providers involved in multi-sectoral

response to GBV. The report should identify problems in functioning of the multi-sectoral response to GBV and the actions to be undertaken to address these issues.

Principles of data collection

In order to get correct and useful information, data collection and function of a system for information management should follow certain principles:

Principles of ethical and safe data collection

The benefits for the GBV victims/survivors that offer information must be greater than the risks. Data collection and documentation must be done in a manner that do not re-victimize and presents the least risk to persons. Basic care and support for GBV victims/survivors must be offered before initiating any further step that may involve information disclosure about a GBV experience/incident. Prior any data collection an informed consent should be obtained from the GBV victim/survivor. The professionals involved in data collection must receive relevant and sufficient training in gathering information about GBV incidents/cases and ongoing support.

Principle of confidentiality of personal data

Personal data collected from GBV victims/survivors should not be transmitted openly, including for the purpose of statistical data generation. Regardless the purpose of the transmission of data (when reporting a case/incident to another service provider or for statistic purpose), the set of information/indicators should be agreed with the GBV victim/survivor and will be limited to relevant and/or mandatory reported information. Security measures should be followed in order to protect the identity of GBV victims/survivors. If a software is used, personal data should be encrypted as a code before being exported from the institution where are collected to centralizing institution.

Principle of avoiding repetition/duplication of the events/cases

A system for information management should recognize the events/cases recorded at different time (and at different institutions) and should generate gathered information/reports without counting the same incident/case several times. A unique code attributed to a person (such as personal identification number) could be used to identify an individual and when the system identifies the unique code should links the information offered by all service providers and gather information as a unique case.

Pyramid principle

A larger amount of basic/primary data could be collected by each service provider but smaller amount of aggregated data should be gathered at an upper level for decision-making process.

Indicators

The indicators represent the numerical expression that characterizes from a quantitative point of view the primary information collected by filling the forms used by different service providers.

There are two types of indicators that could be collected by the service providers:

- Indicators specific to the service provider (indicators contained by the specific forms of each institution). These indicators offer information necessary to that particular service provider.
- A common set of indicators agreed and collected by all service providers. These indicators may offer a real view (without duplicating the same case) of the phenomenon.

Currently, each service provider decide what information they collect from GBV victims/survivors and may use what definitions decides. As a result, the format, content and quality of the resulting GBV data varies dramatically from one service provider to another and one indicator names the same at two institutions may represent different

things. Compiling data from different service providers and then analysing that data may be extremely difficult in these circumstances.

For this reason, forms for gathering information elements and instructions on how to fill them in should be developed and a standard set of meaningful GBV indicators and standardized definitions (common glossary of terms) should be adopted across all service providers in order to reduce variation in how data is collected. There may be different types of indicators/information that could be collected or introduced in the forms, related to:

- Administrative information: which institution/service referred the victim/survivor, way of referral (verbally, written, by telephone), who disclosed the incident/case (victim/survivor, perpetrator, children, relatives, neighbours, others), other institutions/services from which the victim/survivor asked for help/assistance
- Information about GBV victim/survivor: living place, sex, age, nationality, marital status, education, occupation, incomes, dependent children or elderly persons
- Details about the incident (current and past events): frequency, place where the violent incident happened, types of violence, objects used by perpetrator,
- Information about perpetrator: same as for victims/survivors plus history of mental disorders, substance consumption/abuse, criminal history
- Case management plan: risk and protection factors, type of services provided, referral to other institutions/services, safety planning

The collected data should be relevant information for monitoring and evaluation, further projects/activity development and should serve as a tool for decision-making process.

5. Prevention and awareness raising

Stopping GBV before it occurs by addressing the root causes is the aim of the prevention. The common elements that need to be addressed are power and control of a person over another person and gender inequality and discrimination.

GBV prevention aim to understand the causes and contributing factors to GBV and establish strategies to reduce or eliminate them. Prevention require longer-term planning and implementation to envisage substantive changes of the economic, social and political status of GBV victims/survivors and changes of social norms which tolerate abusive behaviours.

Awareness raising is a fundamental component of primary prevention strategies aiming at: a) changing attitudes, behaviours and beliefs that normalise and tolerate GBV among general public; b) preventing men and women from becoming GBV victims/survivors or perpetrators; and c) informing wider public and especially victims/survivors about the resources available to tackle the problem. GBV awareness raising activities attempt to focus the attention of overall community about GBV, mobilizing community-based efforts, mass media campaigns. GBV awareness raising activities have positive influence on the attitudes of victims/survivors, who may be sensitized to recognize GBV forms and consequences, change the perception towards GBV and empowered to remove themselves from violent situations. As a result, the demand for specialised services may be increased.

If the GBV is not widely recognized, the first priority should be awareness-raising. If the community and professionals are not prepared to talk about GBV, then initial efforts must focus on documenting and communicating the problem. The provision of training and services is important, but there will be no demand for intervention if people are in denial that GBV exists and could be addressed effective. Efforts to raise awareness on GBV forms and consequences must address not only victims/survivors, but perpetrators. Awareness raising messages reach easily the target population through mass-media. The mass-media products not only make aware the community but can sensitize

the public authorities to get involved in the multi-sectoral response to GBV. It is mandatory that the materials provided to mass-media do not contain any details related to victims/survivors that can lead to their identification. Also, prior initiating any awareness raising activity, must be clarified certain aspects with media about correct and effective statement of GBV, focusing on types of GBV, its consequences and available resources for victims/survivors and not on sensational aspects (including details about victims/survivors, number of cut and blows, etc.).

6. Coordination

The multi-sectoral response to GBV, as a complex system, reclaims to set-up an inter-institutional framework to cover an extensive list of primary and immediate needs of GBV victims/survivors. The needs that arise as consequences of GBV require social reactions whose legitimate and qualified promoters are governmental institutions and civil society. Therefore, any strategy that claims to develop an effective mechanism for responding to GBV should be based on inter-institutional cooperation and partnership. Implementing partnerships continues to challenge governments, private institutions and donors.

Through a participatory management style, credit and responsibility should share. The sense that every individual and partner organization had a responsibility for addressing GBV could contribute to the success of multi-sectoral response to GBV.

Partnerships are critical to the success of multi-sectoral response to GBV, because they offer a wide safety net for support and referral; public authorities must be part of the process.

Any partnership have stages of progressive engagement that are went through:

- exchanging information between interested groups
- aligning efforts on a common activity, but not sharing funds
- planning, organizing and coordinating activities together
- implementing planned activities in the framework of a formal partnership (memorandum of understanding, collaboration protocol or contract) to define the terms of collaboration, content, and funding

Success depends on a network of institutions that achieve consensus about the problem and together forge a plan to address it.

The formal partnership work well when the goal and expected results of the partnership are defined and agreed by the partner institutions together.

Spelling out in detail, and in writing, the roles, responsibilities and the obligations of each partner organization can ensure follow through. Clarifying and detailing the responsibilities of each involved institution/organization in a written partnership form ensure a clear, smooth collaboration, without unrealistic expectations.

At practical level, the partnership gathers not only the institutions/organizations that can address GBV, but also their modus operandi. To make the multi-sectoral response to GBV functional at institutional level, not based only on “personal connections” build in professional activity, it is necessary to set-up a multi-sectoral coordination body, formal coordination group for GBV activities; the members are usually representatives of the institutions that follow the mechanism for multi-sectoral coordination. This structure has to have regular meetings, on a monthly basis, and would have the objectives listed below:

- elaborate the strategies and annual action plans, common to all institutions/organizations
- propound steps for improving/strengthening the action plan for addressing GBV
- ensure good cooperation and communication between institutions/organizations
- develop and agree the mechanism of multi-sectoral response to GBV (intervention and referral procedures)
- facilitate joint participation in projects, training programmes, prevention and awareness raising activities

- identify source of funding
- monitor and evaluate the progress of agreed strategies

One of the key of multi-sectoral response to GBV coordination is information management and exchange between involved institutions/organizations. It is recommended that one partner to take the leadership, to follow the implementation of the partnerships and to ensure regular communication process (meetings, progress reports, etc.). This is a time-consuming task alongside coordination and management priorities.

The coordination body/institution should undertake the lead of monitoring and evaluation of multi-sectoral response to GBV. However, monitoring and evaluation is a genuine and continuous effort for transparency and feedback among all partners, including collaboration in monitoring progress towards objectives and documenting results. The purpose is to determine if the multi-sectoral response to GBV is following the agreed principles and intervention and referral processes; to evaluate achieved results related to the objectives, activities and resources, and; to identify required adjustments and/or modifications of strategies and action plans. Also, monitoring and evaluation may show which interventions are more effective/less effective.

The coordination body/institution may have responsibilities in fundraising or identification of fund sources for multi-sectoral response to GBV activities. Some types of funding sources are listed below:

- public (governmental) sources of funds
- external loans contracted or guaranteed by government, for which reimbursement, interests and other costs are ensured by the governmental institutions
- non-reimbursable international funds
- public budgets of local governmental institutions
- private sources

All these funding sources can be accessed through different funding mechanism (e.i. subsidies, direct allocations from public budget, projects, call for proposals, sponsorships, donations, etc).

Glossary of terms

Different terms can define a person who have had experienced the violence at least once in the life time. The proper term should be used according to the moment when the professionals meet with the person. A person harmed, injured, or killed as a result of a violent action or a person who has come to feel helpless and passive in the face of misfortune or ill-treatment can be called victim. The term is technically accurate but in the same time it contributes to a feeling of powerlessness for those who have suffered some form of GBV. The term survivor defines the person who seeks help, which has or works to develop an ability to cope with trauma, which learns how to protect self, a person which struggles to take back their life. But, ultimate, the survivor is both a victim of GBV and a survivor of GBV. Sometimes, but rarely, the term client is used to identify a person by the services they receive instead of by the violence they have survived. Considering the objectives of this document, the term victim/survivor will be used to cover both situations, before and after they disclose/report the GBV to a professional.

Domestic violence/Intimate partner violence

All acts of physical, sexual, psychological or economic violence that may be committed at home or in a public place by a person who is a family member or a person that has been an intimate partner or spouse or ex-partner, irrespective of whether they lived together (Council of Europe, Convention on preventing and combating violence against women and domestic violence, CETS No. 210).

Child marriage

Formal marriage or informal union under the age of legal consent is a reality for both boys and girls, although girls are disproportionately the most affected (UNICEF, Child marriage, 2012).

Essential services

A core set of services required, at an absolute minimum, to secure the rights, safety and well-being of any woman, girl, or child who experience violence against women. Whilst the essential services may not be provided in the same way in every country or setting, they include a combination of universal services such as health, care and social welfare and well-being, statutory services such as policing and justice responses, and specialist social services.

Gender-based violence

A form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men (UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), General Recommendation No. 19 on VAW, Art. 1).

Justice service providers

Include state/government officials, judges, prosecutors, police, legal aid, court administration, lawyers, paralegals, and victim/survivor support/social services staff.

Mandatory reporting

Refers to legislation passed by some countries or states that requires professionals and/or individuals to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.

Perpetrator

Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against her/his will (IASC, 2005, Guidelines for gender-based violence interventions in humanitarian settings: Focusing on prevention of and response to sexual violence in emergencies).

Rape/rape attempt

Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape (WHO, World report on violence and health).

Referral

The process of how a woman gets in touch with an individual professional or institution about her case and how professionals and institutions communicate and work together to provide her with comprehensive support. Partners in a referral network usually include different government departments, women's organizations, community organizations, medical institutions and others (UNFPA 2010).

Referral system

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

Reporting GBV case

Disclosure of a GBV incident/case by a service provider to another service provider; sharing information about a GBV case to other institution/organization during the process of referral. The reporting could be made only with and within the limits of victim/survivor's consent, with few exceptions.

Sexual abuse/violence

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim/survivor, in any setting, including but not limited to home and work (WHO, World report on violence and health).

Sexual exploitation

Any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another (UN Secretary-General's Bulletin on protection from sexual exploitation and abuse (PSEA) (ST/SGB/2003/13).

Traffic of human beings

The recruitment, transportation, transfer, harbouring or receipt of persons, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs (Protocol to Prevent, Suppress and Punish Trafficking in Persons contributing to United Nations Convention against Transnational Organized Crime).

Violence against women

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (UN Declaration on the elimination of violence against women. New York, United Nations, 1993). It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.

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Annexes

Annex. 1. Model of form for registering a GBV case
in a psycho-social service

CONFIDENTIAL

Institution	
Date	Name of person who fill in the form
Registering number	Position of person who fill in the form
	Victim/survivor's consent for filling the form (signature)
SECTION 1. INFORMATION ABOUT VICTIM/SURVIVOR	
Name and surname	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Telephone	Age years
Birthdate	SSN
Domicile	<input type="checkbox"/> Urban <input type="checkbox"/> Rural Address
Nationality	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify)
Marital status	<input type="checkbox"/> Unmarried <input type="checkbox"/> Consensual union <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
Education	<input type="checkbox"/> Without education <input type="checkbox"/> Primary school <input type="checkbox"/> Secondary school <input type="checkbox"/> Lyceum <input type="checkbox"/> University <input type="checkbox"/> Post-university education (master, doctoral)
Occupation	<input type="checkbox"/> Unemployed <input type="checkbox"/> Employed <input type="checkbox"/> Freelancer <input type="checkbox"/> Private company owner <input type="checkbox"/> Agriculture <input type="checkbox"/> Student <input type="checkbox"/> Housewife <input type="checkbox"/> Retired
Employer/School	Monthly income (optional)
Number of children	Dependent persons <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent children	_____ children, _____ under 10 years _____ between 10 and 18 years _____ over 18 years
Dependent elderly (over 65 years)	_____ persons
Psychiatric history	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify
Criminal record	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify
SECTION 2. INFORMATION ABOUT PERPETRATOR	
Relation between victim and perpetrator	<input type="checkbox"/> Husband <input type="checkbox"/> Former husband <input type="checkbox"/> Partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other (specify)
Name and surname	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Telephone	Age years
Birthdate	SSN
Domicile	<input type="checkbox"/> Urban <input type="checkbox"/> Rural Address
Nationality	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify)
Marital status	<input type="checkbox"/> Unmarried <input type="checkbox"/> Consensual union <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
Education	<input type="checkbox"/> Without education <input type="checkbox"/> Primary school <input type="checkbox"/> Secondary school <input type="checkbox"/> Lyceum <input type="checkbox"/> University <input type="checkbox"/> Post-university education (master, doctoral)
Occupation	<input type="checkbox"/> Unemployed <input type="checkbox"/> Employed <input type="checkbox"/> Freelancer <input type="checkbox"/> Private company owner <input type="checkbox"/> Agriculture <input type="checkbox"/> Student <input type="checkbox"/> Housewife <input type="checkbox"/> Retired
Employer/School	Monthly income (optional)
History of GBV	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, type of GBV	<input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Psychological (<input type="checkbox"/> Verbal <input type="checkbox"/> Emotional) <input type="checkbox"/> Neglect <input type="checkbox"/> Economic <input type="checkbox"/> Social
Psychiatric history	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify
Substance consumption/abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know <input type="checkbox"/> Alcohol occasionally <input type="checkbox"/> Alcohol frequent <input type="checkbox"/> Tabaco <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Drugs <input type="checkbox"/> Other (specify)
Criminal record	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify

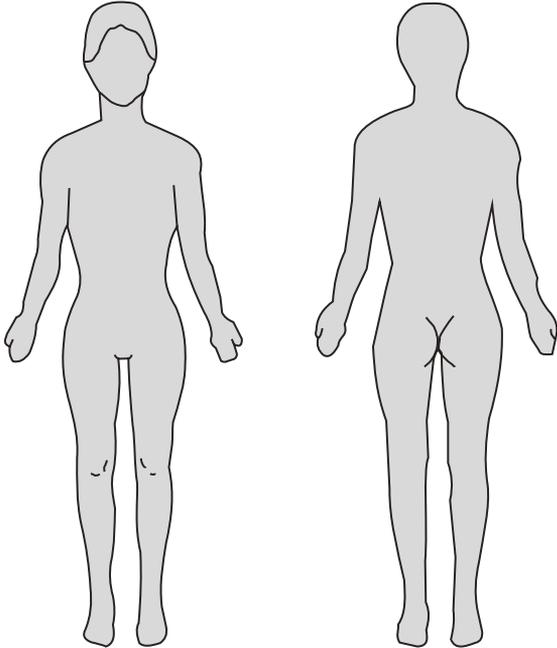
SECTION 3. CASE MANAGEMENT											
	Number of assistance session Date	1	2	3	4	5	6	7	8	9	10
		How the victim/ survivor addressed the service	Spontaneous								
	With appointment										
	Referred by other institution										
Who referred the victim/survivor	Police										
	Forensic department										
	Emergency Department/Room										
	Family doctor										
	Mayor Hall										
	Court										
	NGOs										
	Other (specify)										
Type of referral	Verbally										
	Written										
	By telephone										
	Accompanied by other professional										
Who disclosed the incident/case	Victim/survivor										
	Perpetrator										
	Children										
	Relatives										
	Neighbours										
	Other persons (specify)										
Institutions from which the victim/ survivor request for assistance	Police										
	Forensic department										
	Emergency Department/Room										
	Family doctor										
	Mayor Hall										
	Court										
	NGOs										
	Other (specify)										
Space were the GBV incident took place	Domicile										
	Public space										
	Workplace										
	Other (specify)										
Type of GBV	Physical										
	Sexual										
	Psychological										
	(Verbal)										
	(Emotional)										
	Neglect										
	Economic										
	Social										

Tools used by perpetrator	Body parts										
	Cutting objects										
	Stinging objects										
	Blunt objects										
	Guns										
	Poison/toxic substance										
Case management/ intervention	Psychological counselling/support										
	Legal counselling/support										
	Social support										
	Safety planning										
	Health care										
	Family planning services										
	Forensic certificate										
	Sheltering										
	Referral										
Referral to other institution/service	Police										
	Forensic department										
	Emergency Department/Room										
	Family doctor										
	Child Rights Protection Department										
	Court										
	Mayor Hall										
	NGOs										
	Other (specify)										

Annex. 2. Model of form for registering a GBV case in emergency room



Health facility	Registration number (social case)	Medical record number																				
Date	Name of person who fill in the form																					
Type of addressing	<input type="checkbox"/> Spontaneous <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter <input type="checkbox"/> Police <input type="checkbox"/> Other (specify)																					
<input type="checkbox"/> New case <input type="checkbox"/> Recurrence	Victim/survivor's condition: <input type="checkbox"/> Critic <input type="checkbox"/> Emergency <input type="checkbox"/> Stable																					
SECTION 1. INFORMATION ABOUT VICTIM/SURVIVOR																						
Name and surname	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male																					
Telephone	Age years																					
Birthdate	SSN	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>																				
Domicile <input type="checkbox"/> Urban <input type="checkbox"/> Rural	Address																					
Nationality	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify)																					
Marital status	<input type="checkbox"/> Unmarried <input type="checkbox"/> Consensual union <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow																					
Education	<input type="checkbox"/> Without education <input type="checkbox"/> Primary school <input type="checkbox"/> Secondary school <input type="checkbox"/> Lyceum <input type="checkbox"/> University <input type="checkbox"/> Post-university education (master, doctoral)																					
Occupation	<input type="checkbox"/> Unemployed <input type="checkbox"/> Employed <input type="checkbox"/> Freelancer <input type="checkbox"/> Private company owner <input type="checkbox"/> Agriculture <input type="checkbox"/> Student <input type="checkbox"/> Housewife <input type="checkbox"/> Retired																					
Employer/School	Monthly income (optional)																					
Number of children	Dependent persons <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Dependent children	_____ children, _____ under 10 years _____ between 10 and 18 years _____ over 18 years																					
Dependent elderly (over 65 years)	_____ persons																					
Family doctor	<input type="checkbox"/> No <input type="checkbox"/> Yes, Name	Telephone																				
Psychiatric history	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify																					
Criminal record	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify																					
SECTION 2. INFORMATION ABOUT PERPETRATOR																						
Relation between victim and perpetrator	<input type="checkbox"/> Husband <input type="checkbox"/> Former husband <input type="checkbox"/> Partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other (specify)																					
Name and surname	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male																					
Telephone	Age years																					
Birthdate	SSN	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>																				
Domicile <input type="checkbox"/> Urban <input type="checkbox"/> Rural	Address																					
Nationality	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify)																					
Marital status	<input type="checkbox"/> Unmarried <input type="checkbox"/> Consensual union <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow																					
Education	<input type="checkbox"/> Without education <input type="checkbox"/> Primary school <input type="checkbox"/> Secondary school <input type="checkbox"/> Lyceum <input type="checkbox"/> University <input type="checkbox"/> Post-university education (master, doctoral)																					
Occupation	<input type="checkbox"/> Unemployed <input type="checkbox"/> Employed <input type="checkbox"/> Freelancer <input type="checkbox"/> Private company owner <input type="checkbox"/> Agriculture <input type="checkbox"/> Student <input type="checkbox"/> Housewife <input type="checkbox"/> Retired																					
Employer/School	Monthly income (optional)																					
History of GBV	<input type="checkbox"/> No <input type="checkbox"/> Yes																					
If yes, type of GBV	<input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Psychological (<input type="checkbox"/> Verbal <input type="checkbox"/> Emotional) <input type="checkbox"/> Neglect <input type="checkbox"/> Economic <input type="checkbox"/> Social																					
Psychiatric history	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify																					
Substance consumption/abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know <input type="checkbox"/> Alcohol occasionally <input type="checkbox"/> Alcohol frequent <input type="checkbox"/> Tabaco <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Drugs <input type="checkbox"/> Other (specify)																					
Criminal record	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify																					

SECTION 3. CASE MANAGEMENT						
Type of GBV	<input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Psychological <input type="checkbox"/> Neglecting <input type="checkbox"/> Economic <input type="checkbox"/> Social					
Were the GBV incident took place	<input type="checkbox"/> Domicile <input type="checkbox"/> Public place <input type="checkbox"/> Workplace <input type="checkbox"/> Other (specify)					
Tools used by perpetrator	<input type="checkbox"/> Body parts <input type="checkbox"/> Cutting objects <input type="checkbox"/> Blunt objects <input type="checkbox"/> Stinging objects <input type="checkbox"/> Guns <input type="checkbox"/> Poison/toxic substance					
Institutions from which the victim/survivor request for assistance	<input type="checkbox"/> Police <input type="checkbox"/> Forensic Department <input type="checkbox"/> Family doctor <input type="checkbox"/> Mayor Hall <input type="checkbox"/> Child Rights Protection Departments <input type="checkbox"/> NGOs <input type="checkbox"/> Not sure/don't know					
Intervention	<input type="checkbox"/> Information <input type="checkbox"/> Counselling <input type="checkbox"/> Safety planning <input type="checkbox"/> Referral <input type="checkbox"/> Accompany					
Institutions to which the case was referred	<input type="checkbox"/> Police <input type="checkbox"/> Forensic Department <input type="checkbox"/> Family doctor <input type="checkbox"/> Child Rights Protection Departments <input type="checkbox"/> NGOs <input type="checkbox"/> Other (specify)					
INJURIES MAP						
	Bruise	Scars	Cuts	Bleeding	Pain	
Head						
Eyes						
Ears						
Nose						
Cheeks						
Mouth						
Neck						
Shoulders						
Arms						
Hands						
Chest						
Back						
Abdomen						
Genitalia						
Thighs						
Calves						
Legs						
Vital functions	BP	Breed frequency	Temperature	O ₂ saturation	Glucose	
Investigations	<input type="checkbox"/> Lab					
	<input type="checkbox"/> Radiology <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Chest <input type="checkbox"/> Head <input type="checkbox"/> Spinal <input type="checkbox"/> Pelvis <input type="checkbox"/> Other (specify) <input type="checkbox"/> CT cranium <input type="checkbox"/> CT chest <input type="checkbox"/> CT abdomen <input type="checkbox"/> RMN					
Procedures	<input type="checkbox"/> O ₂ <input type="checkbox"/> Vital functions monitoring <input type="checkbox"/> Intubation <input type="checkbox"/> Aspiration <input type="checkbox"/> Suture <input type="checkbox"/> Gastric lavage <input type="checkbox"/> Thoracic drainage <input type="checkbox"/> Naso-gastric drainage <input type="checkbox"/> Bladder drainage <input type="checkbox"/> Immobilisation (<input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Spinal)					
Diagnostic						
Therapeutic outcome	<input type="checkbox"/> Transferred to other health facility <input type="checkbox"/> Treated, home released: <input type="checkbox"/> Leaving ER without medical consent <input type="checkbox"/> Called death					

Annex. 3. Model of form for registering a GBV case at police department



Police Department	Registration number																				
	Date																				
SECTION 1. INFORMATION ABOUT INCIDENT																					
Date	Hour																				
Recurrence <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Were the GBV incident took place <input type="checkbox"/> Domicile <input type="checkbox"/> Public place <input type="checkbox"/> Workplace <input type="checkbox"/> Other (specify)																					
SECTION 2. INTERVENTION/INCIDENT MANAGEMENT																					
Intimation <input type="checkbox"/> Complaint <input type="checkbox"/> Denouncement <input type="checkbox"/> Intimation	Type of intimation <input type="checkbox"/> Written <input type="checkbox"/> Telephone																				
Solutions/measures <input type="checkbox"/> Case closed <input type="checkbox"/> Penalties <input type="checkbox"/> Not to prosecute <input type="checkbox"/> Intimation to court for trial <input type="checkbox"/> Other (specify)																					
Institutions to which the case was referred <input type="checkbox"/> Forensic Department <input type="checkbox"/> Family doctor <input type="checkbox"/> Child Rights Protection Departments <input type="checkbox"/> NGOs <input type="checkbox"/> Other (specify)																					
SECTION 3. LEGAL CLASSIFICATION OF INCIDENT																					
Physical violence	<input type="checkbox"/> Murder <input type="checkbox"/> Attempted murder <input type="checkbox"/> Premeditated murder <input type="checkbox"/> Attempted premeditated murder <input type="checkbox"/> Infanticide <input type="checkbox"/> Striking <input type="checkbox"/> Injury <input type="checkbox"/> Neglecting																				
Psychological violence	<input type="checkbox"/> Offend <input type="checkbox"/> Threat <input type="checkbox"/> Blackmail <input type="checkbox"/> Defamation <input type="checkbox"/> Bigamy <input type="checkbox"/> Adultery <input type="checkbox"/> Disturbing public peace <input type="checkbox"/> Determine or facilitate of suicide <input type="checkbox"/> Preventing of religious believes																				
Sexual violence	<input type="checkbox"/> Rape <input type="checkbox"/> Attempted rape <input type="checkbox"/> Sexual abuse on children <input type="checkbox"/> Attempted sexual abuse on children <input type="checkbox"/> Sexual perversion <input type="checkbox"/> Sexual corruption <input type="checkbox"/> Incest <input type="checkbox"/> STIs contamination																				
Economic violence	<input type="checkbox"/> Destruction <input type="checkbox"/> Robbery <input type="checkbox"/> Robbery between partners <input type="checkbox"/> Trespassing <input type="checkbox"/> Infraction of faith <input type="checkbox"/> Failure to comply with court orders																				
Neglecting	<input type="checkbox"/> Illegally deprivation of liberty <input type="checkbox"/> Slavery <input type="checkbox"/> Forced labour <input type="checkbox"/> Dangerous behaviour with persons without help <input type="checkbox"/> Family abandon <input type="checkbox"/> Banish from domicile																				
SECTION 1. INFORMATION ABOUT VICTIM/SURVIVOR																					
Name and surname	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male																				
Telephone	Age years																				
Birthdate	SSN <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center; width: 100px; height: 15px;"><tr><td> </td><td> </td></tr></table>																				
Domicile <input type="checkbox"/> Urban <input type="checkbox"/> Rural	Address																				
Nationality <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify)																					
Marital status <input type="checkbox"/> Unmarried <input type="checkbox"/> Consensual union <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow																					
Education <input type="checkbox"/> Without education <input type="checkbox"/> Primary school <input type="checkbox"/> Secondary school <input type="checkbox"/> Lyceum <input type="checkbox"/> University <input type="checkbox"/> Post-university education (master, doctoral)																					
Occupation <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed <input type="checkbox"/> Freelancer <input type="checkbox"/> Private company owner <input type="checkbox"/> Agriculture <input type="checkbox"/> Student <input type="checkbox"/> Housewife <input type="checkbox"/> Retired																					
Employer/School	Monthly income (optional)																				
Number of children	Dependent persons <input type="checkbox"/> Yes <input type="checkbox"/> No																				
Dependent children children, under 10 years between 10 and 18 years over 18 years																					
Dependent elderly (over 65 years) persons																					
Family doctor <input type="checkbox"/> No <input type="checkbox"/> Yes, Name	Telephone																				
Psychiatric history <input type="checkbox"/> No <input type="checkbox"/> Yes Specify																					
Criminal record <input type="checkbox"/> No <input type="checkbox"/> Yes Specify																					

SECTION 2. INFORMATION ABOUT PERPETRATOR																					
Relation between victim and perpetrator	<input type="checkbox"/> Husband <input type="checkbox"/> Former husband <input type="checkbox"/> Partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other (specify)																				
Name and surname	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male																				
Telephone	Age years																				
Birthdate	SSN <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table>																				
Domicile	<input type="checkbox"/> Urban <input type="checkbox"/> Rural Address																				
Nationality	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify)																				
Marital status	<input type="checkbox"/> Unmarried <input type="checkbox"/> Consensual union <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow																				
Education	<input type="checkbox"/> Without education <input type="checkbox"/> Primary school <input type="checkbox"/> Secondary school <input type="checkbox"/> Lyceum <input type="checkbox"/> University <input type="checkbox"/> Post-university education (master, doctoral)																				
Occupation	<input type="checkbox"/> Unemployed <input type="checkbox"/> Employed <input type="checkbox"/> Freelancer <input type="checkbox"/> Private company owner <input type="checkbox"/> Agriculture <input type="checkbox"/> Student <input type="checkbox"/> Housewife <input type="checkbox"/> Retired																				
Employer/School	Monthly income (optional)																				
History of GBV	<input type="checkbox"/> No <input type="checkbox"/> Yes																				
If yes, type of GBV	<input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Psychological (<input type="checkbox"/> Verbal <input type="checkbox"/> Emotional) <input type="checkbox"/> Neglect <input type="checkbox"/> Economic <input type="checkbox"/> Social																				
Psychiatric history	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify																				
Substance consumption/abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know <input type="checkbox"/> Alcohol occasionally <input type="checkbox"/> Alcohol frequent <input type="checkbox"/> Tabaco <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Drugs <input type="checkbox"/> Other (specify)																				
Criminal record	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify <input type="checkbox"/> Not investigated																				



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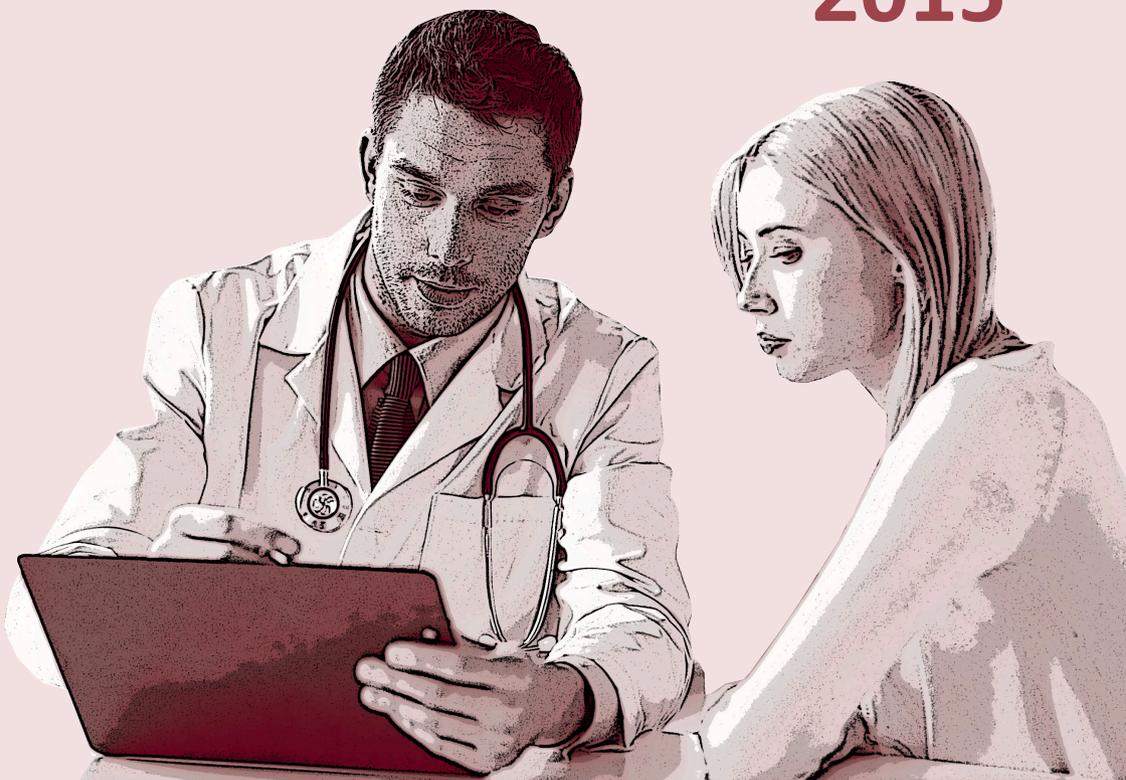
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Health care services provision, part of multi-sectoral response to GBV

Standard Operating Procedures

2015



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Published by the UNFPA Regional Office for Eastern Europe and Central Asia (UNFPA EECARO), 2015.

The views expressed in this publication are those of the authors, and do not necessarily represent the views of UNFPA, the United Nations or any of its affiliated organizations.

Design & printing: Image Studio s.r.l.

ISBN 978-973-87875-9-9

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Purpose and objectives

Health system and health-care providers play a critical role in terms of identification, assessment, treatment, crisis intervention, documentation, referral, and follow-up of GBV cases.

The agreed conclusions: Elimination and prevention of all forms of violence against women and girls of the 57th Commission on the Status of Women call for action to:

“Address all health consequences, including the physical, mental and sexual and reproductive health consequences, of violence against women and girls by providing accessible health-care services that are responsive to trauma and include affordable, safe, effective and good-quality medicines, first line support, treatment of injuries and psychosocial and mental health support, emergency contraception, safe abortion where such services are permitted by national law, post-exposure prophylaxis for HIV infection, diagnosis and treatment for sexually transmitted infections, training for medical professionals to effectively identify and treat women subjected to violence, as well as forensic examinations by appropriately trained professionals.”

The Standard Operating Procedures (SOPs) were developed to provide clear and detailed description of routine actions of health care providers who may provide assistance/services for GBV victims/survivors.

The objectives of SOPs for intervention on GBV cases of health care providers are the following:

- assist for effective identification of GBV victims/survivors,
- ensure and/or increase the victim/survivor’s safety at all stages of the intervention;
- ensure quality and consistency of service provision;
- facilitate improved and coordinated GBV documentation and data collection;
- guaranty the confidentiality of the services provided to GBV victims/survivors;
- facilitate effective referral of GBV victims/survivors within health sector and to other service providers; and
- link the health care facilities with the other services provided to GBV victims/survivors.

While both men and boys can also suffer from the direct and indirect impacts of gender-based violence, this SOP’s primary focus is on women and girls as they are overwhelmingly targeted for violence and abuse; and the forms of violence they experience, the severity, frequency and consequences are very different from violence experienced by men.

Applicability

An essential range of health care services are required for supporting women and girls who have experienced GBV. Five core elements were identified as necessary for a comprehensive and effective clinical health service response:

- First line support (includes referrals)
- Care of injuries and urgent medical issues
- Sexual assault exam and treatment
- Mental health assessment
- Stress management

The SOPs describe clear procedures that regulate the step-by-step routine activity, the roles, and responsibilities to be followed by the staff of any facility, which provides health care services. This may be primary, secondary or tertiary level health care facility.

For a better implementation of the SOPs, a minimal training of health care providers in using the present SOPs is indicated. Preferably, the training should be part of a comprehensive training programme/curriculum which includes sections on multi-sectoral response to GBV, specific response to GBV of health care providers and prevention and awareness.

The SOPs does not include any description of the specific duties of the health care providers regarding care of health conditions. Any other specific procedures, regulated by country legislation, regulations and statutes, may be added when the present SOPs are adapted to the country.

When organizing care for GBV victims/survivors, special attention needs to be given to the development of an adequate woman-centred care, guaranteeing confidentiality and privacy. To avoid stigmatisation of patient, the complete care package should be offered in one consultation room and this room should not be identifiable as such. Moreover, priority access for rape victims/survivors should be ensured.

All personal of the health facility needs to be informed about the patient-flow for GBV victims/survivors and the ethical obligation to respect confidentiality.

Guiding principles

Principles of multi-sectoral response to GBV

Victim-centred approach. All service providers engaged in multi-sectoral response to GBV prioritize the rights, needs and wishes of victim/survivor.

Partnership. The multi-sectoral response to GBV implies good cooperation and coordination of involved institutions/organizations.

Participative management. The rules regarding the multi-sectoral intervention and referral, the strategies and action plans, including planning, implementing, monitoring and evaluating programmes should be done in a participatory manner, including the input of beneficiaries (if applicable).

Strategic planning. The policies that address GBV phenomenon should be translated in inter-institutional common strategies, with specific objectives and activities.

Integrated services. The procedures for intervention and referral as well as the protection measures require a multi-disciplinary approach based on unified work methodology.

Prevention. An effective integrated approach sets as a priority also the prevention of GBV.

Accountability. All interventions/organizations have to ensure the accountability (and measures of it) for staff to implement and respect the agreed programs/rules and to follow these guiding principles in their work.

Sustainability. Despite the political changes or staff turnover/demotivation, once the multi-sectoral response to GBV is assumed, the institutions/organizations should ensure all conditions to implement and sustain this approach.

Principles and standards for service provision to GBV victims/survivors

Gender-sensitive approach. Services provided need to demonstrate an approach which recognizes the gender dynamics, impacts and consequences of violence against women. Health services should take into account the needs of specific groups of women and girls, including those belonging to marginalized groups. Health service providers need to respect the diversity of service users and apply a non-discriminatory approach. This implies that all women survivors have equal and full access to health care and receive care at the same level of quality.

Victim/survivor’s centred. During the intervention on GBV incidents/cases, respecting the victim/survivor’s wishes, rights, and dignity is the best approach aimed to create an environment full of respect, which may facilitate the victim/survivor’s ability to identify her needs and to make decisions about possible ways of action. Health care providers should support victims/survivors in their decision-making.

Safety and security. The safety of both the victim and the health-care provider should be a priority when organizing and offering care to GBV victims/survivors. Evaluating the safety of the victim/survivor needs to be done at the moment of identification and when the patient reveals she/he has been victim/survivor of GBV. Also assessing one’s own safety should be part of each consultation. When starting the consultation with a victim/survivor it is important to consider the possible threats (violent husbands, family members) to ensure that the consultation can be done without likely harm to one-self, the patient or other colleagues.

Confidentiality and privacy. Respecting confidentiality is an important measure to ensure the safety of both the victim/survivor and the health care provider. All the time, the confidentiality of the victim/survivor shall be respected. This includes sharing only the necessary information, only in the situation that is necessary or requested, and only with the victim/survivor’s agreement. Privacy during the consultation (identification and clinical management) and confidentiality of data collection, record keeping, reporting and information sharing will decrease the exposure of both patient and health care providers. Maintaining confidentiality ensures that a victim/survivor does not experience further threats and/or violence as a result of seeking assistance and also protects health care providers from threats of violent perpetrators or family members. Shared confidentiality in the health profession means that some patient information may be shared with other medical colleagues on a “need to know basis” only. Information may be shared with colleagues if there is a medical reason for it and the health care provider is referring the victim/survivor to another health care provider. This must be explained to the victim/survivor beforehand and the victim must understand what information and to whom this will be shared, and consent must be obtained. If the confidentiality is limited by a regulation regarding mandatory reporting, the victim/survivor should be informed immediately.

Informed choice. Any action should be made only with the victim/survivor’s permission and after obtaining of an informed consent.

Non-discrimination. Regardless of age, race, national origin, religion, sexual orientation, gender identity, disability, marital status, educational and socio-economic status, all victims/survivors are equal and shall be treated the same and have equal access to services.

Conditions and behaviours that might indicate GBV

The following are short lists of clinical or psychological conditions and behaviours that may raise attention to the health care provider and request for exploring the GBV existence. If more of them are present might indicate that the patient is a subject of GBV.

Conditions that might indicate GBV

- Multiple injuries, at different stages of healing, in multiple body zones that may not be fall result
- Unexplained injuries or with unclear/confusing explanations
- Symmetrical injuries
- Bruises, wounds, lacerations, bites, burns on different stages of recovery, especially on arms and face
- Injuries hidden by clothes
- Injuries inconsistent with explanation of cause
- Unexplained chronic gastrointestinal symptoms
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Chronic pain (unexplained)
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations
- Frequently missed appointments

- Non-compliance with treatment
- Early self-discharge from hospital
- Symptoms of depression, anxiety, PTSD, sleep disorders
- Alcohol and other substance use

Behaviours associated with GBV

- Frequent appointments for vague symptoms
- Woman tries to hide injuries or minimize their extent
- Woman is reluctant to speak in front of partner or accompanying adult, or appears submissive or afraid in front of partner or accompanying adult
- Non-compliance with treatment
- Frequently missed appointments
- Woman appears frightened, overly anxious, or depressed
- Suicidality or self-harm
- Partner is aggressive or dominant, talks for the woman or refuses to leave the room
- Poor or non-attendance at antenatal clinics
- Early self-discharge from hospital

How to interact with a GBV victim/survivor

Asking about GBV might be challenging for any service provider. The following recommendations help the provider to increase confidence in asking about GBV and also to avoid re-victimisation.

- Take the initiative to ask about violence – do not wait for the woman to bring it up. This shows that you take a professional responsibility for her situation, and it helps to build trust.
- Avoid asking a woman about GBV in the presence of a family member, friend, or children.
- Be patient with GBV victims/survivors, keeping in mind that in crisis they may have contradictory feelings. Don't pressure the victim/survivor to disclose. If she/he does not disclose, tell her/him what made you think about violence.
- Avoid unnecessary interruptions and ask questions for clarification only after she has completed her account.
- Avoid passive listening and non-commenting. This may make her think that you do not believe her and that she is wrong, and the perpetrator is right. Carefully listen to her experience and assure her that her feelings are justified.
- Use the same language as the victim/survivor; if the victim/survivor speaks other language than the provider, ask for a provider who speaks the same language or for an interpreter to assist her/him.
- Adapt language and words at the understanding level of the victim/survivor. Do not use professional jargon and expression that might confuse the victim/survivor.
- Formulate questions and phrases in a supportive and non-judgmental manner, using a sympathetic voice. Use open-ended questions and avoid questions starting with "why", which tends to imply blame of GBV victim/survivor.
- Don't blame the woman. Avoid questions such as "Why do you stay with him?", "Did you have an argument before violence happened?", "What were you doing out alone?", "What were you wearing?" Instead, reinforce that GBV cannot be tolerated.
- Use supportive statements, such as "I am sorry that this happened to you" or "You really have been through a lot", which may encourage the woman to disclose more information.

- Emphasize that violence is not victim/survivor's fault and only the perpetrator is responsible for.
- Explain that the information will remain confidential and inform her about any limitations to confidentiality.
- Use eye contact as culturally appropriate, and focus all attention on the victim/survivor. Avoid doing paper work at the same time.
- Be aware of your body language. How you stand and hold your arms and head, the nature of your facial expression and tone of voice all convey a clear message to the woman about how you perceive the situation. Show a non-judgemental and supportive attitude and validate what she is saying. Avoid body language conveying the message of irritation, disbelief, dislike or anger toward the victim/survivor.
- Do not judge a victim/survivor's behaviour based on culture or religion.

Procedures

The step-by-step procedures are grouped by the type of intervention that can be implemented. While specific guidelines, protocols, or legal mandates may vary, the management and provision of health care to GBV victims/survivors should include the following procedures: identification, evaluation, health care service delivery (with the five core elements), collection of evidence, documenting GBV, and referral.

The order of sections and/or steps might be changed when interfering with a GBV victim/survivor; however, any assistance of a GBV victim/survivor will begin with the identification. Each health care facility may implement the sections that are according to the statute and mandate.

If there is any evidence or suspicion that a patient suffers a form of GBV, the health care provider must make all the efforts to ensure that the patient obtains all the support that may receive. In all stages of the assistance, the victim/survivor's autonomy and confidentiality are subsequent to victim/survivor's security.

Identification

First step in any GBV intervention is to identify the victim/survivor; this may be done in different ways: provider's identification, reporting by other provider/person, and self-disclosure of the victim/survivor. In case of identification in health settings, two approaches are used to facilitate the disclosure of GBV: universal screening and case finding. Universal screening, also known as routine enquiry, requires asking all women presenting in health settings about their exposure to GBV. Universal screening can be burdensome in health care settings, particularly when there are limited referral options, limited capacities for effective response, and overstretched resources/providers. Case-finding, or clinical enquiry, refers to asking women about GBV, in case they present certain clinical symptoms/history and (if appropriate) to examine the women. The second approach based on selective and careful clinical considerations, is found to be the most effective, particularly when the health staff is specially trained in how to best respond and refer.

In any situation, addressing health needs which may threaten the life or integrity of the victim/survivor must be a priority. Refer patients with severe, life-threatening conditions for emergency treatment immediately.

The following actions should be done to facilitate the disclosure of GBV and to ensure a safe and effective identification of GBV victim/survivor:

- Greet the person in a welcoming manner.
- Introduce yourself and briefly explain the institution's mandate/services.
- Kindly ask the person to introduce herself/himself (if there is no health condition that limits this).
- Ask the patient about the preference to be examined by a doctor who is of the same sex (especially in cases of sexual violence).
- Give the patient the chance to ask questions about everything may consider important.
- Remember the needs of different population groups (e.g. persons with physical or mental disabilities, religious persons, and ethnic minorities) and make efforts to address them.
- Create a confidential and compassionate environment, actively listen to the patient and give validating messages (please refer to section *How to interact with a GBV victim/survivor*).
- Pay attention to asking questions about GBV behind curtains (especially in hospital-based health care); a third person may hear the conversation.
- Prior any examination or manoeuvre, inform and explain to the patient what it includes, why it is done and how, to avoid transforming the examination into another traumatic experience.
- Decide if it is appropriate to ask about GBV exposure. Remember that accompanying person might be the perpetrator itself and asking about GBV may put the victims/survivors in an unsafe situation.
- If decided so, ask about exposure to GBV in order to improve diagnosis/identification and subsequent care and referral (please refer to the section *How to interact with a GBV victim/survivor*).
- If any suspicion of GBV, check the victim/survivor's medical history (if possible) or ask if certain conditions repeat from time to time.
- Do not leave the victim/survivor alone, especially when self-injuries are suspected or the risk for it is present.

Evaluation

After identification of a GBV victim/survivor, the health care provider should make a decision on the next steps (care/support, collection of evidence, documenting GBV, and referral) to be followed, according to the resources, skills and mandate to effectively address GBV. An assessment of victim/survivor's needs and resources should be undertaken that would serve as basis for development of further steps of medical care and follow-up.

- Obtain consent for services that will be provided. In case of children or persons with limited discernment, obtain consent from the parents or caregivers. If the victim/survivor cannot read and write, the informed consent statement will be read up to the victim/survivor and a verbal consent will be obtained (this will be mentioned in the informed consent form or health records).
- Explain the right to provide limited consent and to choose which information is released and which is kept confidential.
- Give adequate information for informed consent. Inform the victims/survivors about possible implications of sharing information about the case with other institutions/services.
- Specify if there is any legal mandatory reporting to other institution of a GBV incident/case and the content of the reported information, if possible.
- Provide the victim/survivor with information on GBV and its consequences on health.
- Ensure that the victim/survivor is assisted in a non-judgemental, compassionate and understanding way, and all efforts will be made to help her/him.
- Ask the victim/survivor to tell in her own words what happened, to talk about the perpetrator, types of violence and severity. In case of reporting by other provider/referral some information might be already available.
- Evaluate the needs and resources, to understand the social, familial and individual context that affects the victim/survivor's situation.
- Think to the care/support that should be provided, tailored on the needs and expectations in order to protect the GBV victim/survivor.

Service provision/Intervention

Following identification and evaluation of GBV case, health care providers should undertake a medical examination and provide medical care.

Throughout the entire process of medical examination and care, health care providers should always keep in mind that GBV victims/survivors might be very emotional.

First-line support

- Be non-judgemental and supportive and validate what the GBV victim/survivor is saying.
- Provide practical care and support that responds to GBV victim/survivor's concerns, but do not intrude.
- Ask about history of violence, listening carefully, but not pressuring GBV victim/survivor to talk (care should be taken when discussing sensitive topics when interpreters are involved).
- Help GBV victim/survivor access information about resources, including legal and other services that the victim/survivor might think are helpful.
- Assist GBV victim/survivor to increase safety for herself and victim/survivor's children, where needed.
- Provide or mobilize social support.
- Conduct the consultation in private.
- Keep confidentiality, while informing GBV victim/survivor of the limits of confidentiality (e.g. when there is mandatory reporting).

Medical history and examination

- Ask GBV victim/survivor to tell in their own words what happened.
- A detailed description of the violence should be obtained, its duration, whether any weapons were used, as well as the date and time of the incident/s.
- Keep in mind that some victims/survivors may intentionally avoid particularly embarrassing details of the incident.
- Check for any other symptoms that may indicate a GBV form (e.g. dehydration, malnutrition).

- After taking the history, health care professionals should conduct a complete physical examination (head-to-toe; for sexual violence also including the patient's genitalia) (WHO 2013 Recommendation 11), observing the following general principles:
 - Explain the medical examination, what it includes, why it is done and how, to avoid the exam itself becoming another traumatic experience. Also, give the patient a chance to ask questions.
 - Ask the patient if she wishes a female doctor (especially in cases of sexual violence).
 - Do not leave the patient alone (e.g. when she is waiting for the examination).
 - Ask her to disrobe completely and to put on a hospital gown, so that hidden injuries can be seen.
 - When examine parts of the body for physical signs of GBV, first examine uncovered parts and then, kindly ask the victim/survivor to uncover the rest of the body for examination. Do not ask to uncover all parts at a time; the nudity can be humiliating for the victim/survivor.
 - Examine especially areas covered by clothes and hair.
 - If she has experienced sexual violence, examine her whole body – not just the genitals or the abdominal area.
 - Examine both serious and minor injuries.
 - Note emotional and psychological symptoms as well.
 - Throughout the physical examination inform the patient what you plan do next and ask for permission. Always let her know when and where touching will occur. Show and explain instruments and collection materials.
 - Patients may refuse all or part of the physical examination. Allowing her a degree of control over the examination is important to her recovery.

Clinical care of injuries and urgent medical issues

- Treat in situ less severe injuries, for example, cuts, bruises and superficial wounds. Any wounds should be cleaned and treated as necessary.
- The following medications may be indicated:
 - antibiotics to prevent wounds from becoming infected;

- a tetanus booster or vaccination (according to local protocols);
 - medications for the relief of pain, anxiety or insomnia.
- In case of sexual violence, the health care provider should provide or refer to other health provider that may provide:
- investigation for ongoing pregnancy;
 - prevention of unwanted pregnancy by offering or prescribing emergency contraception within 5 days of sexual assault, ideally as soon as possible after the assault, to maximize effectiveness; a single dose of 1.5 mg levonorgestrel is recommended, since it is as effective as two doses of 0.75 mg given 12-24 hours apart. If levonorgestrel is not available, the combined oestrogen-progesterone regimen may be offered, along with anti-emetics if available. If oral contraception is not available and it is feasible, copper-bearing intrauterine devices (IUDs) may be inserted up to 5 days after sexual assault for those GBV victims/survivors who are medically eligible. If sexual assault happened in more than 5 days, or emergency contraception fails, GBV victims/survivors should be offered safe abortion, in accordance with national law.
 - Reduction of the risk of contracting HIV by administering post-exposure prophylaxis for GBV victims/survivors presenting within 72 hours of a sexual assault;
 - prophylactic treatment for sexually-transmitted infections (chlamydia, gonorrhoea, trichomonas, syphilis). The choice of drugs and regimens should follow national guidance;
 - Hepatitis B vaccination without hepatitis B immune globuline should be offered as per national guidelines. Hepatitis B status should be evaluated from a blood sample, prior administering the first vaccine dose; if immune, no further course of vaccination is required.
- Provide or mobilize social support, if needed, or at the victim/survivor's request.
- Assist the victim/survivor in safety planning, to increase the safety for herself and her children, where needed (please refer to section Safety plan).
- Plan and provide follow-up health care, if and as required.

Psychological/mental health assessment and management

In case of partner violence and sexual violence, the recommended psychological interventions are divided by the moment of intervention:

- immediate after the GBV incident psychological support should be offered to respond to the immediate psychological needs of GBV victim/survivor: psychological first aid involves the following elements: providing practical care and support, which does not intrude; assessing needs and concerns; helping people to address basic needs (for example, food and water, information); listening to people, but not pressuring them to talk; comforting people and helping them to feel calm; helping people connect to information, services and social supports; protecting people from further harm; and provide written information on coping strategies for dealing with severe stress.
- up to 3 months post-trauma: continue providing practical care and support after assessing needs and expectations. Apply “watchful waiting” for 1-3 months after the event, unless the person is depressed, has alcohol or drug use problems, psychotic symptoms, has suicidal or self-harming thoughts or has difficulties in day-by-day functions. If the victim/survivor presents post-rape symptoms or any other mental health problems, refer her/him to specialist health care providers for psychological/mental interventions.
- from 3 months post-trauma: assess mental health and address any problem revealed or refer the victim/survivor to a specialist.

Collecting evidence

The evidence of GBV should be collected only by the health care providers that, according to legislation and regulations, are mandated to do such/ these procedures AND specially trained in evidence collection techniques. The specific steps of collecting evidence should be added according to the protocols of each country. Both medical and forensic specimens should be collected during the course of the examination. Providing medical and legal (forensic) services at the same time, in the same place and by the same person reduces the number of examinations that the patient has to undergo and can ensure that the needs of the patient are addressed more comprehensively.

- Explain for what purpose the collected evidence might be important/useful.
- Ask the victim/survivor if she/he desires the evidence of violence to be collected.
- Make sure that information about evidence collection is included and checked on the informed consent or health care forms.

- If the conditions for collecting evidence, named at the beginning of the section, are not fulfilled and the victim/survivor expresses the desire to have evidence collected, refer her/him to the nearest facility that can provide this service. Provide victim/survivor with the exact information on the service that should assist in this matter.
- Recall the importance to collect evidence as soon as possible in particular GBV situations (e.g. sexual violence).
- Explain what should be done and what should be avoided in order to preserve/not to destroy the evidence (e.g. not to wash, change clothes).
- Reinsure the victim/survivor about the confidentiality of the information/evidence.
- Decrease the risk of trauma and time loss by integrating medical and forensic procedures, if possible.

Risk assessment and management

Risk assessment and management can reduce the level of risk. The safety plan is part of the case intervention that can prevent future violent incidents or avoid escalation or exposure to extreme situations. The safety plan is developed taking in consideration risk factors and resources available.

To develop an effective safety plan, understanding the risk factors for repeat and escalating violence is needed. The more risk factors are identified and associated with a GBV case, the higher the risk to which the GBV victims/survivors is exposed.

Risk factors that might be identified:

- Previous acts/incidents of GBV against the victim/survivor, the children or other family members. History of abuse, forms and patterns of violence used, former convictions or reports to police, weapons used are indicators to evaluate the danger.
- Violent behaviour outside the family.
- Separation and divorce are times of high risk.
- The coalition of other family members with the perpetrator.
- Legal or illegal possession and/or use of weapons or threaten to use weapons.
- Alcohol or drugs consumption may disinhibit behaviours and lead to escalation of violence.

- Threats, in particular, threats of murder must be taken seriously.
- Extreme jealousy and possessiveness.
- Extremely patriarchal concepts and attitudes.
- Persecution and psychological terror (stalking).
- Non-compliance with restraining orders by courts or police.
- Possible triggers that may lead to a sudden escalation of violence (changes in the relationship).

A first safety plan needs to be developed and if necessary referral needs to be proposed and organized in a safe non-stigmatizing way.

- List the persons (friends, neighbours) that might be called in an emergency situation or who could give shelter for few days.
- Identify one or more neighbours you can tell about the violence, and ask them to help if they hear a disturbance in your house.
- Practice how to get out of your home safely.
- Pack a safety bag and put it in a place from where can be taken easily in an emergency situation.
- Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he wants to calm him down. You have the right to protect yourself and your children.
- Think about the possibility to address for future help to other service providers.
- Remember, you do not deserve to be hit or threatened.

Documenting GBV

- Collect and register information about the GBV victim/survivor, including: demographic information (i.e. name, age, sex), consent obtained, history (ex. general medical and gynaecological history), account of the incident, results of the physical examination, tests and their results, treatment plan, medications given or prescribed, victim/survivor education and information offered, referrals.
- Collect and register full details of the GBV including:
 - evidence to support the alleged offence;
 - history of any other incidents, including those with previous partners;
 - relation between the victim/survivor and the perpetrator;
 - type of violence;
 - witnesses present during the incident, including children;
 - whether weapons were used (how and what type);
- Describe in detail any injury revealed. For this purpose, use specific forms and body maps for more accurate representation.
- Note emotional and psychological symptoms as well.
- Note what victim/survivor discloses using own words.
- Document your doubts and the evidence they are based on.
- Inform the victims/survivors about the possible usage of the records and obtain the consent on that.
- Keep all record in a safe and confidential place. The guidelines embedded in each country will dictate how comprehensive the information should be.
- Allocate adequate time to enter data in data collection system.

Referral

Health care providers are often the first professionals that are in contact with the GBV victim/survivor. Therefore, health care providers may refer GBV victims/survivors to other health professionals within the same or another health care facility and/or to other services (police, specialized services, social protection, etc). Likewise, health care professionals may also have to assist GBV victims/survivors referred by other service providers. GBV victims/survivors have complex needs, therefore, an effective response to GBV requires a comprehensive set of services available through a multi-sectoral coordinated response that can be ensured by an effective referral.

Effective referrals require that health care providers:

- ! Are able to recognize and facilitate the disclosure of GBV, and provide first-line support.
- ! Are able to assess the individual situation and needs of the patient. If the assessed risk is high, the victim/survivor requires immediate crisis intervention, such as immediate medical or psychological support and/or access to a shelter. If the assessed risk is not high, referrals to other social, psychological or legal support might be appropriate.
- ! Are knowledgeable about national laws on GBV, including definitions of relevant criminal offences, about available protection measures and any reporting obligations on their part. This knowledge is required only to the extent of relevant professional obligations.
- ! Obtain the consent of the victim/survivor before sharing information about her case with other agencies or service providers and follow the procedure that protects the woman's confidentiality. There are situations in which sharing information must be made even if a victim/survivor does not give consent.

The steps below should be followed to ensure an effective referral:

- Keep up to date a directory of institutions/organisations, which provide services for GBV victims/survivors. The directory must include institution's name, contact person, address, other contact details, list of services provided.
- Evaluate what referral may be useful for the GBV victim/survivor, according to the assessed needs and wishes.
- Inform the victim/survivor about the possibility to be referred to other service providers, as requested and/or needed.

- Obtain the consent of the victim/survivor to make the referral, prior any further step.
- Clarify with the victim/survivor what information will be shared to other service providers and what information will be kept confidential (specify if there are any legal regulation/limitation).
- Give to the victim/survivor complete and correct information about service providers, following the 3W scheme described below:
 - WHO** – which institution/organization provides services to GBV victims/survivors, adding contact information of a person (name, telephone number) that can be reached as an entry point to that service
 - WHAT** – what sort of assistance they can expect to receive from a specific service provider, adding cost information related to that service
 - WHERE** – where exactly is the place (the exact address) of the indicated services
- Make the referral according to the victim/survivor's choice.
- Accompany the referral by a short written report and a telephone discussion with the other service provider, as a method for avoiding the situation when the victim/survivor has to repeat the story and answering the same questions during multiple interviews, passing again through the psychological trauma caused by the GBV incident.
- Encourage the victim/survivor's autonomy by empowering her/him to do the referral by itself.
- Accompany the victim/survivor to the referred service provider, if needed and possible.
- Explain to the victim/survivor that she/he can come back for further assistance. Bring up the issue at the next appointment.
- Explain to the victim/survivor about medical condition follow-up plan.
- Share contact detail for follow-up.
- Close the assistance either when the best possible outcome has been attained (the victim/survivor is referred to other service provider), or the needs/wishes of the victims/survivors change.

- Have agreements and protocols about the referral process with relevant services/institutions, including clear responsibilities of each service.
- Ensure that procedures between services/institutions for information sharing and referral are consistent and known by staff.

Individual safety plan for women who experienced violence by intimate partners or other family members - model

Client _____ Health care provider _____

Date _____ Re- evaluation (dates) _____

1. If my own or my children's safety is in danger at home, I can go to _____ or _____ (decide this although you would not expect another violent act).
2. In a violent or threatening situation a safe way out is _____ (e.g. which doors, windows, elevator, stairs or emergency exit I could use).
3. If an argument seems unavoidable, I will try to have it in a room or an area that I can leave easily. I will try to avoid any room where weapons may be available.
3. I can talk about violence with the following persons and ask them to call the police if they hear suspicious noises in my house: _____.
4. I can use (e.g. a sign, a word) _____ as a code with my children or friends so that they can call for help.
5. If my partner does not live with me anymore, I can ensure my safety at home (locks, keys, alarm system etc.) _____.
6. I can keep my handbag/safety bag (a place at home/at a friend's home): _____.
7. I need the following things in case of a quick departure from home (content of the safety bag):
 - money/cash
 - extra pair of home and car keys
 - extra clothes
 - personal hygiene items
 - mobile phone, important phone numbers, phone card
 - medical prescriptions
 - important documents/cards (passport/identity card, health insurance card etc.)
 - children's favourite toys
 - other, _____
8. The health care provider has told me that:
 - I am not responsible for the violent behaviour of my partner but I can decide how to improve my and my children's safety.
 - I deserve better than this: me and my children have the right to lead a safe life.
 - Violence is a crime and I can report it to the police.
 - There are restriction/barring orders and I know how I can apply for them.
 - There are places where to get support from: _____
9. The health professional has suggested/we have agreed that I can continue dealing with the problem at the following help providers: _____.
10. I can keep this safety plan without endangering my own or my children's safety at: _____.

Glossary of terms

Different terms can define a person who have had experienced the violence at least once in the life time. The proper term should be used according to the moment when the professionals meet with the person. A person harmed, injured, or killed as a result of a violent action or a person who has come to feel helpless and passive in the face of misfortune or ill-treatment can be called victim. The term is technically accurate but in the same time it contributes to a feeling of powerlessness for those who have suffered some form of GBV. The term survivor defines the person who seeks help, which has or works to develop an ability to cope with trauma, which learns how to protect self, a person which struggles to take back their life. But, ultimate, the survivor is both a victim of GBV and a survivor of GBV. Sometimes, but rarely, the term client is used to identify a person by the services they receive instead of by the violence they have survived. Considering the objectives of this document, the term victim/survivor will be used to cover both situations, before and after they disclose/report the GBV to a professional.

Domestic violence/Intimate partner violence

All acts of physical, sexual, psychological or economic violence that may be committed at home or in a public place by a person who is a family member or a person that has been an intimate partner or spouse or ex-partner, irrespective of whether they lived together (Council of Europe, Convention on preventing and combating violence against women and domestic violence, CETS No. 210).

Child marriage

Formal marriage or informal union under the age of legal consent is a reality for both boys and girls, although girls are disproportionately the most affected (UNICEF, Child marriage, 2012).

Essential services

A core set of services required, at an absolute minimum, to secure the rights, safety and well-being of any woman, girl, or child who experience violence against women. Whilst the essential services may not be provided in the same way in every country or setting, they include a combination of universal services such as health, care and social welfare and well-being, statutory services such as policing and justice responses, and specialist social services.

Gender-based violence

A form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men (UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), General Recommendation No. 19 on VAW, Art. 1).

Justice service providers

Include state/government officials, judges, prosecutors, police, legal aid, court administration, lawyers, paralegals, and victim/survivor support/social services staff.

Mandatory reporting

Refers to legislation passed by some countries or states that requires professionals and/or individuals to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.

Perpetrator

Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against her/his will (IASC, 2005, Guidelines for gender-based violence interventions in humanitarian settings: Focusing on prevention of and response to sexual violence in emergencies).

Rape/rape attempt

Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape (WHO, World report on violence and health).

Referral

The process of how a woman gets in touch with an individual professional or institution about her case and how professionals and institutions communicate and work together to provide her with comprehensive support. Partners in a referral network usually include different government departments, women's organizations, community organizations, medical institutions and others (UNFPA 2010).

Referral system

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

Reporting GBV case

Disclosure of a GBV incident/case by a service provider to another service provider; sharing information about a GBV case to other institution/organization during the process of referral. The reporting could be made only with and within the limits of victim/survivor's consent, with few exceptions.

Sexual abuse/violence

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim and survivor, in any setting, including but not limited to home and work (WHO, World report on violence and health).

Sexual exploitation

Any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another (UN Secretary-General's Bulletin on protection from sexual exploitation and abuse (PSEA) (ST/SGB/2003/13).

Traffic of human beings

The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs (Protocol to Prevent, Suppress and Punish Trafficking in Persons contributing to United Nations Convention against Transnational Organized Crime).

Violence against women

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (UN Declaration on the elimination of violence against women. New York, United Nations, 1993). It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.

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Police services provision, part of multi-sectoral response to GBV

Standard Operating Procedures

2015



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Published by the UNFPA Regional Office for Eastern Europe and Central Asia (UNFPA EECARO), 2015.

The views expressed in this publication are those of the authors, and do not necessarily represent the views of UNFPA, the United Nations or any of its affiliated organizations.

Design & printing: Image Studio s.r.l.

ISBN 978-973-87875-9-9

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Purpose and objectives

As police are often the gatekeepers to the system, their response to a victim/survivor is often the basis upon which women decide whether or not to continue in the system. In other cases they may actually prevent women from even having the ability to make this decision.

The Standard Operating Procedures (SOPs) provide clear and detailed description of routine actions of police which provide assistance/services for GBV victims/survivors.

The objectives of SOPs for intervention on GBV cases of police are the following:

- assist for effective identification of GBV victims/survivors,
- ensure and/or increase the victim/survivor's safety at all stages of the intervention;
- ensure quality and consistency of service provision;
- facilitate improved and coordinated GBV documentation and data collection;
- guaranty the confidentiality of the services provided to GBV victims/survivors;
- facilitate effective referral for GBV victims/survivors within and outside the law enforcement sector; and
- link the police with the other service provided to GBV victims/survivors.

While both men and boys can also suffer from the direct and indirect impacts of gender-based violence, this SOP's primary focus is on women and girls as they are overwhelmingly targeted for violence and abuse; and the forms of violence they experience, the severity, frequency and consequences are very different from violence experienced by men.

Applicability

For justice services to be effective, they should ensure that a broad range of options are available to all GBV victims/survivors, from reporting or initial contact to ensuring appropriate remedies. Essential justice services are of universal relevance for all formal justice systems, including relevant legal domains (criminal, civil, administrative and family law) as well as common law, civil law traditions and religious based justice traditions. The essential services encompass:

- prevention measures
- initial contact
- investigation
- pre-trial/hearing process
- trial/hearing process
- perpetrator accountability and reparation
- post trial processes
- protection, support, communication and coordination

The police represent a part of the formal justice system, responsible to investigate and prosecute GBV cases that are disclosed to these institutions and constitute offences under the national laws. Also, it is one of the most important key-entry points for GBV victims/survivors, often the first stop for asking for legal aid by GBV victims/survivors. Because the other justice providers, except police, intervene later in the flow of GBV victim/survivor's assistance and their procedures are very specific and regulated by specific laws, the present SOPs will refer only to the police response to GBV.

The SOPs describe clear procedures that regulate the step-by-step routine activity, the roles, and responsibilities to be followed by the staff of any police department/institution/agency. The SOPs will detail two essential services, initial contact and investigation.

For a better implementation of the SOPs, a minimal training of counsellors in using the present SOPs is indicated. Preferably, the training should be part of a comprehensive training programme/curriculum, which includes sections on multi-sectoral response to GBV, specific response to GBV of police and prevention and awareness.

The SOPs does not include any description of the specific duties of the police officers (internal flow of information and procedures, specific documentation of incidents, reporting). Any other specific procedures, regulated by country legislation, regulations and statutes, may be added when the present SOPs are adapted to the country.

Guiding principles

Principles of multi-sectoral response to GBV

Victim-centred approach. All service providers engaged in multi-sectoral response to GBV prioritize the rights, needs and wishes of victim/survivor.

Partnership. The multi-sectoral response to GBV implies good cooperation and coordination of involved institutions/organizations.

Participative management. The rules regarding the multi-sectoral intervention and referral, the strategies and action plans, including planning, implementing, monitoring and evaluating programmes should be done in a participatory manner, including the input of beneficiaries (if applicable).

Strategic planning. The policies that address GBV phenomenon should be translated in inter-institutional common strategies, with specific objectives and activities.

Integrated services. The procedures for intervention and referral as well as the protection measures require a multi-disciplinary approach based on unified work methodology.

Prevention. An effective integrated approach sets as a priority also the prevention of GBV.

Accountability. All interventions/organizations have to ensure the accountability (and measures of it) for staff to implement and respect the agreed programs/rules and to follow these guiding principles in their work.

Sustainability. Despite the political changes or staff turnover/demotivation, once the multi-sectoral response to GBV is assumed, the institutions/organizations should ensure all conditions to implement and sustain this approach.

Principles of working with GBV victims/survivors

Safety and security. The safety of both the victim/survivor and the police officer should be a priority when investigating a GBV case. Evaluating the safety of the GBV victim/survivor needs to be done at the moment of identification and when the person reveals she/he has been victim of GBV. When starting the interaction with a GBV victim/survivor it is important to consider the possible threats (violent husbands, family members) to ensure that the investigation can be done without likely harm to one-self, the GBV victim/survivor or other colleagues.

Confidentiality. Respecting confidentiality is an important measure to ensure the safety of both the GBV victim/survivor and the police officer. All the time, the confidentiality of the victim/survivor shall be respected. This includes sharing only the necessary information, only in the situation that is necessary or requested, and only with the victim/survivor's agreement. Privacy during the case investigation and confidentiality of data collection, record keeping, reporting and information sharing will decrease the exposure of both GBV victim/survivor and police officer. Maintaining confidentiality ensures that a GBV victim/survivor does not experience further threats and/or violence as a result of seeking assistance and also protects police officer from threats of violent perpetrators or family members. Shared confidentiality in the police profession means that GBV victim/survivor information may be shared with other police officers on a "need to know basis" only. Information may be shared with colleagues if there is a practical/administrative reason for it and the police officer is referring the GBV victim/survivor to another police officer. This must be explained to the GBV victim/survivor beforehand and she must understand what information and to whom this will be shared, and, if possible, consent must be obtained. If the confidentiality is limited by a regulation regarding mandatory reporting, the victim/survivor should be informed immediately.

Informed choice. Any action should be made only with the GBV victim/survivor's permission and after obtaining of an informed consent.

Victim's needs centred. During the intervention on GBV incidents/cases, respecting the GBV victim/survivor's wishes, rights, and dignity is the best approach aimed to create an environment full of respect, which may facilitate the GBV victim/survivor's ability to identify her needs and to make decisions about possible ways of action. Police should support victims/survivors in their decision-making, considering the victim/survivor risks and vulnerabilities.

Perpetrator accountability requires police services to effectively hold the perpetrators accountable while ensuring a fair investigation of the incident. Police need to make all efforts in identifying the perpetrator (when is the case), to inform the perpetrator on the legal consequences of its violent acts, and to take all legal steps for referring the case to justice.

Non-discrimination. Regardless of age, race, national origin, religion, sexual orientation, gender identity, disability, marital status, educational and socio-economic status, all victims/survivors are equal and shall be treated the same and have equal access to services.

Conditions and behaviours that might indicate GBV

In many cases, the GBV victim/survivor might change their mind after asking for help from law enforcement and does not want to make a formal complaint. Moreover, some of them try to deny the real reason for seeking help. Some of the barriers GBV victims/survivors face in official reporting GBV and leaving violent relations/situations are:

- diminished cognitive functioning and mental or physical disability;
- lack of awareness of what GBV means and the diversity of forms;
- fear of the perpetrator;
- shame, fear of social consequences, especially in traditional and religious communities;
- financial dependency on the perpetrator (often the victims/survivors have no job, money, place to leave);
- investments in partners, families, properties, common business to leave;
- a perceived limited awareness or actual lack of access to available services;
- lack of culturally appropriate services;
- fear that they will not be believed;
- perception that services will not be able to offer assistance.

However, it is possible to identify the GBV victim/survivor through signs of abuse if observed and shared by a relative, neighbour or other service provider, and even if a woman doesn't want or is scared to go through legal procedures, she still has a chance to receive help through other channels like offices of psychosocial services or women's support groups.

Conditions that might indicate GBV

- Multiple injuries, in multiple body zones that may not be fall result
- Unexplained injuries or with unclear/confusing explanations
- Symmetrical injuries
- Bruises, wounds, lacerations, bites, burns on different stages of recovery, especially on arms and face
- Injuries hidden by clothes

- Constant feeling of danger (always feeling on the alert)
- Fear of everything
- Headaches
- Substance abuse
- Physical reactions (trembling or fainting on remembering the traumatic event)

Behaviours associated with GBV

- Discomfort, inability to focus in the presence of partner
- Attempts to justify the behaviour of the abuser
- Entrenched belief that the abuser will change
- Partner refusing to leave the room where officer is talking to GBV victim/survivor
- Indecisiveness
- Changes in statements, story of incidents
- Denial of and minimizing the event and the consequences, and the belief that matters are under control
- Tendency to generalize (like saying “all people are abusive”)
- Lack of access to a phone where she/he can be contacted
- Moodiness and emotional instability
- Loss of emotional control
- Difficulty in making decisions

How to interact with a GBV victim/survivor

Asking about GBV might be challenging for any service provider. The following recommendations help provider to increase confidence in asking about GBV and also to avoid re-victimisation.

- If possible, leave anything (e.g. gun, cudgel) linked with the law enforcement status, and might intimidate the GBV victim/survivor, outside the room where the interaction with the GBV victim/survivor will take place. If not possible and it is mandatory to keep them with you, explain this to the victim/survivor and highlight that this has nothing to do with her/his situation.
- Take the initiative to ask about violence – do not wait for the woman to bring it up. This shows that you take a professional responsibility for her situation, and it helps to build trust.
- Avoid asking about GBV in the presence of family member, friend, children or any other person.
- Be patient with GBV victims/survivors, keeping in mind that in crisis they may have contradictory feelings. Don't pressure the victim/survivor to disclose. If she/he does not disclose, tell her/him what made you think about violence.
- Avoid unnecessary interruptions and ask questions for clarification only after she has completed her account.
- Avoid passive listening and non-commenting. This may make her think that you do not believe her and that she is wrong, and the perpetrator is right. Carefully listen to her experience and assure her that her feelings are justified.
- Use the same language as the victim/survivor; if the victim/survivor speaks other language that the provider, ask for a provider who speaks the same language or for an interpreter to assist her/him.
- Adapt language and words at the understanding level of the victim/survivor. Do not use professional jargon and expression that might confuse the victim/survivor.
- Formulate questions and phrases in a supportive and non-judgmental manner, using a sympathetic voice. Use open-ended questions and avoid questions starting with "why", which tends to imply blame of GBV victim/survivor.
- Don't blame the woman. Avoid questions such as "Why do you stay with him?", "Did you have an argument before violence happened?", "What were you doing out alone?", "What were you wearing?" Instead, reinforce that GBV cannot be tolerated.

- Use supportive statements, such as “I am sorry that this happened to you” or “You really have been through a lot”, which may encourage the woman to disclose more information.
- Emphasize that violence is not victim/survivor’s fault and only the perpetrator is responsible for.
- Explain that the information will remain confidential and inform her about any limitations to confidentiality.
- Use eye contact as culturally appropriate, and focus all attention on the victim/survivor. Avoid doing paper work at the same time.
- Be aware of your body language. How you stand and hold your arms and head, the nature of your facial expression and tone of voice all convey a clear message to the woman about how you perceive the situation. Show a non-judgemental and supportive attitude and validate what she is saying. Avoid body language conveying the message of irritation, disbelief, dislike or anger toward the victim/survivor.
- Do not judge a victim/survivor’s behaviour based on culture or religion.

Procedures

A positive initial contact experience with the justice system is crucial for GBV victims/survivors. The initial contact must demonstrate to the GBV victims/survivor that the justice system, in particular police officers, are committed to her safety, take her complaint seriously, and want to ensure that she is well supported during the justice assistance. In the same time, investigations of GBV are essential to be started in a timely and professional manner, and meet the quality requirements for evidence collection and investigation.

The step-by-step procedures are grouped by the type of action that can be done, organized in the following sections: identification, evaluation, legal assistance/investigation, collect evidence, documentation, and referral. If a person suffers a form of GBV, the law enforcement staff must make all efforts to ensure that the victim/survivor obtains all the support that may receive. In all stages of the assistance, the victim's autonomy and confidentiality are subsequent to victim's security.

Identification

First step in any GBV intervention is to identify the victim/survivor; this may be done in different ways: self-disclosure of the victim/survivor, reporting by other provider/person, and provider's identification (police legal action ex officio). Also, the law enforcement staff may meet the GBV victim/survivor for the first time at institution premises or at the place where the violent incident happened, in emergency situations (after a telephone call from victim/survivor or other persons).

When police intervene after an emergency telephone call:

- Make contact with the victim/survivor as soon as possible to address safety concerns (for victim/survivor, children who are present).
- Immediately separate the victim/survivor from the perpetrator.
- Identify and secure any weapons that may be at hand, to protect all persons present.
- Refer for emergency medical assistance if needed.
- Evaluate the scene for people, vehicles, or objects involved as well as possible threats.
- Relay all vital information to other officers, including any possible language barriers.

- In case of physical violence with life threatening outcomes or sexual violence, secure the crime scene to ensure that evidence is not lost, changed, or contaminated.
- Request assistance from other specialists (e.g. field evidence technicians, crime laboratory personnel, and the prosecuting attorney) when appropriate.
- Isolate, search and secure the perpetrator (if present) and remove him from the scene.

In cases when the victim/survivor is asking for assistance directly at police premises or in case of referral from other institutions/services:

- A victim/survivor reaching out for assistance may be in crisis. The victim/survivor's behaviours may actually be symptomatic of this condition and can range from hysteria, crying and rage to laughter, calmness, and unresponsiveness. There is no one typical reaction, so it is important to refrain from judging or disregarding any victim/survivor.
- Greet the person in a welcoming manner.
- Introduce yourself and briefly explain the institution's mandate/services.
- Kindly ask the person to introduce herself/himself.
- Addressing immediate health needs which may threaten the life or integrity of the victim/survivor and ensuring the safety of the victims/survivors and possible accompanying children must be priorities. Refer victims/survivors with severe, life-threatening conditions for emergency treatment immediately, prior any further step of investigation.
- Ask the person about the preference to be assisted by a police officer of the same sex (especially in cases of sexual violence).
- Give the person the chance to ask questions about everything may consider important.
- Gain victim/survivor's trust to increase the quality and accuracy of the information you need for your investigation and prosecution.
- Remember the needs of different population groups (e.g. persons with physical or mental disabilities, religious persons, and ethnic minorities) and make efforts to address them.
- Create a confidential and compassionate environment, attentively listen to the person and give validating messages (please refer to section *How to interact with a GBV victim/survivor*).

- Limit the number of people a victim/survivor must deal with.
- Pay attention to asking questions about GBV in situation when a third person may hear the conversation.
- Do not leave the victim/survivor alone, especially when self-injuries are suspected or the risk for it is present.

A good police officer should be always aware of possible link of GBV with other crimes. For example, there might be a potential link between missing persons and honour killing. The missing person could be a victim/survivor of a domestic homicide. A child may have run away from home to escape domestic violence or other forms of abuse (child marriage) that are occurring in the home.

Evaluation

After identification of a GBV victim/survivor, the police staff should make a decision on the next steps (legal assistance/investigation, collection of evidence, documenting GBV, and referral) to be followed, according to the resources, skills and mandate to effectively address GBV. An assessment of victim/survivor's needs and resources should be undertaken that would serve as basis for development of further steps of investigation.

- Obtain consent for services that will be provided. If the victim/survivor cannot read and write, the informed consent statement will be read up to the victim/survivor and a verbal consent will be obtained (this will be mentioned in the informed consent form or other records).
- Explain the right to provide limited consent where they can choose which information is released and which is kept confidential.
- Give adequate information for informed consent. Inform the victims/survivors about possible implications of sharing information about her/his case with other institutions/services.
- Ask the victim/survivor to tell in her own words what happened, to talk about the perpetrator, types of violence, current GBV incident and previous GBV experiences. Encourage the victim/survivor to be specific and to tell her personal story, not what she might consider being common with other GBV situations.
- Minimize the number of times a victim/survivors must relay her story.

- Assure the victim/survivor that she/he is assisted in a non-judgemental, compassionate and understanding way, and all efforts will be made to help her/him.
- Ask the victim/survivor to express her/his own expectations from the law enforcement assistance/intervention.
- Think to the assistance/intervention that should be provided, tailored on the needs and expectations in order to protect the GBV victim/survivor.

Service provision/Intervention

Investigation and evidence collection is critical in GBV cases. Due to the fact that most of the GBV forms happen behind closed doors and are rarely reported, the victim/survivor's testimony is sometimes the only evidence of the violent behaviour. A correct and complete investigation can provide additional evidence for prosecutors to support the victim/survivor's testimony. In some countries, police or justice have the legal mandate to issue and enforce restraining or protection orders.

While prioritizing the safety of victims/survivors, police officers should also focus efforts on gathering evidence in order to charge a suspect and build a prosecution case upon victim/survivor's willingness and her further decision to proceed with related legal procedures. The police cannot rely entirely on the victim/survivor's statement. In all domestic violence cases, investigating officers should explore the history of domestic violence. This information should be used to support the prosecution file and to prove that the offence is part of a pattern of domestic abuse and is not an isolated or single incident.

Investigation

- Explain to the victim/survivor about her/his legal rights and ways to exercise them.
- Advise the victim/survivor on options and assistance available as well as all information that may be necessary or helpful to enable her/him to make a decision.
- Advise the victim/survivor on the right to make a complaint and follow court trial, in accordance with the offence/contravention.
- The victim/survivor should clearly understand that filling up the abuse report is not a criminal action.
- Record the victim/survivor's complaint in the registration book and assign a registration number for future follow up.

- After advising the victim/survivor on the available options, explain clearly the further process, including legal procedures and obtaining counselling and shelter.
- When explaining the processes avoid legal terminology as much as possible as many victims/survivors may not understand legal terms and may be confused by them.
- The following questions the victim/survivor may want answered: How long will I be here today? How many times will I have to come back? Will the perpetrator find out what I am saying? Can you keep me and my family safe? How long will the investigation take? Will there be a trial? Who will decide if there is going to be a trial? What will I have to do if there is a trial? How long does a trial take? What is a trial like?
- Reinsure the victim/survivor about the confidentiality of the information/evidence.
- Ask the victim/survivor to tell in her own words what happened, to talk about the perpetrator, types of violence and severity. In case of reporting by other provider some information might be already available.
- Evaluate the needs and resources, to understand the social, familial and individual context that affects the victim/survivor's situation.
- Inform the victim/survivor about institution's mandate, the possible action/intervention that can be made by law enforcement institutions.
- Specify the mandatory legal actions (e.g. for certain crimes, the submission of a case file to justice is mandatory, regardless of the victim/survivor's complaint).
- Offer procedural guidance/assistance and counselling, in the mandate limits, as may be necessary, to avoid wasting time and re-victimisation.
- Offer psychological support (at basic level) to respond to the immediate psychological needs of GBV victim/survivor. If not possible, ask for assistance from a specialised service or refer the victim/survivor.
- Mobilize social support, if needed or at the victim/survivor's request.
- Assist the victim/survivor in safety planning, to increase safety for herself and her children, where needed (please refer to section *Safety plan*).
- Ensure the safety of the victim/survivor, if mandated to do so, during the period of investigation if/when necessary.
- Open a case file and process all relevant documents to be sent to the judiciary if/when necessary.

- Note what victim/survivor discloses using her/his own words.
- Keep all record in a safe and confidential place.
- Inform the victims/survivors about the possible usage of the records.
- Plan any follow-up assistance/intervention, if and as required.
- Avoid the confrontation with the perpetrator.
- Apply penalties/fines to the perpetrators, according to the law.
- Retain in the police custody/arresting/propose for arresting the perpetrator, according to the police mandate.
- Continue the investigation for submitting the file to prosecution/court.
- Follow-up on the results of the Judicial Department.

Collecting evidence

Officers shall request assistance or direction from crime scene technicians and forensic scientists.

Depending on the country legal framework, documentation of physical injuries and psychological status of a GBV victims/survivors are on the mandate of forensic. Professional forensic examination increases the likelihood that injuries will be documented and evidence collected to aid in the investigation and prosecution of perpetrators. Officers, or any other person except the forensic staff, should not normally be present in the examining room. The medico-legal examination must be conducted and documented in a timely and gender sensitive manner that takes into account the needs and perspectives of the victim/survivor and respect her dignity and integrity.

Officers shall protect the integrity of the evidence and guard the chain of custody by properly marking, packaging, and labelling all evidence collected, including:

- Clothing worn at the time of the assault and immediately afterward, especially in case of sexual assault.
- Photographs and/or videotape of the victim/survivor's injuries (if any), the suspect's injuries (if any), and the crime scene prior to processing. When photographing a victim/survivor, the officer must be sensitive to the location of the body injuries and it is recommended to be of the same sex as the victim/survivor.
- Diagram of the crime scene.

- DNA evidence plays a crucial role in the sexual assault investigation. In addition to the victim/survivor's and suspect's bodies and clothing, there are many other potential sources such as condoms, sheets, blankets, pillows, and bottles that may contain biological evidence such as blood, sweat, tissue, saliva, hair, and urine. To properly collect DNA evidence, officers shall follow internal standard operating procedures, if mandated, or to ask for officers in charge with DNA collection.

The officer should explain to the victim/survivor about collection of evidence process:

- Explain what should be done and what should avoid in order to preserve/not to destroy the evidence (e.g. not to wash, change clothes).
- Explain for what purpose the collected evidence might be important/useful.
- Ask the victim/survivor if she/he desires the evidence of violence to be collected (according to the state law).
- Refer the victim/survivor to the nearest facility that can collect forensic evidence. Provide victim/survivor with the exact information on the service that should assist in this matter.
- Accompany the victims/survivors to forensic service, if needed or requested.
- Recall the importance to collect evidence as soon as possible in a particular GBV situation (e.g. sexual violence).

Risk assessment and management

The safety plan is part of the case intervention that can prevent future violent incidents or avoid escalation or exposure to extreme situations. The safety plan is developed taking in consideration risk factors and resources available.

To develop an effective safety plan, understanding the risk factors for repeat and escalating violence is needed. The more risk factors are identified and associated with a GBV case, the higher the risk to which the GBV victims/survivors is exposed.

Risk factors that might be identified:

- Previous acts/incidents of GBV against the victim/survivor, the children or other family members. History of abuse, forms and patterns of violence used, former convictions or reports to police, weapons used are indicators to evaluate the danger.
- Violent behaviour outside the family.
- Separation and divorce are times of high risk.

- The coalition of other family members with the perpetrator.
- Legal or illegal possession and/or use of weapons or threaten to use weapons.
- Alcohol or drugs consumption may disinhibit behaviours and lead to escalation of violence.
- Threats, in particular, threats of murder must be taken seriously.
- Extreme jealousy and possessiveness.
- Extremely patriarchal concepts and attitudes.
- Persecution and psychological terror (stalking).
- Non-compliance with restraining orders by courts or police.
- Possible triggers that may lead to a sudden escalation of violence (changes in the relationship).

A first safety plan needs to be developed and if necessary referral needs to be proposed and organized in a safe non-stigmatizing way.

- List the persons (friends, neighbours) that might be called in an emergency situation or who could give shelter for few days.
- Identify one or more neighbours you can tell about the violence, and ask them to help if they hear a disturbance in your house.
- Practice how to get out of your home safely.
- Pack a safety bag and put it in a place from where can be taken easily in an emergency situation.
- Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he wants to calm him down. You have the right to protect yourself and your children.
- Think about the possibility to address for future help to other service providers.
- Remember, you do not deserve to be hit or threatened.

Documenting GBV

The documentation of GBV incidents is done in several phases during the service provision by the police: the very first interaction of the GBV victim/survivor with the police system (emergency call system, police registration desk), when interviewing the victim/survivor and perpetrator, during investigation, and at the final step when the police summarizes the whole case.

Any GBV incident should be documented using a specific structured incident form. Using a specific form may maximize the quality of data collected, facilitate track record and follow-up of GBV incidents, and offer useful information for improving intervention and policy making process. If not possible to have a specific form, a set of indicators regarding GBV incidents may be added to the existing forms.

Documenting GBV incidents may include the following information:

- Administrative information on collection of evidence (e.g. type of samples, professional/provider who collect the evidence, place of evidence collection, etc).
- Observations of the crime scene, including the behaviour of the victim/survivor and of the perpetrator.
- Full details of the current incident including evidence to support the alleged offence.
- Type of violence.
- Use of weapons or other tools (how and what type).
- Whether the suspect planned the incident.
- Nature and seriousness of the victim/survivor's injuries (physical and emotional).
- Reference to previous incidents including those with previous partners.
- Details of any threats made before or since the incident.
- The relations between the victim/survivor and perpetrators.
- Details of witnesses present during the incident, especially if children were present.
- Details of family members, especially the dependents ones.
- Safety planning measures.
- Future plans and actions measures taken.

Any officer who interviews a victim/survivor or a perpetrator, identifies evidence, or processes a crime scene shall write a report detailing the actions and findings.

Referral

- Assist the victim/survivor, including giving assistance or advice in obtaining shelter.
- Where signs of physical or sexual violence are evident, ensure that the victim/survivor undergoes medical examination and receives medical attention.
- Keep up to date a directory of institutions/organisations which provide services for GBV victims/survivors. The directory must include institution's name, contact person, address, other contact details, list of services provided.
- Evaluate what referral may be useful for the GBV victim/survivor, according to the assessed needs and wishes.
- Inform the victim/survivor about the possibility to be referred to other service providers, as requested and/or needed.
- Obtain the consent of the victim/survivor to make the referral, prior any further step.
- Clarify with the victim/survivor what information will be shared to other service providers and what information will be kept confidential (specify if there are any legal regulation/limitation).
- Give to the victim/survivor complete and correct information about service providers, following the 3W scheme described below:
 - WHO** – which institution/organization provide services to GBV victims/survivors, adding contact information of a person (name, telephone number) that can be reached as an entry point to that service
 - WHAT** – what sort of assistance they can expect to receive from a specific service provider, adding cost information related to that service
 - WHERE** – where exactly is the place (the exact address) of the indicated services
- Make the referral according to the victim/survivor's choice.
- Accompany the referral by a short written report and a telephone discussion with the other service provider, as a method for avoiding the situation when the victim/survivor has to repeat the story and answering the same questions during multiple interviews, passing again through the psychological trauma caused by the GBV incident.
- Encourage the victim/survivor's autonomy by empowering her/him to do the referral by itself.
- Accompany the victim/survivor to the referred service provider, if needed and possible.

Plan for interview when conducting an investigation - model

Category	Sample questions
Who	was the complainant/victim/survivor? made the report? discovered the offence? saw or heard something of importance? had a motive for committing the offence? committed the offence? helped the offender? was interviewed? worked on the case? marked the evidence? received the evidence?
What	type of offence was committed? actions were taken by the suspect and using what methods? do the witnesses know about it? evidence was obtained? was done with the evidence? tools or weapons were used? actions did you take? further action is needed? other agencies were notified?
Where	was the offence committed? were the tools or weapons found? was the suspect seen? were the witnesses? was the offence discovered? does the offender live or frequently go? is the offender? would the offender be most likely to go? was the offender located/apprehended? was the evidence marked? was the evidence stored?

When	<p>was the offence committed? was the offence reported? did you arrive? did you contact witnesses? was the offender located/apprehended? did help arrive?</p>
How	<p>was the offence committed? did the offender get to and from the scene? did the offender obtain information needed to commit the offence? were the tools or weapons obtained? did you get your information regarding the offence?</p>
Why	<p>was the offence committed? were particular tools or weapons used? was the offence reported? were witnesses reluctant to talk? was the witness eager to point out the offender? was there a delay in reporting the offence?</p>
With whom	<p>does the offender associate? are the witnesses connected? do you expect to locate the suspect?</p>
How much	<p>knowledge was necessary to commit the offence? damage was done? property was taken, if any? trouble was it to carry the property away? information are the witnesses withholding? is the complainant/victim/survivor withholding? additional information do you need to help clear the offence?</p>

Individual safety plan for women who experienced violence by intimate partners or other family members - model

Client _____ Police officer _____

Date _____ Re- evaluation (dates) _____

1. If my own or my children's safety is in danger at home, I can go to _____ or _____ (decide this although you would not expect another violent act).

2. In a violent or threatening situation a safe way out is _____ (e.g. which doors, windows, elevator, stairs or emergency exit I could use).

3. If an argument seems unavoidable, I will try to have it in a room or an area that I can leave easily. I will try to avoid any room where weapons may be available.

3. I can talk about violence with the following persons and ask them to call the police if they hear suspicious noises in my house: _____.

4. I can use (e.g. a sign, a word) _____ as a code with my children or friends so that they can call for help.

5. If my partner does not live with me anymore, I can ensure my safety at home (locks, keys, alarm system etc.) _____.

6. I can keep my handbag/safety bag (a place at home/at a friend's home): _____.

7. I need the following things in case of a quick departure from home (content of the safety bag):

- money/cash
- extra pair of home and car keys
- extra clothes
- personal hygiene items
- mobile phone, important phone numbers, phone card
- medical prescriptions
- important documents/cards (passport/identity card, health insurance card etc.)
- children's favourite toys
- other, _____

8. The police officer has told me that:

- I am not responsible for the violent behaviour of my partner but I can decide how to improve my and my children's safety.
- I deserve better than this: me and my children have the right to lead a safe life.
- Violence is a crime and I can report it to the police.
- There are restriction/barring orders and I know how I can apply for them.
- There are places where to get support _____

9. The police officer has suggested/we have agreed that I can continue dealing with the problem at the following help providers: _____.

10. I can keep this safety plan without endangering my own or my children's safety at: _____.

Glossary of terms

Different terms can define a person who have had experienced the violence at least once in the life time. The proper term should be used according to the moment when the professionals meet with the person. A person harmed, injured, or killed as a result of a violent action or a person who has come to feel helpless and passive in the face of misfortune or ill-treatment can be called victim. The term is technically accurate but in the same time it contributes to a feeling of powerlessness for those who have suffered some form of GBV. The term survivor defines the person who seeks help, which has or works to develop an ability to cope with trauma, which learns how to protect self, a person which struggles to take back their life. But, ultimate, the survivor is both a victim of GBV and a survivor of GBV. Sometimes, but rarely, the term client is used to identify a person by the services they receive instead of by the violence they have survived. Considering the objectives of this document, the term victim/survivor will be used to cover both situations, before and after they disclose/report the GBV to a professional.

Domestic violence/Intimate partner violence

All acts of physical, sexual, psychological or economic violence that may be committed at home or in a public place by a person who is a family member or a person that has been an intimate partner or spouse or ex-partner, irrespective of whether they lived together (Council of Europe, Convention on preventing and combating violence against women and domestic violence, CETS No. 210).

Child marriage

Formal marriage or informal union under the age of legal consent is a reality for both boys and girls, although girls are disproportionately the most affected (UNICEF, Child marriage, 2012).

Essential services

A core set of services required, at an absolute minimum, to secure the rights, safety and well-being of any woman, girl, or child who experience violence against women. Whilst the essential services may not be provided in the same way in every country or setting, they include a combination of universal services such as health, care and social welfare and well-being, statutory services such as policing and justice responses, and specialist social services.

Gender-based violence

A form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men (UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), General Recommendation No. 19 on VAW, Art. 1).

Justice service providers

Include state/government officials, judges, prosecutors, police, legal aid, court administration, lawyers, paralegals, and victim/survivor support/social services staff.

Mandatory reporting

Refers to legislation passed by some countries or states that requires professionals and/or individuals to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.

Perpetrator

Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against her/his will (IASC, 2005, Guidelines for gender-based violence interventions in humanitarian settings: Focusing on prevention of and response to sexual violence in emergencies).

Rape/rape attempt

Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape (WHO, World report on violence and health).

Referral

The process of how a woman gets in touch with an individual professional or institution about her case and how professionals and institutions communicate and work together to provide her with comprehensive support. Partners in a referral network usually include different government departments, women's organizations, community organizations, medical institutions and others (UNFPA 2010).

Referral system

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

Reporting GBV case

Disclosure of a GBV incident/case by a service provider to another service provider; sharing information about a GBV case to other institution/organization during the process of referral. The reporting could be made only with and within the limits of victim/survivor's consent, with few exceptions.

Sexual abuse/violence

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim and survivor, in any setting, including but not limited to home and work (WHO, World report on violence and health).

Sexual exploitation

Any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another (UN Secretary-General's Bulletin on protection from sexual exploitation and abuse (PSEA) (ST/SGB/2003/13).

Traffic of human beings

The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs (Protocol to Prevent, Suppress and Punish Trafficking in Persons contributing to United Nations Convention against Transnational Organized Crime).

Violence against women

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (UN Declaration on the elimination of violence against women. New York, United Nations, 1993). It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.

References/related documents

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Psycho-social services provision, part of multi-sectoral response to GBV

Standard Operating Procedures

2015



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Published by the UNFPA Regional Office for Eastern Europe and Central Asia (UNFPA EECARO), 2015.

The views expressed in this publication are those of the authors, and do not necessarily represent the views of UNFPA, the United Nations or any of its affiliated organizations.

Design & printing: Image Studio s.r.l.

ISBN 978-973-87875-9-9

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Purpose and objectives

The provision of quality psycho-social services represent an essential component of a coordinated multi-sectoral response to GBV. Social services comprise a range of services that are critical in supporting the rights, safety and wellbeing of women and girls experiencing violence including crisis information and help lines, safe accommodation, legal and rights information and advice.

The Standard Operating Procedures (SOPs) provide clear and detailed description of routine actions of psycho-social service providers, named therefore counsellors, who may provide assistance/services for GBV victims/survivors.

The objectives of SOPs for intervention on GBV cases of psycho-social services are the following:

- assist for effective identification of GBV victims/survivors,
- ensure and/or increase the victim/survivor's safety at all stages of the intervention;
- ensure quality and consistency of service provision;
- facilitate improved and coordinated GBV documentation and data collection;
- guaranty the confidentiality of the services provided to GBV victims/survivors;
- facilitate effective referral for GBV victims/survivors to other service providers; and
- link the psycho-social services with the other resources available for GBV victims/survivors.

While both men and boys can also suffer from the direct and indirect impacts of gender-based violence, this SOP's primary focus is on women and girls as they are overwhelmingly targeted for violence and abuse; and the forms of violence they experience, the severity, frequency and consequences are very different from violence experienced by men.

Applicability

The SOPs describes clear procedures that regulate step-by-step routine activity, the roles, and responsibilities to be followed by the staff of any psycho-social service for GBV victims/survivors. These services could be governmental social assistance departments or specialized services for GBV victims/survivors.

The essential social services for GBV victims/survivors that should be provided in a broad range of settings and situations are:

- Crisis information
- Crisis counselling
- Help lines
- Safe accommodation
- Material and financial aid
- Creation, recovery, replacement of identity documents
- Legal and rights information, advice and representation, including in plural legal systems
- Psycho-social support and counselling
- Women- centred support
- Children’s services for any child affected by violence
- Community information, education and community outreach
- Assistance towards economic independence, recovery and autonomy
- Data collection and information management

The provision of essential social services must be supported by the foundational elements which must be in place: informed consent and confidentiality, accessibility, referral, risk assessment and management, appropriately trained staff and workforce development, monitoring and evaluation, and system coordination and accountability.

The specialized services for GBV victims/survivors might be provided by governmental/public/state institutions (public services); by non-profit/non-governmental or for profit/commercial organizations (private services); and in a framework of a contract between a public/state authority and a private party (non-profit or for profit), in which the private party provides a public service or project and assumes substantial technical and operational responsibilities (public-private partnership).

For a better implementation of the SOPs, a minimal training of counsellors in using the present SOPs is indicated. Preferably, the training should be part of a comprehensive training programme/curriculum, which includes sections on multi-sectoral response to GBV, specific response to GBV of psycho-social services and prevention and awareness.

The SOPs does not include any description of the specific duties of the counsellors regarding psychotherapy, social benefits or other type of specific assistance. Any other specific procedures, regulated by country legislation, regulations and statues, may be added when the present SOPs are adapted to the country.

Guiding principles

Principles of multi-sectoral response to GBV

Victim/survivor-centred approach. All service providers engaged in multi-sectoral response to GBV prioritize the rights, needs and wishes of victim/survivor.

Partnership. The multi-sectoral response to GBV implies good cooperation and coordination of involved institutions/organizations.

Participative management. The rules regarding the multi-sectoral intervention and referral, the strategies and action plans, including planning, implementing, monitoring and evaluating programmes should be done in a participatory manner, including the input of beneficiaries (if applicable).

Strategic planning. The policies that address GBV phenomenon should be translated in inter-institutional common strategies, with specific objectives and activities.

Integrated services. The procedures for intervention and referral as well as the protection measures require a multi-disciplinary approach based on unified work methodology.

Prevention. An effective integrated approach sets as a priority also the prevention of GBV.

Accountability. All interventions/organizations have to ensure the accountability (and measures of it) for staff to implement and respect the agreed programs/rules and to follow these guiding principles in their work.

Sustainability. Despite the political changes or staff turnover/demotivation, once the multi-sectoral response to GBV is assumed, the institutions/organizations should ensure all conditions to implement and sustain this approach.

Principles of working with GBV victims/survivors

Gender-sensitive approach. Services provided need to demonstrate an approach which recognizes the gender dynamics, impacts and consequences of violence against women. Psycho-social services should take into account the needs of specific groups of women and girls, including those belonging to marginalized groups. Psycho-social providers need to respect the diversity of service users and apply a non-discriminatory approach. This implies that all women survivors have equal and full access to psycho-social services and receive support at the same level of quality.

Victim/survivor's centred. During the intervention on GBV incidents/cases, respecting the victim/survivor's wishes, rights, and dignity is the best approach aimed to create an environment full of respect, which may facilitate the victim/survivor's ability to identify her needs and to make decisions about possible ways of action. Psycho-social providers should support victims/survivors in their decision-making.

Safety and security. The safety of both the victim/survivor and the psycho-social provider should be a priority when organizing and offering care to GBV victims/survivors. Evaluating the safety of the victim/survivor needs to be done at the moment of identification and when the person reveals she/he has been victim of GBV. Also assessing one's own safety should be part of evaluation/intervention. When starting the interaction with a victim/survivor it is important to consider the possible threats (violent husbands, family members) to ensure that the interaction take place without likely harm to one-self, the victim/survivor or other colleagues.

Confidentiality and privacy. Respecting confidentiality is an important measure to ensure the safety of both the victim/survivor and the psycho-social provider. All the time, the confidentiality of the victim/survivor shall be respected. This includes sharing only the necessary information, only in the situation that is necessary or requested, and only with the victim/survivor's agreement. Ensuring privacy and confidentiality of intervention, data collection, record keeping, reporting and information sharing will decrease the exposure of both victim/survivor and psycho-social providers. Maintaining confidentiality ensures that a victim/survivor does not experience further threats and/or violence as a result of seeking assistance and also protects psycho-social providers from threats of violent perpetrators or family members. Shared confidentiality in the psycho-social profession means that some information related to a victim/survivor may be shared with other psycho-social colleagues on a "need to know basis" only. Information may be shared with colleagues if there is a medical reason for it and the psycho-social provider is referring the victim/survivor to another psycho-social provider. This must be explained to the victim/survivor beforehand and the victim/survivor must understand what information and to whom this will be shared, and consent must be obtained. If the confidentiality is limited by a regulation regarding mandatory reporting, the victim should be informed immediately.

Informed choice. Any action should be made only with the victim/survivor's permission and after obtaining of an informed consent.

Non-discrimination. Regardless of age, race, national origin, religion, sexual orientation, gender identity, disability, marital status, educational and socio-economic status, all victims/survivors are equal and shall be treated the same and have equal access to services.

Conditions and behaviours that might indicate GBV

The psychological effects of GBV are complex; often, the traumatic impact may not be acute but due to the recurrent and constant character of GBV, the effects are chronic and deep and may lead in some cases to dramatic outcomes or serious psychopathologies.

Conditions that might indicate GBV

Most common psychological and psychosomatic effects:

- Feelings of guilt, shame, anger, sadness, despair, helpless, hopelessness, emptiness, powerless, suffocation
- Constant feeling of danger (always feeling on the alert)
- Fear of everything
- Failure to take care of themselves and others
- Difficulty in concentrating
- Profound loneliness (alienation)
- Loss of ability to make plans
- Lack of initiative, fear of facing life alone, meaning of and interest in life
- Lack of self-esteem
- Agitation, nervousness
- Tachycardia
- Phobic behaviour
- Gastrointestinal disorders
- Sleep disorders
- Eating disorders
- Headaches
- Muscular pain
- Substance abuse

Specific psychological effects more common in case of sexual violence:

- Rumination
- Intrusive thoughts (the memory of the trauma suddenly comes back in a disturbing manner)
- Physical reactions (trembling or fainting on remembering the traumatic event)
- Flashbacks
- Nightmares

Behaviours associated with GBV

- Isolation due to avoidance of people, places, activities, behaviour and attitudes which the batterer dislikes (as a defence from escalating the violence)
- Frequent change of jobs
- Reducing social and leisure activities
- Avoidance of people, places or situations which could remind the victim/survivor of or discover the event
- Loss of the ability to protect herself and her underage children
- Indecisiveness
- Denial and minimizing of the event and the consequences

How to interact with a GBV victim/survivor

Asking about GBV might be challenging for any service provider. The following recommendations help the provider to increase confidence in asking about GBV and also to avoid re-victimisation.

- Take the initiative to ask about violence – do not wait for the woman to bring it up. This shows that you take a professional responsibility for her situation, and it helps to build trust.
- Avoid asking a woman about GBV in the presence of a family member, friend, or children.

Be patient with GBV victims/survivors, keeping in mind that in crisis they may have contradictory feelings. Don't pressure the victim/survivor to disclose. If she/he does not disclose, tell her/him what made you think about violence.

- Avoid unnecessary interruptions and ask questions for clarification only after she has completed her account.
- Avoid passive listening and non-commenting. This may make her think that you do not believe her and that she is wrong, and the perpetrator is right. Carefully listen to her experience and assure her that her feelings are justified.
- Use the same language as the victim/survivor; if the victim/survivor speaks other language that the provider, ask for a provider who speaks the same language or for an interpreter to assist her/him.
- Adapt language and words at the understanding level of the victim/survivor. Do not use professional jargon and expression that might confuse the victim/survivor.
- Formulate questions and phrases in a supportive and non-judgmental manner, using a sympathetic voice. Use open-ended questions and avoid questions starting with "why", which tends to imply blame of GBV victim/survivor.
- Don't blame the woman. Avoid questions such as "Why do you stay with him?", "Did you have an argument before violence happened?", "What were you doing out alone?", "What were you wearing?" Instead, reinforce that GBV cannot be tolerated.
- Use supportive statements, such as "I am sorry that this happened to you" or "You really have been through a lot", which may encourage the woman to disclose more information.
- Emphasize that violence is not victim/survivor's fault and only the perpetrator is responsible for.

- Explain that the information will remain confidential and inform her about any limitations to confidentiality.
- Use eye contact as culturally appropriate, and focus all attention on the victim/survivor. Avoid doing paper work at the same time.
- Be aware of your body language. How you stand and hold your arms and head, the nature of your facial expression and tone of voice all convey a clear message to the woman about how you perceive the situation. Show a non-judgemental and supportive attitude and validate what she is saying. Avoid body language conveying the message of irritation, disbelief, dislike or anger toward the victim/survivor.
- Do not judge a victim/survivor's behaviour based on culture or religion.

First impressions always have a lasting and meaningful impact. The first impression of a GBV victim/survivor coming for psycho-social services is the building, the entrance room and the general environment. This impression can influence the victim/survivor's reaction and the willingness to undergo future actions and all this happens before the counsellor had the chance to greet the victim/survivor.

The discussion with the GBV victim/survivor should take place at a round table or, better, without a table. Sitting on two sides of a table might add an additional barrier in communicating with GBV victims/survivors. A victim/survivor who has the sensation of unequal power with the counsellor might limit the shared information and the trust in the professional.

Staying exactly face-to-face and watching the victim/survivor in her/his eyes might give the wrong impression of confronting, as usually the perpetrator is doing.

Placing the victim/survivor in a position from where she/he can see the entrance/exit door may give the sense of controlling the situation, opposite by the common situation with the perpetrator when often the victim/survivor is isolated and controlled.

Addressing upper layers from Maslow's hierarchy of needs¹ might be challenging if the physical requirements for human survival are not met. Provide refreshments, snacks and water to the victim/survivor as many of them might have limited or restricted access to food. Keep in mind that some service providers do not have funding for victim/survivor's refreshments so the cost would come out of their pocket.

¹ Introduced in 1943 by the humanist psychologist Abraham Maslow, the concept of a hierarchy of needs suggests that people have to fulfil basic needs before moving on to other, more advanced needs. This hierarchy is most often displayed as a pyramid. There are five different levels in Maslow's hierarchy of needs:

1. Physiological needs: needs vital to survival, such as the need for water, air, food, and sleep.
2. Security needs: steady employment, health care, safe neighborhoods, and shelter from the environment.
3. Social needs: needs for belonging, love, and affection, friendships, romantic attachments, and families help fulfil this need for companionship and acceptance, as does involvement in social, community, or religious groups.
4. Esteem needs: things that reflect on self-esteem, personal worth, social recognition, and accomplishment.
5. Self-actualizing needs: self-aware, concerned with personal growth, less concerned with the opinions of others, and interested fulfilling their potential.

Procedures

The general objective of psycho-social services for GBV victims/survivors is to help the victim/survivor to regain self-esteem and the control of their own life. The psycho-social support may include actions to reduce the victim/survivor's suffering and loneliness and social distances, to improve physical health conditions, for social and family reintegration, and provide legal or socio-economic support. In all stages of the assistance, the victim/survivor's autonomy and confidentiality are subsequent to victim/survivor's security.

The step-by-step procedures are grouped by the level of intervention that can be implemented, organized in the following sections: identification, evaluation, intervention, documenting GBV, referral, and case management coordination. The order of sections and/or steps might be changed when interfering with a GBV victim/survivor; however, any assistance of a GBV victim/survivor will begin with the identification. Each counsellor may implement the sections that are according to the statute and mandate. If there is any evidence or suspicion that a person suffers a form of GBV, the counsellor must make all the efforts to ensure that the person obtains all the support that may receive.

Prior any intervention/assistance of GBV victims/survivors, the counsellor must ensure that all her/his personal stereotypes (e.g. blaming victim/survivor or the violence, expecting them to leave, etc.) or barriers are addressed and solved, as well as their own experiences of GBV, to be neutral and supportive.

Identification

First step in responding to GBV is to recognize/identify the victim/survivor and the reasons to initiate the intervention. This can be done by facilitating the self-disclosure as a GBV victim/survivor, or by finding out due to referral or reporting (mandatory or not). The victim/survivor's autonomy and confidentiality are subsequent to victim/survivor's security. This step may include obtaining informed consent for case management services if appropriate or for referral to other service providers.

Addressing health needs which may threaten the life or integrity must be priority. Refer the victims/survivors with severe, life-threatening conditions for emergency treatment immediately, prior ant step in addressing psycho-social needs.

- Greet the person in a welcoming manner.
- Introduce yourself and briefly explain the institution's mandate/services.
- Kindly ask the person to introduce herself/himself.

- Avoid any physical contact with the victim/survivor or accompanying persons, as well as sudden movements. This may be stressful for victims/survivors, especially for those suffering of physical violence.
- Ask the person about the preference to be assisted by a counsellor of the same sex (especially in cases of sexual violence).
- Give the victim/survivor the chance to ask questions about everything may consider important.
- Remember the needs of different population groups (e.g. persons with physical or mental disabilities, religious persons, and ethnic minorities) and make efforts to address them.
- Create a confidential and compassionate environment, active listen to the person and give validating messages (please refer to sections *How to interact with a GBV victim/survivor* and *Working environment*).
- Build the trust of the victim/survivor.
- Do not leave the victim/survivor alone, especially when self-injuries are suspected or the risk for it is present.

Evaluation

After identification of a GBV victim/survivor, the counsellor should make a decision on the next steps (support/counselling, documenting GBV, referral and case management coordination) to be followed, according to the resources, skills and mandate to effectively address GBV.

The evaluation refers to obtaining and analysing information about physical and psychological health of the victim/survivor, social life, relationships and economic status; all this information will help the counsellor to set up the most appropriate intervention, according to the victim/survivor's needs and available resources.

- Obtain consent for services that will be provided. If the victim/survivor cannot read and write, the informed consent statement will be read up to the victim/survivor and a verbal consent will be obtained (this will be mentioned in the informed consent or other forms).
- Explain the right to provide limited consent where they can choose which information is released and which is kept confidential.

- Give adequate information for informed consent. Inform the victims/survivors about possible implications of sharing information about her/his case with other institutions/services.
- Specify if there is any legal mandatory reporting to other institution of a GBV incident/case.
- Ensure the victim/survivor that she/he is assisted in a non-judgemental, compassionate and understanding way, and all efforts will be made to help her/him.
- Think to the care/support that should be provided, tailored on the needs and expectations in order to protect the GBV victim/survivor.
- Ask the victim/survivor to tell in her own words what happened, to talk about the perpetrator, types of violence, current GBV history (type of abuse, duration, frequency, intensity and latest most violent episode), and previous GBV experiences. Encourage the victim/survivor to be specific and personal.
- Evaluate the level of danger and define some rules for self-protection
- Ask about the consequences of the GBV in her/his life
- Psycho-physical-social condition of the victim/survivor and her children
- Background of her family of origin
- Primary and secondary social network
- Ask about victim/survivor's and family's economic situation, dependency or independency, and their living/housing conditions
- Ask about previous efforts to tackle the violent situation, coping strategies, previous attempts to get away from abuse
- Situation of the children (in relation to the GBV, their relations with parents)
- Explore the victim/survivor's feelings about what happened
- Expectations and wishes of GBV victim/survivor (from counsellor, from herself/himself, from perpetrator, from other persons) and what motivates her/him to seek help

Service provision/Intervention

The intervention implies an assemblage of comprehensive essential services for GBV victims/survivors that reduces the effects and consequences of harmful experiences, and prevent further trauma, including re-victimisation. The intervention will follow the individualized intervention plan developed based identified needs and available resources. All intervention actions must be victim/survivor's focused, implemented in a multi-sectoral and holistic manner, adaptable, and sustainable.

Crisis counselling

The crisis counselling aims to achieve immediate safety, make sense of their experience, reaffirm their rights and alleviate feelings of guilt and shame. Crisis counselling could be provided through a wide range of methods including in person, via telephone, mobile phone, e-mail and in various locations and diverse settings.

The long-term counselling, psychotherapy or other form of long-term support/intervention are not covered through this section.

- Address the basic needs (hunger, thirst, sleepiness).
- Ask the victim/survivor to express her/his own ideas on outcomes, coping strategies, resources. Explore together with the victim/survivor all these ways of solving the situation.
- Offer psychological support to respond to the immediate psychological needs of GBV victim/survivor.
- Explain and/or offer alternative choices to the victim/survivor: a) immediate access to safe accommodation; b) immediate access to emergency health care services; and c) the option to re-contact the service, in any circumstances/choice.
- Explore with the victim/survivor the possibility to obtain a restraining/protection order (if applicable).
- Assist the victim/survivor in safety planning, to increase safety for herself and her children, where needed (please refer to section *Safety plan*).
- Explain and agree long-term plan and share contact detail for follow-up.

Safe accommodation

Often, GBV victims/survivors need to leave their housing immediately in order to be safe, by accessing safe houses, refuges, women's shelters or other safe space.

- Provide safe and secure emergency accommodation until the immediate threat is removed.

- Ensure security measures are in place, including: confidential location (where possible), security personnel, and security system.
- Provide basic accommodation needs.
- Provide other specific and complementary essential services, according to victim/survivor's needs and choices: psychological support/counselling, legal advice, support for social reintegration, etc.
- Ensure that the safety and needs of accompanying children are addressed.

Long-term psycho-social support and counselling

Formal and informal counselling services have proven effective in addressing the psychological needs of victims/survivors experiencing depression, anxiety, and/or PTSD. Some of the psycho-social services include support groups, individual counselling, and a 24-hour hotline. Informal counselling services operate on different levels within many communities, ranging from victim/survivor's support groups to faith- and community-based group interventions.

- Empower the victim/survivor to make their own choices.
- Develop plans and actions by assessing and considering victim/survivor's personal needs, different opinions and points of view and by examining the possibility of not doing anything and leaving things as they are. Involve the victim/survivor in developing the intervention plan.
- Provide or mobilize social support.
- Undertake specific actions that will reduce the victim/survivor's suffering, loneliness and social distances, rebuild self-esteem.
- Strengthen self-protection mechanisms and coping strategies, by emphasizing the victim/survivor's resources and capacities, to be able to manage future violent or vulnerable situations without feeling powerless.
- Accept the possibility of failure of the intervention and or undertaken actions and illustrate this to the victim/survivor. Facilitate reflection on the consequences if this should happen.
- Explore/ask all along if there is any other subjects that the victim/survivor wants to discuss about.
- Briefly explain what was agreed for the intervention plan and what actions to be undertaken by the victim/survivor.

- Explain to the victim/survivor about the follow-up plan and share contact detail for follow-up.
- During follow-up sessions, explore the changes in the victim/survivor's situation, effectiveness of coping strategies, results of any actions undertaken by the victims/survivors; explore the difficulties occurred and help the victim/survivor to address them; redefine the problem, plan and further actions.

Other support services

- Provide material and financial aid: emergency transport, food, safe accommodation, basic personal and health care items, cash for certain expenditures (e.g. forensic certificate fee, taxi transfer to and from other services).
- Assist victims/survivors to establish their identity by supporting them to create, recover or replace identity documents.
- Provide legal information to GBV victims/survivors on their rights and range of option available, such as divorce/marriage, child custody, guardianship, restriction/protection measures, and migration status.
- Provide (or refer to) services for children which are appropriate, child sensitive, child-friendly and in line with international standards.
- Provide telephone help lines free of charge or toll-free, preferably 24 hours a day, 7 days a week, or at a minimum, for four hours per day including weekends and holidays. Ensure that staff answering help lines have appropriate knowledge, skills and are adequately trained. Ensure that the help line has protocols connecting it with other social services, and health and justice services to respond to individual circumstances of women and girls.

Risk assessment and management

Risk assessment and management can reduce the level of risk. The safety plan is part of the case intervention that can prevent future violent incidents or avoid escalation or exposure to extreme situations. The safety plan is developed taking in consideration risk factors and resources available.

To develop an effective safety plan, understanding the risk factors for repeat and escalating violence is needed. The more risk factors are identified and associated with a GBV case, the higher the risk to which the GBV victims/survivors is exposed.

Risk factors that might be identified:

- Previous acts/incidents of GBV against the victim/survivor, the children or other family members. History of abuse, forms and patterns of violence used, former

convictions or reports to police, weapons used are indicators to evaluate the danger.

- Violent behaviour outside the family.
- Separation and divorce are times of high risk.
- The coalition of other family members with the perpetrator.
- Legal or illegal possession and/or use of weapons or threaten to use weapons.
- Alcohol or drugs consumption may disinhibit behaviours and lead to escalation of violence.
- Threats, in particular, threats of murder must be taken seriously.
- Extreme jealousy and possessiveness.
- Extremely patriarchal concepts and attitudes.
- Persecution and psychological terror (stalking).
- Non-compliance with restraining orders by courts or police.
- Possible triggers that may lead to a sudden escalation of violence (changes in the relationship).

A first safety plan needs to be developed and if necessary referral needs to be proposed and organized in a safe non-stigmatizing way.

- List the persons (friends, neighbours) that might be called in an emergency situation or who could give shelter for few days.
- Identify one or more neighbours you can tell about the violence, and ask them to help if they hear a disturbance in your house.
- Practice how to get out of your home safely.
- Pack a safety bag and put it in a place from where can be taken easily in an emergency situation.
- Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he wants to calm him down. You have the right to protect yourself and your children.
- Think about the possibility to address for future help to other service providers.
- Remember, you do not deserve to be hit or threatened.

Documenting GBV

Each GBV case should be documented by psycho-social service providers; the documentation provides at least a comprehensive summary of the most relevant information about a GBV incident, if not the case history. The documentation of a GBV case could be made using standardized forms, hand notes, charts, photos, paper registries, etc. Collecting relevant data about each GBV case and gathering them in a data base will a) generate data for monitoring and evaluating GBV cases progress, b) offer a clear view on the disclosed cases in a specific area, and c) help to evaluate the functioning of multi-sectoral response to GBV.

- Collect and register information about GBV victim/survivor/case, including: demographic information (i.e. name, age, sex), marital status, details about children in custody, history of psychiatric conditions, substance and drug consumption, family members and relations between them, information about socio-economic statute of victim/survivor/family, consent obtained.
- Collect and register full details of the GBV incident and history of violence including:
 - evidence to support the alleged offence;
 - history of any other incidents, including those with previous partners;
 - relation between victim/survivor and perpetrator;
 - type of violence and frequency of events;
 - whether weapons were used (how and what type);
 - witnesses present during the incident, including children.
- Describe in detail the consequences/effects of violence (physical, psychical and social).
- Describe risk and protection (personal and social/environmental) factors.
- Record the actions planned or undertaken to tackle the violent situation.
- Note safety planning and case characteristics in this matter.
- During follow-up counselling sessions, collect data regarding case evolution.
- Note what victim/survivor discloses using her/his own words.
- Document your doubts and the evidence they are based on.
- Inform the victims/survivors about the possible usage of the records and obtain the consent on that.

- Keep all records in a safe and confidential place. The guidelines embedded in each country will dictate how comprehensive the information should be.
- Allocate adequate time to enter data in data collection system.

Referral

Referral's system goal is to address the immediate and multiple needs of the victim/survivor in a manner that will ensure the safest and most effective way of reporting and in accordance with victim/survivor's preferences for care and treatment. Also, referral is about a coordinated approach to service delivery. All service providers should be aware of the system and able to activate referrals whether or not they are the first point of contact for a victim/survivor. A referral system can function effectively if information/details about institutions/organizations, specific service providers (professionals) and contact details are systematized and shared between all relevant institutions.

- Evaluate what referral may be useful for the GBV victim/survivor, according to the assessed needs and wishes.
- Inform the victim/survivor about the possibility to be referred to other service providers, as requested and/or needed.
- Obtain the consent of the victim/survivor to make the referral, prior any further step.
- Clarify with the victim/survivor what information will be shared to other service providers and what information will be kept confidential (specify if there are any legal regulation/limitation).
- Give to the victim/survivor complete and correct information about service providers, following the 3W scheme described below:
 - WHO** – which institution/organization provides services to GBV victims/survivors, adding contact information of a person (name, telephone number) that can be reached as an entry point to that service
 - WHAT** – what sort of assistance they can expect to receive from a specific service provider, adding cost information related to that service
 - WHERE** – where exactly is the place (the exact address) of the indicated services
- Make the referral according to the victim/survivor's choice. Do not push the victim/survivor to take any action that she/he is not comfortable with.

- Accompany the referral by a short written report and a telephone discussion with the other service provider, as a method for avoiding the situation when the victim/survivor has to repeat the story and answering the same questions during multiple interviews, passing again through the psychological trauma caused by the GBV incident.
- Encourage the victim/survivor's autonomy by empowering her/him to do the referral by itself.
- Accompany the victim/survivor to the referred service provider, if needed and possible.
- Explain for what purpose the collected evidence might be important/useful. Ask the victim/survivor if she/he desires the evidence of violence to be collected. Recall the importance to collect evidence as soon as possible in particular GBV situations (e.g. sexual violence). Explain what should be done and what should avoid in order to preserve/not to destroy the evidence (e.g. not to wash, change clothes).
- In accordance with the needs and desires, refer victim/survivor to other services. Some key services that could provide essential support for GBV victims/survivors are:
 - nearest facility that can assist her/him in collecting evidence;
 - police to make an official complaint;
 - health facility for medical care.
- Keep up to date a directory of institutions/organisations which provide services for GBV victims/survivors. The directory must include institution's name, contact person, address, other contact details, list of services provided.
- Have agreements and protocols about the referral process with relevant services/institutions, including clear responsibilities of each service.
- Ensure that procedures between services/institutions for information sharing and referral are consistent and known by staff.

Individual safety plan for women who experienced violence by intimate partners or other family members - model

Client _____ Counsellor _____

Date _____ Re- evaluation (dates) _____

1. If my own or my children's safety is in danger at home, I can go to _____ or _____ (decide this although you would not expect another violent act).
2. In a violent or threatening situation a safe way out is _____ (e.g. which doors, windows, elevator, stairs or emergency exit I could use).
3. If an argument seems unavoidable, I will try to have it in a room or an area that I can leave easily. I will try to avoid any room where weapons may be available.
3. I can talk about violence with the following persons and ask them to call the police if they hear suspicious noises in my house: _____.
4. I can use (e.g. a sign, a word) _____ as a code with my children or friends so that they can call for help.
5. If my partner does not live with me anymore, I can ensure my safety at home (locks, keys, alarm system etc.) _____.
6. I can keep my handbag/safety bag (a place at home/at a friend's home): _____.
7. I need the following things in case of a quick departure from home (content of the safety bag):
 - money/cash
 - extra pair of home and car keys
 - extra clothes
 - personal hygiene items
 - mobile phone, important phone numbers, phone card
 - medical prescriptions
 - important documents/cards (passport/identity card, health insurance card etc.)
 - children's favourite toys
 - other, _____
8. The counsellor has told me that:
 - I am not responsible for the violent behaviour of my partner but I can decide how to improve my and my children's safety.
 - I deserve better than this: me and my children have the right to lead a safe life.
 - Violence is a crime and I can report it to the police.
 - There are restriction/barring orders and I know how I can apply for them.
 - There are places where to get support _____
9. The counsellor has suggested/we have agreed that I can continue dealing with the problem at the following help providers: _____.
10. I can keep this safety plan without endangering my own or my children's safety at: _____.

Glossary of terms

Different terms can define a person who have had experienced the violence at least once in the life time. The proper term should be used according to the moment when the professionals meet with the person. A person harmed, injured, or killed as a result of a violent action or a person who has come to feel helpless and passive in the face of misfortune or ill-treatment can be called victim. The term is technically accurate but in the same time it contributes to a feeling of powerlessness for those who have suffered some form of GBV. The term survivor defines the person who seeks help, which has or works to develop an ability to cope with trauma, which learns how to protect self, a person which struggles to take back their life. But, ultimate, the survivor is both a victim of GBV and a survivor of GBV. Sometimes, but rarely, the term client is used to identify a person by the services they receive instead of by the violence they have survived. Considering the objectives of this document, the term victim/survivor will be used to cover both situations, before and after they disclose/report the GBV to a professional.

Domestic violence/Intimate partner violence

All acts of physical, sexual, psychological or economic violence that may be committed at home or in a public place by a person who is a family member or a person that has been an intimate partner or spouse or ex-partner, irrespective of whether they lived together (Council of Europe, Convention on preventing and combating violence against women and domestic violence, CETS No. 210).

Child marriage

Formal marriage or informal union under the age of legal consent is a reality for both boys and girls, although girls are disproportionately the most affected (UNICEF, Child marriage, 2012).

Essential services

A core set of services required, at an absolute minimum, to secure the rights, safety and well-being of any woman, girl, or child who experience violence against women. Whilst the essential services may not be provided in the same way in every country or setting, they include a combination of universal services such as health, care and social welfare and well-being, statutory services such as policing and justice responses, and specialist social services.

Gender-based violence

A form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men (UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), General Recommendation No. 19 on VAW, Art. 1).

Justice service providers

Include state/government officials, judges, prosecutors, police, legal aid, court administration, lawyers, paralegals, and victim/survivor support/social services staff.

Mandatory reporting

Refers to legislation passed by some countries or states that requires professionals and/or individuals to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.

Perpetrator

Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against her/his will (IASC, 2005, Guidelines for gender-based violence interventions in humanitarian settings: Focusing on prevention of and response to sexual violence in emergencies).

Rape/rape attempt

Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape (WHO, World report on violence and health).

Referral

The process of how a woman gets in touch with an individual professional or institution about her case and how professionals and institutions communicate and work together to provide her with comprehensive support. Partners in a referral network usually include different government departments, women's organizations, community organizations, medical institutions and others (UNFPA 2010).

Referral system

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

Reporting GBV case

Disclosure of a GBV incident/case by a service provider to another service provider; sharing information about a GBV case to other institution/organization during the process of referral. The reporting could be made only with and within the limits of victim/survivor's consent, with few exceptions.

Sexual abuse/violence

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim and survivor, in any setting, including but not limited to home and work (WHO, World report on violence and health).

Sexual exploitation

Any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another (UN Secretary-General's Bulletin on protection from sexual exploitation and abuse (PSEA) (ST/SGB/2003/13).

Traffic of human beings

The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs (Protocol to Prevent, Suppress and Punish Trafficking in Persons contributing to United Nations Convention against Transnational Organized Crime).

Violence against women

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (UN Declaration on the elimination of violence against women. New York, United Nations, 1993). It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.

References/related documents

IASC (2005), Guidelines for gender-based violence intervention in humanitarian settings: focusing on prevention of and response to sexual violence in emergencies.

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