

# Training for Health Professionals on Engaging Men in Pre-natal Care



This programme is funded  
by the European Union



**TOGETHER AGAINST  
GENDER STEREOTYPES AND  
GENDER-BASED VIOLENCE**  
#eu4genderequality

These slides are based on the Training Package for Healthcare Professionals on Engaging Men in Prenatal Care. They were produced in the framework of the “EU 4 Gender Equality: Together against gender stereotypes and gender-based violence” programme, funded by the European Union, implemented jointly by UN Women and UNFPA.

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MODULE 1:

GENDER AND HEALTH

## LEARNING OBJECTIVES

- Understand the role of gender in health and daily public health practice
- 1. Be comfortable with core concepts
  - Difference between sex and gender
  - Empowerment
  - Difference between equality and equity

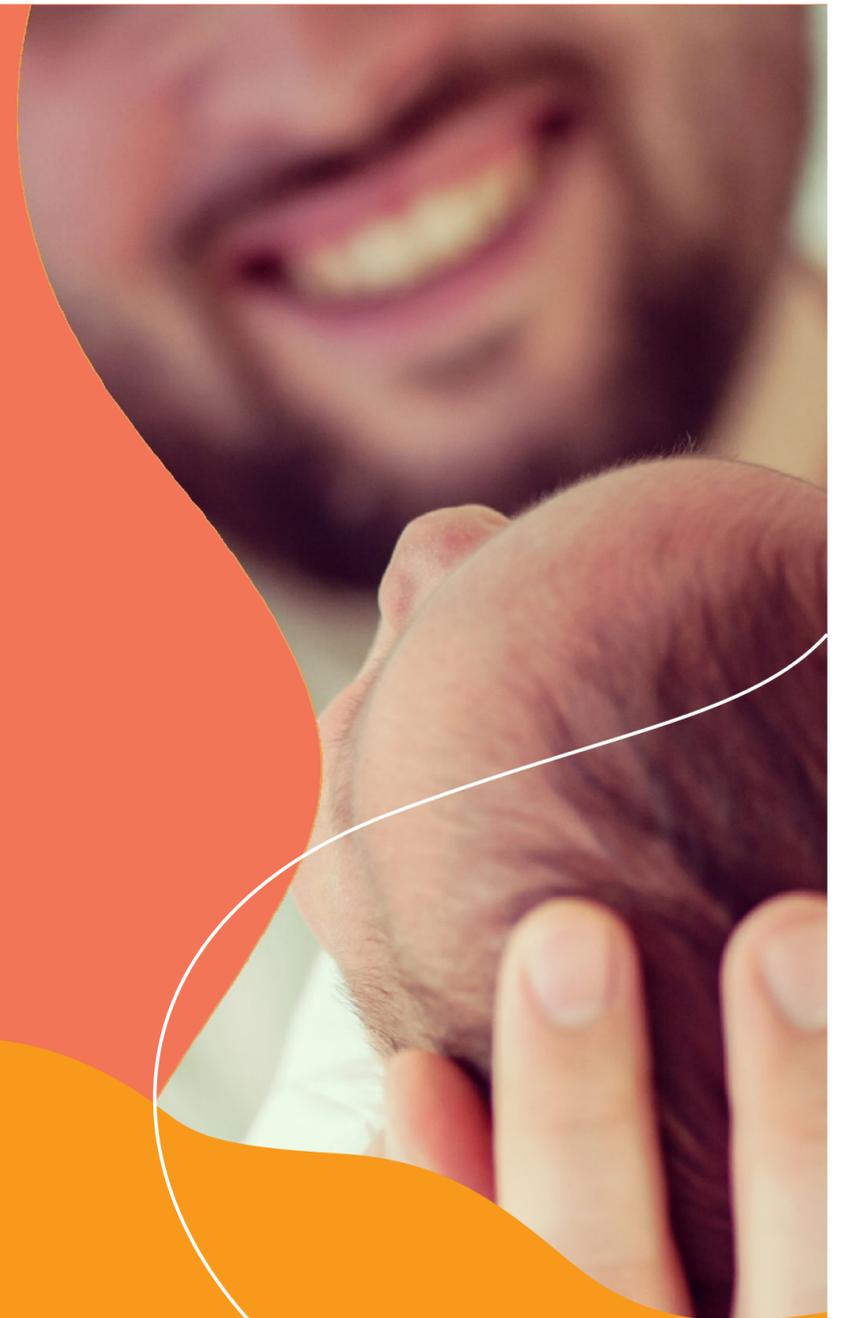


## SESSIONS

1. DOES GENDER MATTER IN HEALTH?
2. SEX AND GENDER
3. UNPACKING GENDER CONCEPTS
4. IDENTITY AND POWER
5. EQUALITY AND EQUITY



# SESSION 1: DOES GENDER MATTER IN HEALTH?

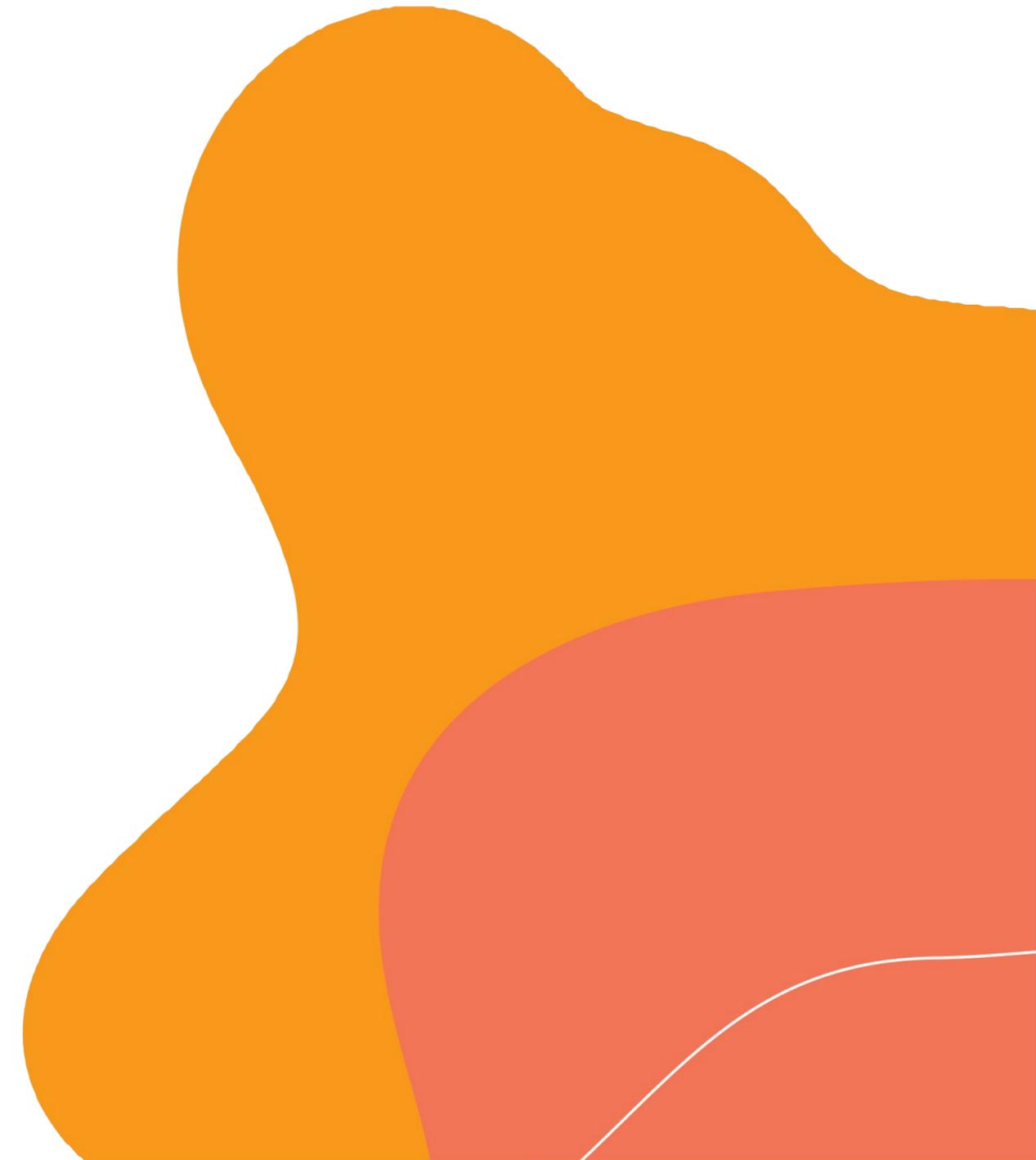


# FLASH CARD FACTS

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## LEARNING OBJECTIVES

- Did you know this fact before?
- How can you explain this fact?  
Give one or two suggested reasons.
- What can be done in the health sector to address this fact?



# WHAT DO THE FLASH CARDS FACTS TELL US?

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- Biological differences between men, women, and non-binary people are not enough to explain different disease patterns.
- Differences in life chances and norms for women, men, and non-binary people affect health outcomes.
- Health differences for women, men, and non-binary people exist beyond sexual and reproductive health.
- Many differences in health outcomes can be mitigated or prevented altogether.

CONCLUSION?

BOTH SEX AND GENDER  
MATTER FOR THE  
HEALTH OF MEN,  
WOMEN, AND  
NON-BINARY PEOPLE.

# SESSION 2: SEX AND GENDER



# SEX AND GENDER

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- **Sex:** biological and physiological characteristics of males, females, and intersex people, such as reproductive organs, chromosomes, or hormones
  - Usually difficult to change
  - *Ex: only women bear children, only men have testicular cancer*
- **Gender:** norms, roles, and relationships of and between women, men, and non-binary people. It varies from society to society and can be changed.
- Gender norms, roles, and relationships lead to different, often unequal opportunities between groups of women, men, and non-binary people.
  - *Ex: more road traffic injuries among men and more trachoma among women.*



# SEX AND GENDER QUIZ

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- This study collected [gender/sex]-disaggregated data.
- The health ministry developed a [gender/sex]-sensitive maternal and child health policy.
- My health facility has staffing policies on [gender/sex] balance.
- What is your [gender/sex]? Male, female, or intersex?

# GENDER IS SOCIALLY CONSTRUCTED



# SESSION 3: UNPACKING GENDER CONCEPTS



# GENDER IS...

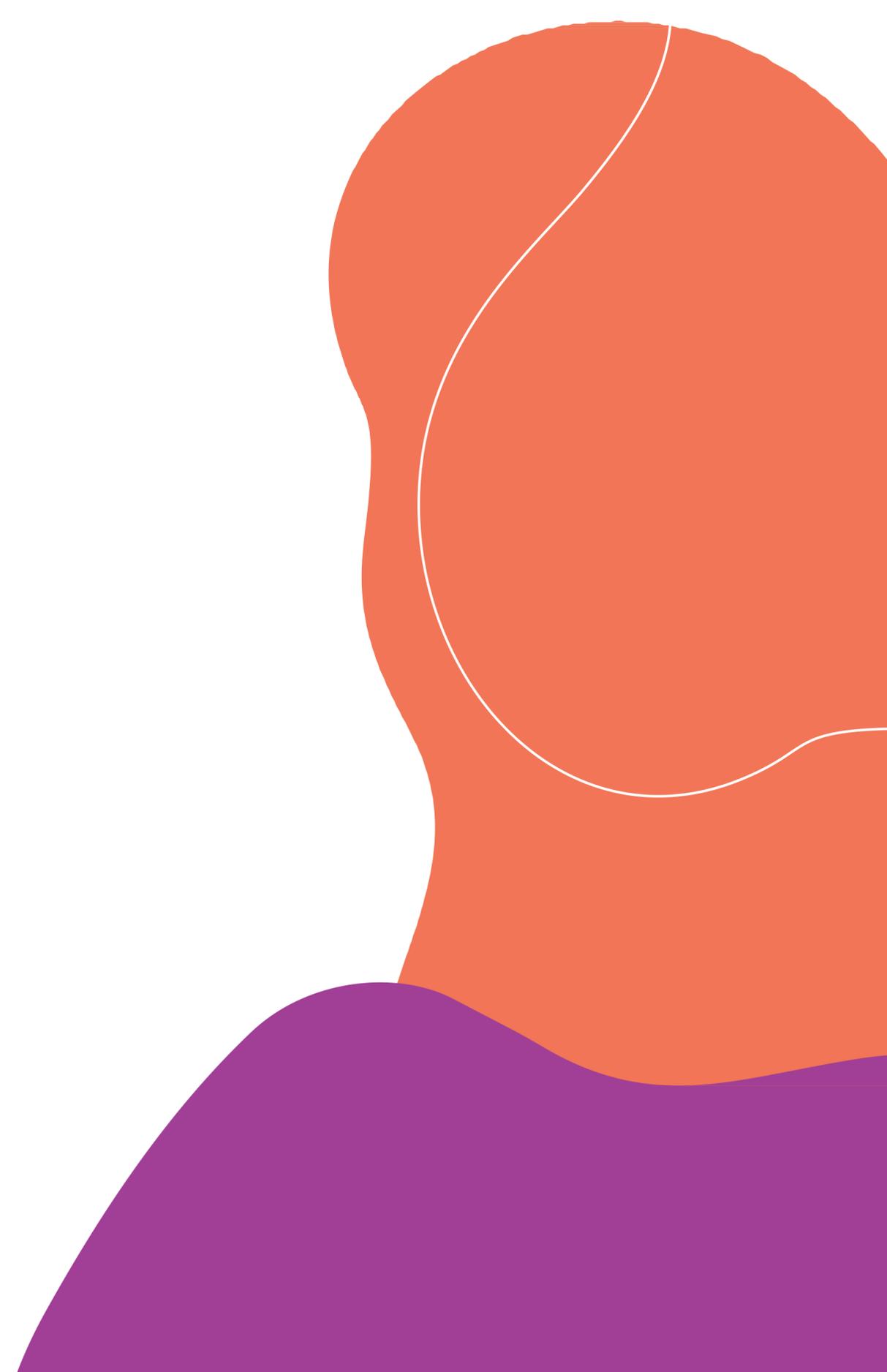
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- **Relational:** women, men, and non-binary people live together in society
- **Hierarchical:** more importance or value is often placed on “masculine” characteristics (or certain male groups)
- **Historical:** beliefs and practices change over time – which means they can be modified!
- **Contextually specific:** diversity among women, men, and non-binary people changes gender norms, roles, and relations.
  - **Ex:** ethnicity, age, sexual orientation, religion, and other factors influence gender norms and vice versa
- **Institutionally structured:** beliefs about women and men are often upheld in values, legislation, religion, etc.

# GENDER NORMS...

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- Beliefs about women, men, girls, boys, and non-binary adults and children
- Are not always explicitly prescribed in laws
- Are passed from generation to generation through socialization
- Change over time
- Differ in different cultures and populations



# IMPORTANT NOTES ON GENDER NORMS

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- Religious or cultural traditions contribute to defining expected behavior of women, men, and non-binary people at different ages
- Many consider gender norms to be the “natural order of things”
- Attempts to change gender norms may be contested if not addressed properly
  - Change requires short, medium, and long-term strategies!

# GENDER NORMS, SUMMARY

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- Gender norms lead to inequality if they reinforce:
  - Mistreatment of one group or sex over another
  - Differences in power and opportunity

# GENDER ROLES

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- Prescribe what men, women, and non-binary people can and should do in a given society
- Explain what women, men, and non-binary people are responsible for in households, communities, and the workplace



# GENDER RELATIONS

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- Social relations between and among women, men, and non-binary people
- Can determine hierarchies between groups of men, women, and non-binary people based on gender norms and roles
- Can contribute to unequal power relations

# GENDER NORMS, ROLES, AND RELATIONS AFFECT EVERYONE!

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- But they affect women, men, and non-binary people differently.
- All three components of gender are important.
- **Why?** They can increase exposure to risk factors or vulnerability to health conditions due to:
  - Stereotypes and discrimination
  - Gender-based division of labor



# GENDER STEREOTYPES

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- Images, beliefs, attitudes, or assumptions about certain groups of women and men
- Usually negative and based on assumed gender norms and roles



# GENDER-BASED DIVISION OF LABOR:

- Where, how, and under what conditions women, men, and non-binary people work
- Includes formal and informal market activities
- Includes work outside the home and tasks in the community and household (paid or unpaid)

# CONCLUDING THOUGHTS

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- Different roles are not the cause of inequality; it is the value placed on these roles that leads to inequality
  - Most societies ascribe a higher value to masculine norms and roles
- Gender norms, roles, and relations affect women, men, and non-binary people differently
  - Norms and roles that undervalue women and non-binary people often lead to:
    - Social exclusion
    - Decreased access to important resources to protect their health
  - Many norms encourage men and boys to engage in high-risk behavior that harms both themselves and others

# SESSION 4: IDENTITY AND POWER

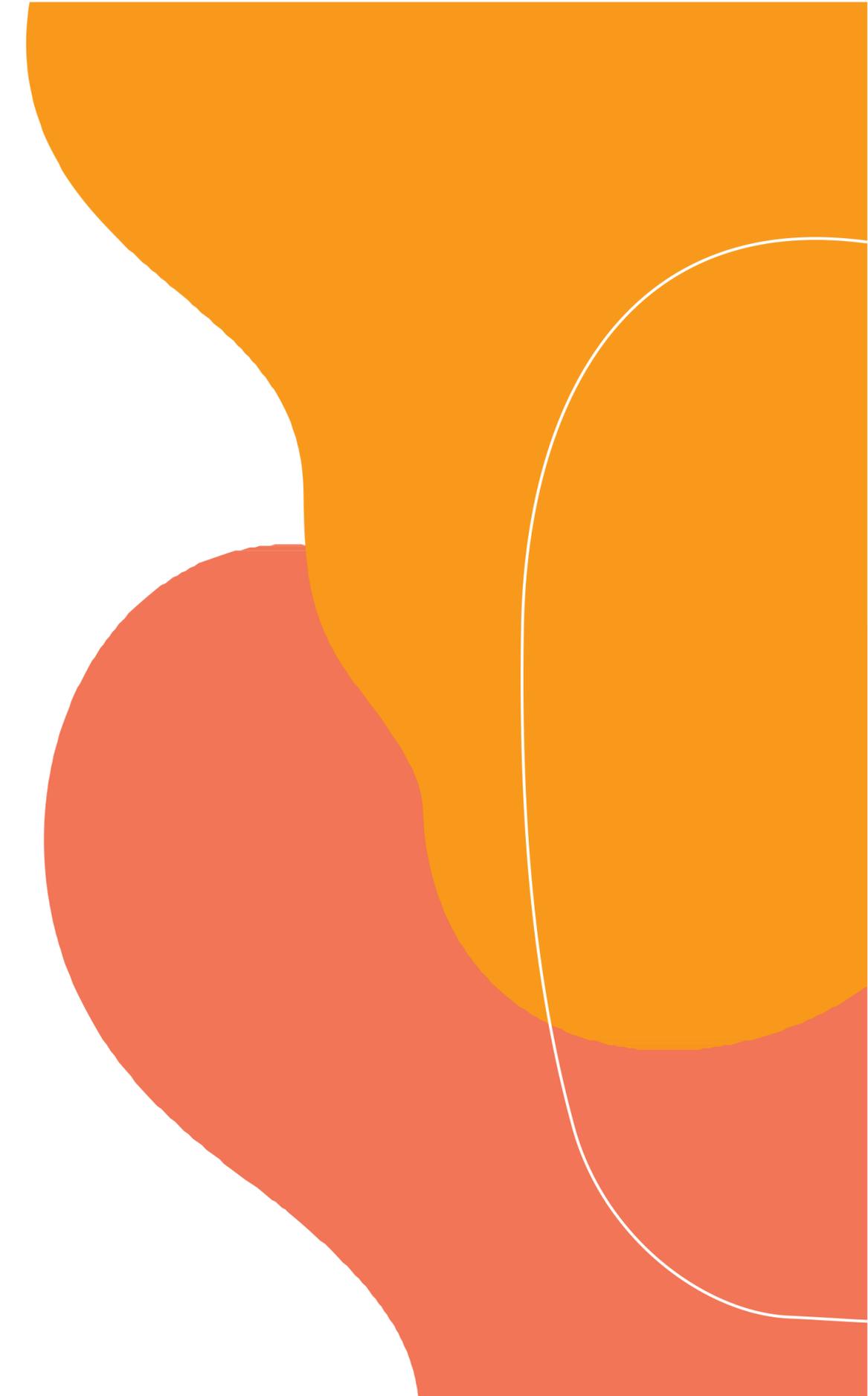


# POWER WALK DISCUSSION

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- What did you notice as people took steps forward or remained still?
- Once you know who everyone is, where are the women? Where are the men? Where are non-binary people?
- Why can some people take a step forward and others not?

# EMPOWERMENT:



- Process that helps people gain and/or strengthen control over their lives
- About putting power in the hands of women, men, and non-binary people of all groups
- An important gender mainstreaming strategy.

Was lack of empowerment an obstacle for your power walk character? How?

# SESSION 5: EQUALITY AND EQUITY



# BOTH GENDER EQUALITY AND GENDER EQUITY IN HEALTH ARE NEEDED

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- **Gender equality: equal chances or opportunities** to access and control social, economic, and political resources, including protection under the law (health services, education, voting rights, etc.)
- **Gender equity refers to fairness** and considers the different needs of women, men, and non-binary people to achieve gender equality.

BOTH GENDER  
EQUALITY AND  
GENDER EQUITY  
ARE NEEDED!

# EMPOWERMENT:

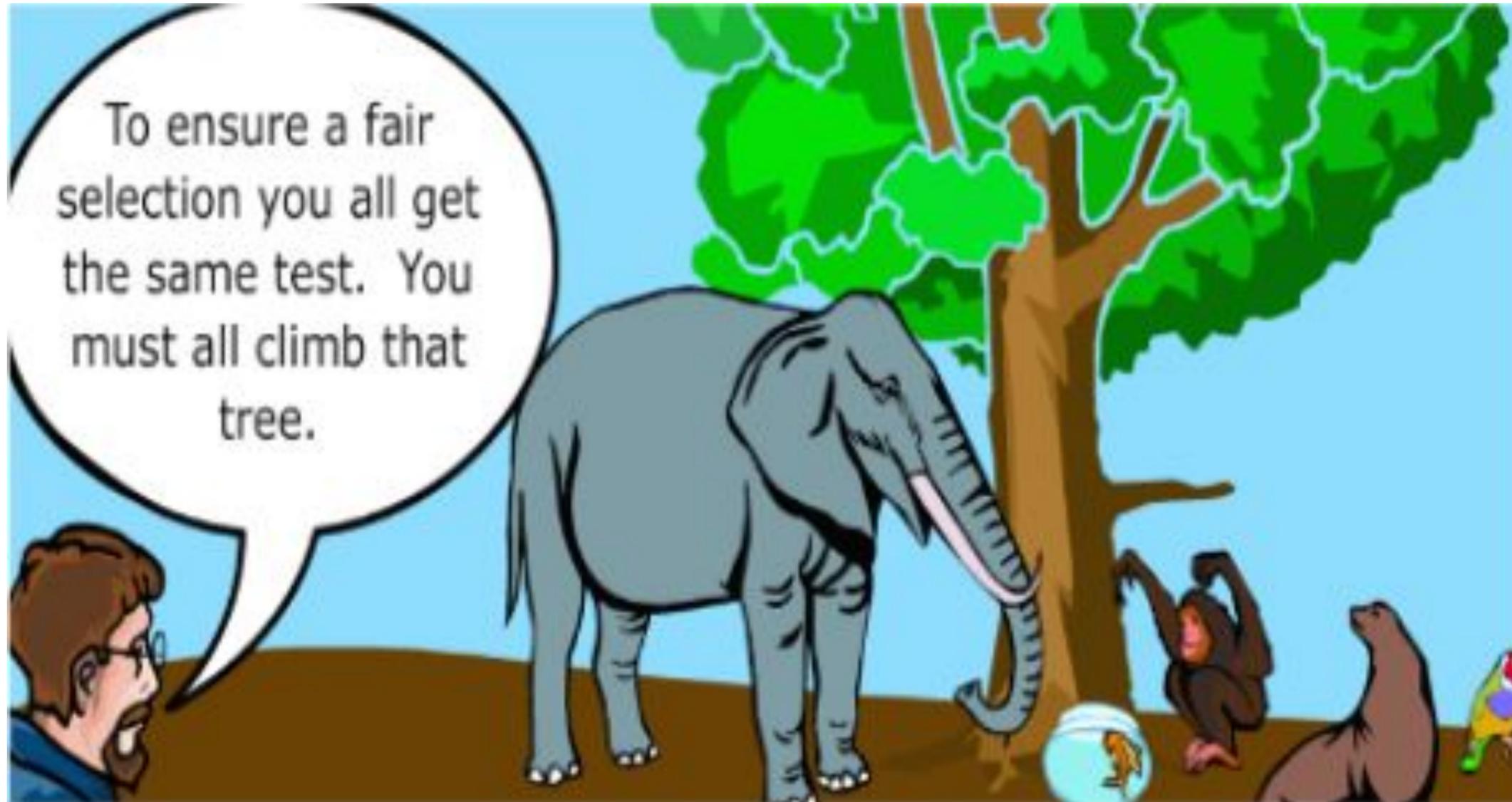
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- The absence of unfair, avoidable, or preventable differences in health among population groups

Both gender equality and gender equity are needed to achieve health equity



# IS THIS TEST EQUITABLE?



# MAKING CHANGES TO ADDRESS GENDER-BASED INEQUITIES

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## CASE STUDY

A campaign offering free prenatal workshops for expecting fathers is being offered by your health care facility.

The campaign has been advertised through posters around the community and in the health care facility.

- What gender considerations should be made?
- How can the campaign be modified to ensure it is delivered in an equitable way?



# CONTINUOUS SUPPORT

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- Achieving gender equality, gender equity, and health equity is not a one-off goal
- They need to be constantly promoted and actively sustained

Make sure there are no gender words without gender actions!



# CONCLUSION: KEY MESSAGES

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- **Gender matters in health.** It is not enough to look at sex to understand patterns of illness and health outcomes.
- **Gender norms, roles, and relations** often lead to inequalities, which have important effects on health.



THANK YOU!

# MODULE 2:

EVIDENCE AND

PRACTICE FOR MALE

ENGAGEMENT

## LEARNING OBJECTIVES

1. Understand the benefits of and barriers to male engagement in prenatal care
2. Practice engagement with men in prenatal visits and counseling sessions with couples
3. Identify principles and best practices to guide work with men during pregnancy and delivery

## SESSIONS

1. BENEFITS AND BARRIERS
2. PRENATAL VISIT PRACTICE
3. PRINCIPLES AND POLICIES
4. FEATURES OF SUCCESSFUL ENGAGEMENT



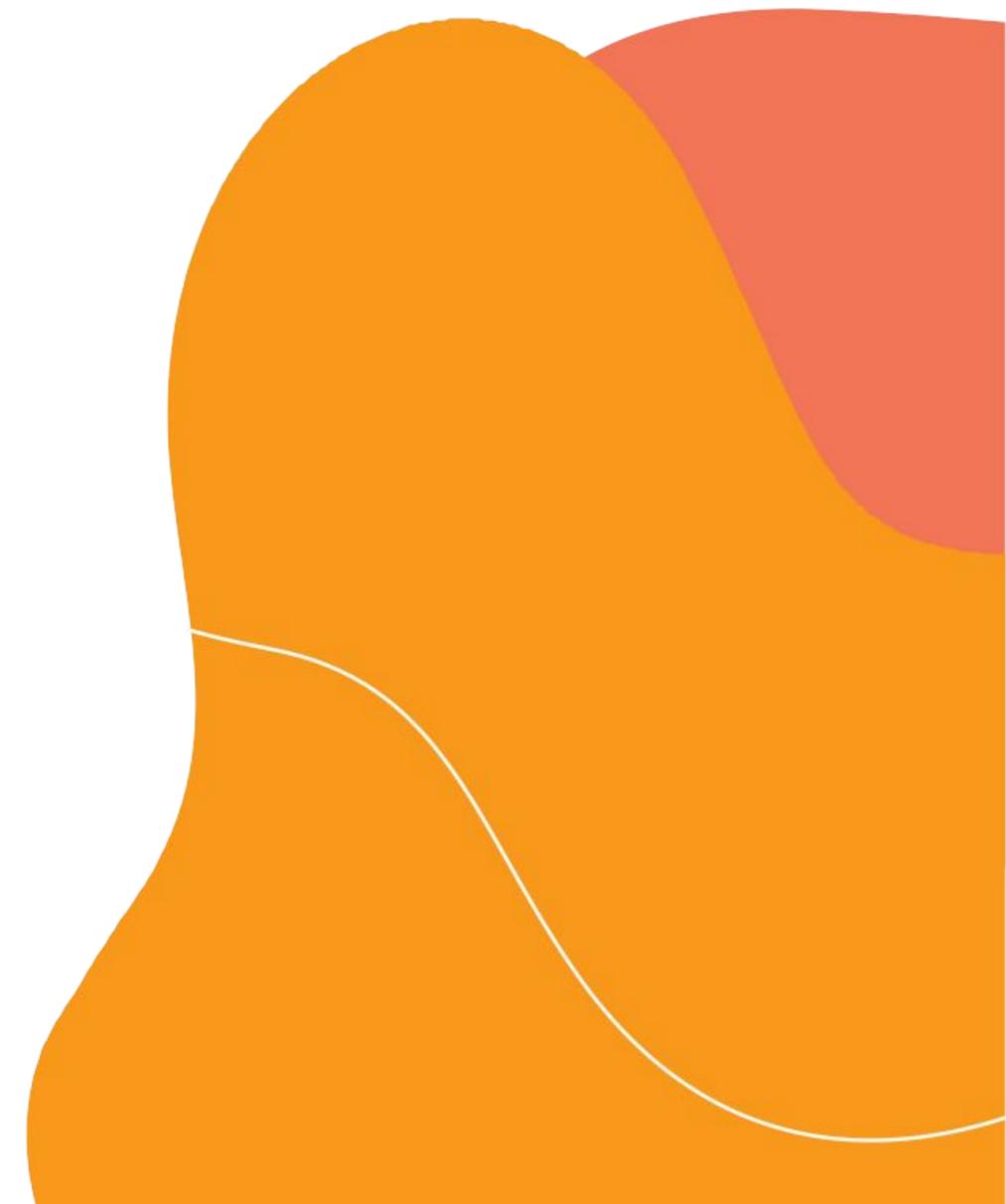
# SESSION 1: BENEFITS AND BARRIERS



# BENEFITS FOR WOMEN DURING PREGNANCY

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- Psychological, emotional, and moral support for pregnant women
- Enhanced couple relationship
- Can decrease risk of continued smoking by women during pregnancy



# BENEFITS FOR WOMEN DURING DELIVERY

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- Shortened labor and reduced epidural rate
- Reduced pain, panic, and exhaustion of women during labor
- Generally more positive childbirth experience for women



# BENEFITS FOR MEN

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- Enhanced couple relationship
- Development of paternal identity
- Stronger attachment to baby once born



# BENEFITS FOR CHILD

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- Promotes early paternal involvement after birth, which has been associated with improved cognitive development of preterm and low birth weight babies

# SOME BARRIERS...

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- Harsh, critical behavior and language from health professionals
- Midwives, nurses, and doctors are often overworked, stressed, and lack sufficient resources; taking care of male partners is considered an additional burden
- Perceiving fathers as “the problem” or assuming that they aren’t interested or won’t show up



# SOME BARRIERS...

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- Lack of physical space or resources in facility, beyond that allocated to pregnant women
- Clinic environment is feminized: pink color schemes, women/babies in artwork, "women's interest" magazines
- Prenatal classes focus on women and motherhood; don't include fatherhood



# SOME BARRIERS...

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- Time of appointments; men may be working daytime hours, night shifts, and some may not have formal or predictable employment
- Men aren't explicitly invited or addressed

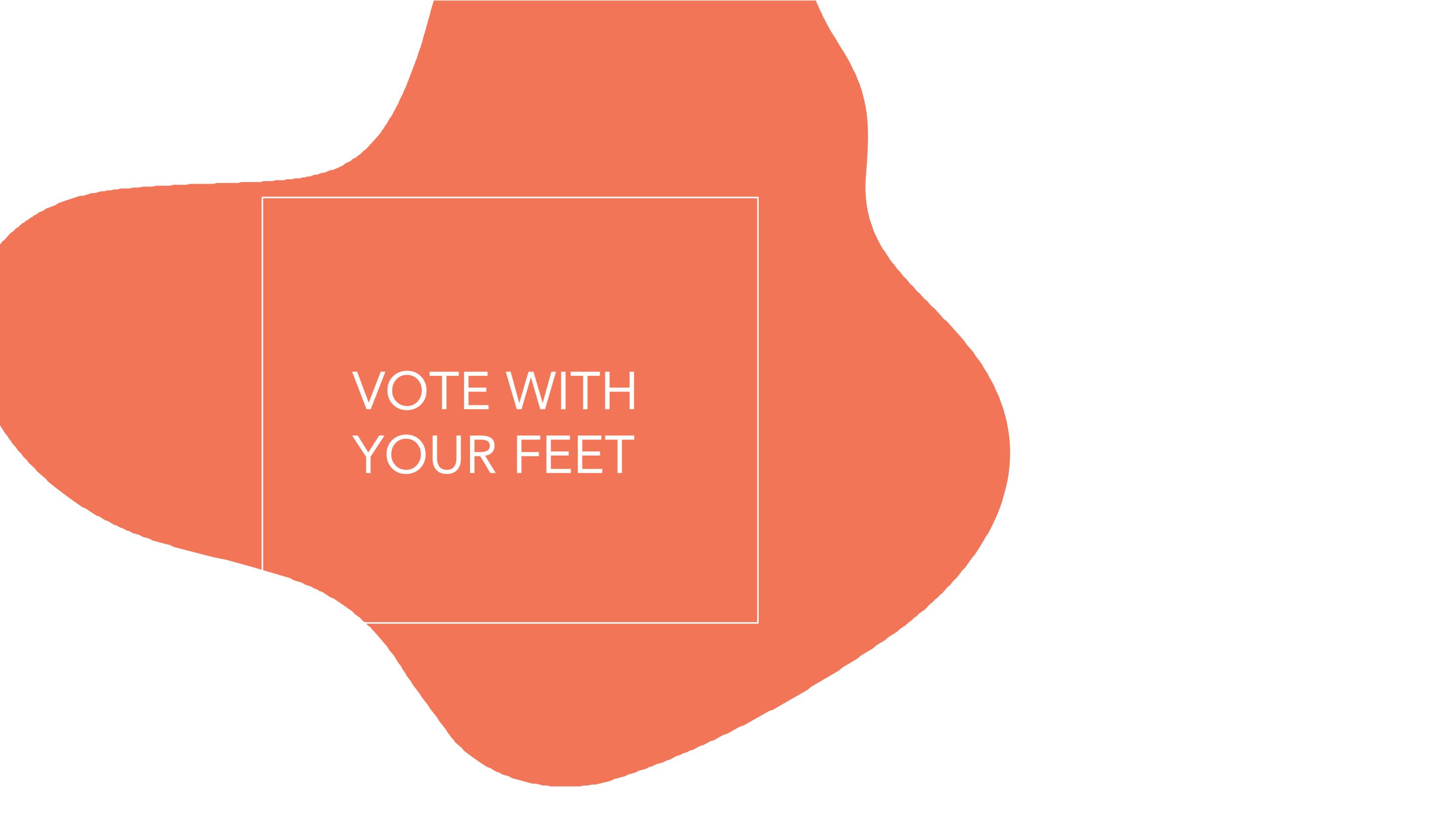


# SOME BARRIERS...

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- Men's experiences:
  - Feel anxiety about their partner and child's life and health
  - Feel insufficiently prepared and don't know how to contribute
  - Are afraid that seeing the birthing process will negatively affect their relationship with their partner





VOTE WITH  
YOUR FEET

# TRUE OR FALSE

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- A 2013 Swedish study found that prenatal education correlated positively with increased partner involvement

**TRUE:** It also resulted in less false labor admissions and less anxiety, but more labor interventions.

# TRUE OR FALSE

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- A 2018 study found that 23.1% of men in Azerbaijan attend at least one prenatal visit with their partner.

**FALSE:** This is the rate in **Moldova**. In Azerbaijan, only **4.4%** of men report joining for at least some of a prenatal visit. Most drop off their partner, wait outside, or stay in the waiting room.



# TRUE OR FALSE

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- New fathers can help regulate a newborn's body temperature and stabilize heartrate through skin-to-skin contact soon after birth.

**TRUE:** Skin to skin contact immediately after birth reduces infant crying, improves parent-infant interaction, stabilizes temperature, and promotes breastfeeding when done with mothers. Fathers can play an especially important role by providing skin-to-skin contact immediately after a woman has had a cesarean section, if she is unable to provide immediate care herself.

# TRUE OR FALSE

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- In the UK, a healthcare facility found that by addressing parents as “Dear Mom and Dad” instead of “Dear Parents” they could increase men’s attendance from 20% to 42%.

**FALSE:** Simply addressing fathers directly resulted in an **80%** attendance rate by men.



RAPID  
ASSESSMENTS

# INDIVIDUAL ACTION PLAN

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- What is one thing you would like to start doing?
  - What is one thing you feel you should stop doing?
  - What is one thing you are already doing that you should continue?
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# SESSION 2: PRENATAL VISIT PRACTICE



# PRENATAL VISIT ROLE PLAY DISCUSSION

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- What kinds of gender stereotypes, norms, roles, or relations did you observe?
- What did you think of the solutions proposed by the group?
- Would you do anything differently?
- Did you identify any risks in the scenario? If so, how would you address them?



# FATHERHOOD INTERVIEWS



- What do you enjoy most during this pregnancy?
- What is the hardest thing for you during this pregnancy?
- What do you think your baby will be like?
- How do you think your life is changing and will change?

# SESSION 3: PRINCIPLES AND POLICIES



# PRINCIPLES FOR MALE ENGAGEMENT

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- What principles should guide your healthcare facility's work with men in prenatal care?



# WHO MALE ENGAGEMENT PRINCIPLES

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1. Should not reduce women's autonomy in care-seeking and decision-making in relation to their own health and the health of their children
2. Should avoid reinforcing gendered stereotypes of men as decision-makers.
3. Should promote the positive role men can play as partners and fathers



# WHO MALE ENGAGEMENT PRINCIPLES

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4. Where rates of intimate partner violence are high, must be implemented with caution
5. Must not compromise women's safety and confidentiality
6. Should promote egalitarian decision-making between couples and respect women's rights and autonomy



# WHO MALE ENGAGEMENT PRINCIPLES

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7. Should recognize the diversity in women's values, preferences, partnership and family arrangements
8. Should ensure women's permission, consent, and perspective on male involvement before inviting men to be involved
9. Access to quality care for women and newborns must not be contingent on men's attendance or involvement



# WHO MALE ENGAGEMENT PRINCIPLES

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10. Facilities should be male-friendly and systems should be oriented towards dealing with men as well as women during pregnancy, childbirth, and after birth
11. Physical infrastructure and capacity of health workers should be set up for men to accompany their partners

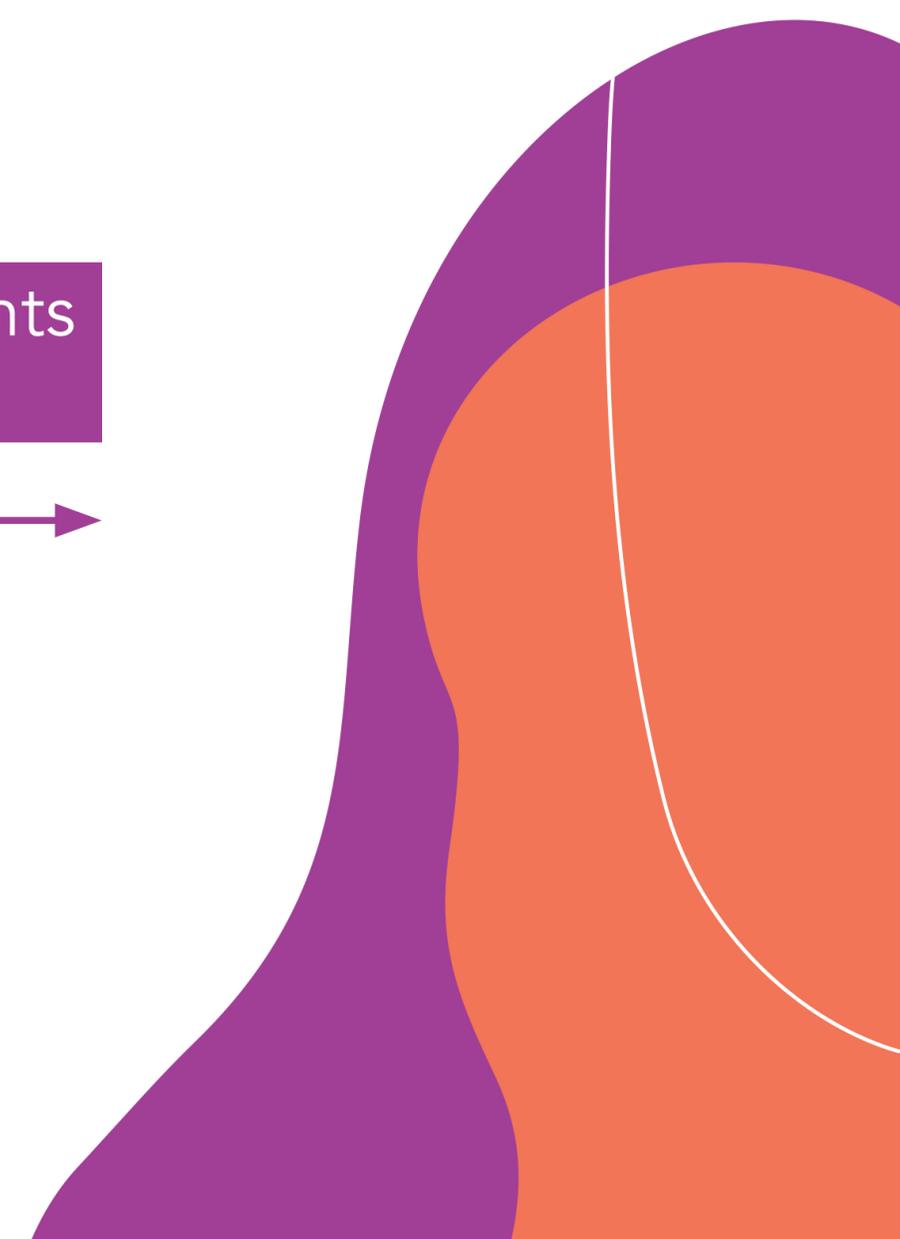
# CONTINUUM FOR ENGAGING MEN

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Men as clients

Men as allies

Men as agents of change



# CONTINUUM FOR ENGAGING MEN

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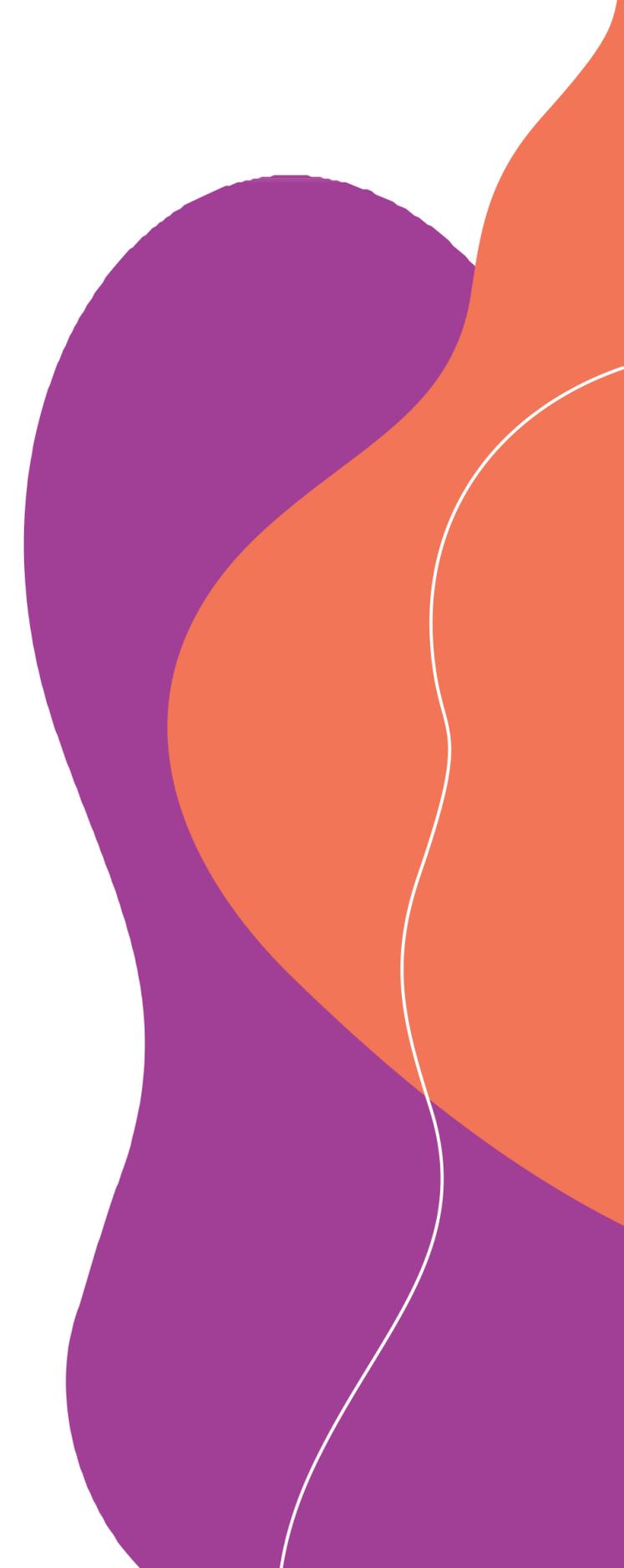
**Clients:** focus on providing services to men in the same way as to women (ex: prenatal classes). If programs choose merely to provide services for men, they miss the central point that men's and women's social positions constrain their reproductive roles. This approach can potentially accept men's dominant position in certain cultural settings as a given in a focus on their needs— rather than on gender relations — to improve reproductive health.



# CONTINUUM FOR ENGAGING MEN

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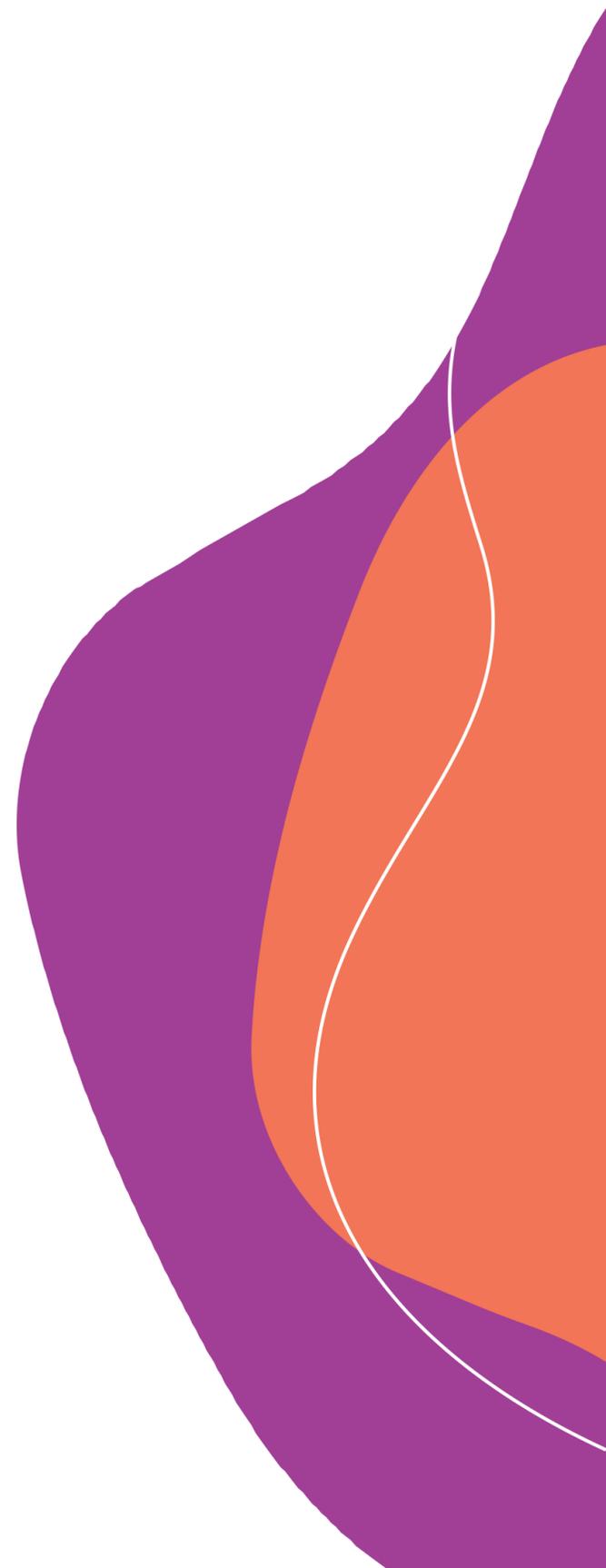
**Allies:** reflects the view that men can improve – and impede – women’s reproductive health. These programs view men as allies and resources in efforts to improve reproductive health. Although this approach makes important contributions to reproductive health, such as the focus on men as clients, it does not always address the gender inequity that constrains health.



# CONTINUUM FOR ENGAGING MEN

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*Agents of change:* acknowledge the fundamental role men play in supporting women's reproductive health and in transforming the social roles that constrain reproductive health and rights. Many interventions offer men the opportunity to examine and question the gender norms that harm their health and that of their sexual partners. Programs at this stage also encourage men to take action in their own relationships, families and communities.

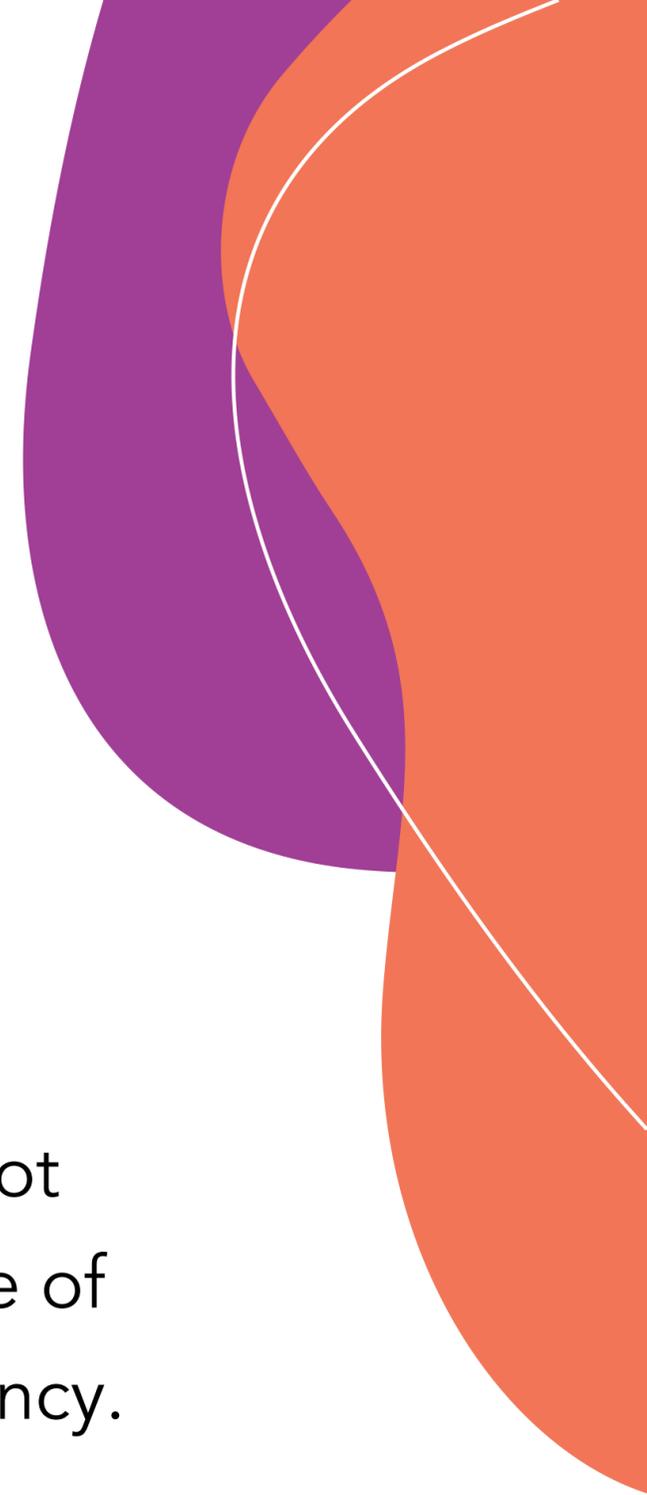


# CASE STUDY

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In India, a private organization implemented a program called Meeting Husbands. Male and female outreach workers and trained midwives implemented the program. The aim was to motivate husbands to support their wives' clinic attendance and to ensure the consumption of iron and calcium supplements at prescribed times.

Male outreach workers visited the husbands of pregnant women who were not attending monthly antenatal clinics and informed them about the importance of antenatal care and taught them to identify the symptoms of high-risk pregnancy. They also encouraged men to mobilize resources and transport to a medical facility because that is often a man's responsibility when a woman goes into labor.



# CASE STUDY

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In Kenya, a national association implemented a large-scale program to involve men in prenatal care through a variety of channels, including the workplace. Workplace motivators informed men about parenting resources and campaigns; promoted workers taking full paternal leave; conducted home visits to answer men's questions; and referred interested men to the local clinics for parenting classes.



# SESSION 4: FEATURES OF SUCCESSFUL ENGAGEMENT

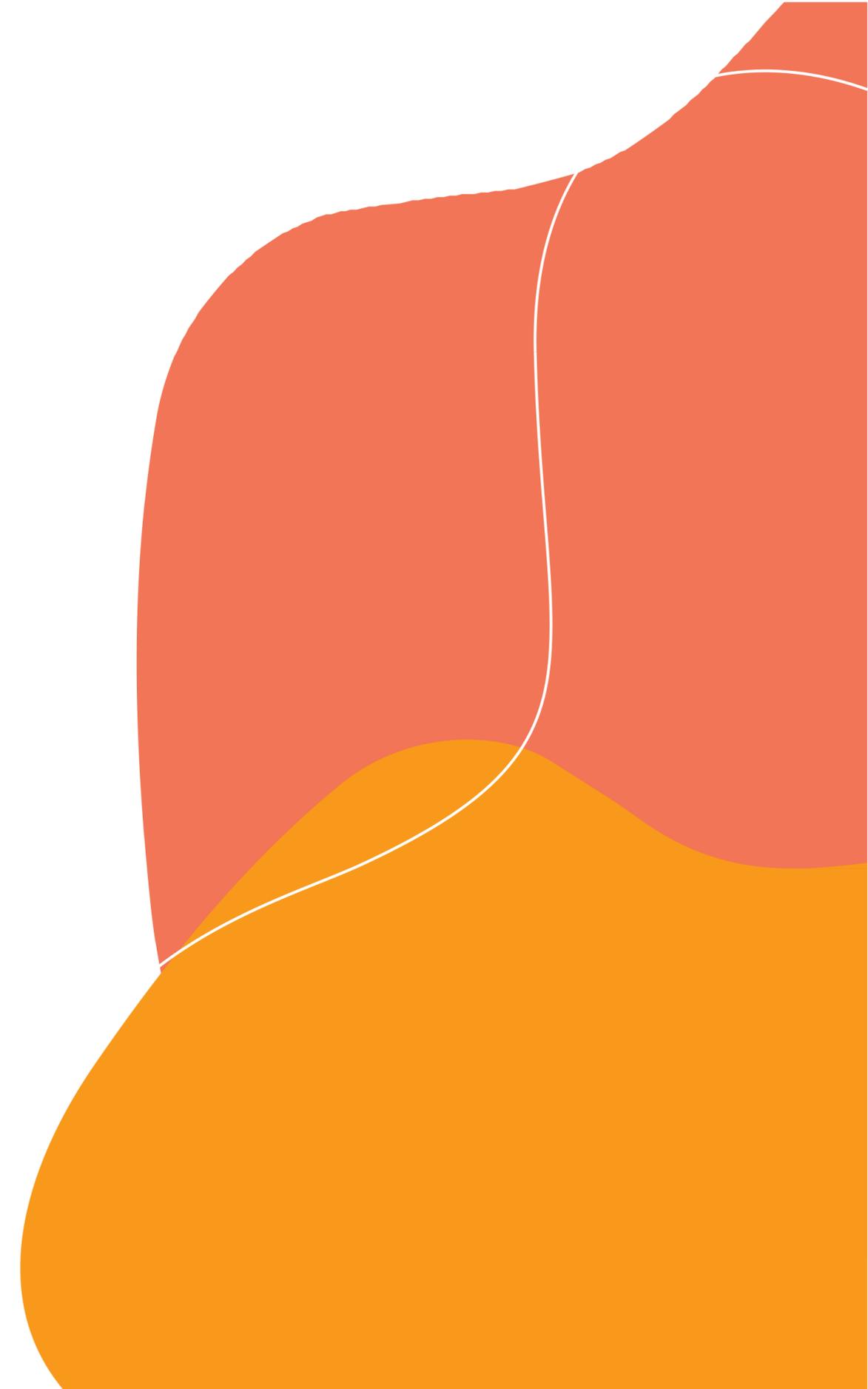


# FRAMEWORK ON ENGAGING MEN

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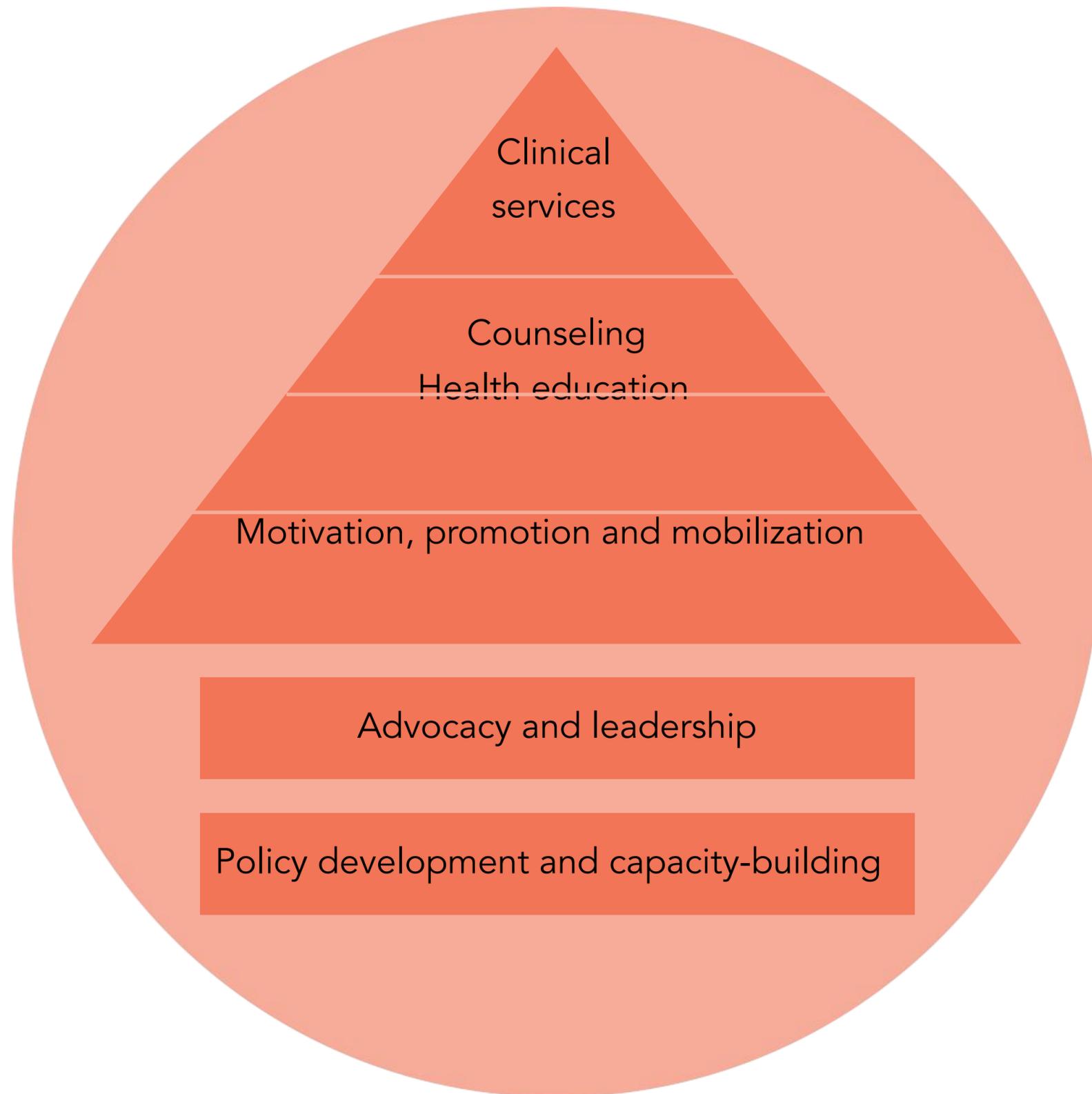
Most health programs engaging men use one of the five approaches:

1. Motivation, promotion, mobilization
2. Health education or information giving
3. Counseling
4. Clinical services
5. Advocacy and leadership



# FRAMEWORK ON ENGAGING MEN

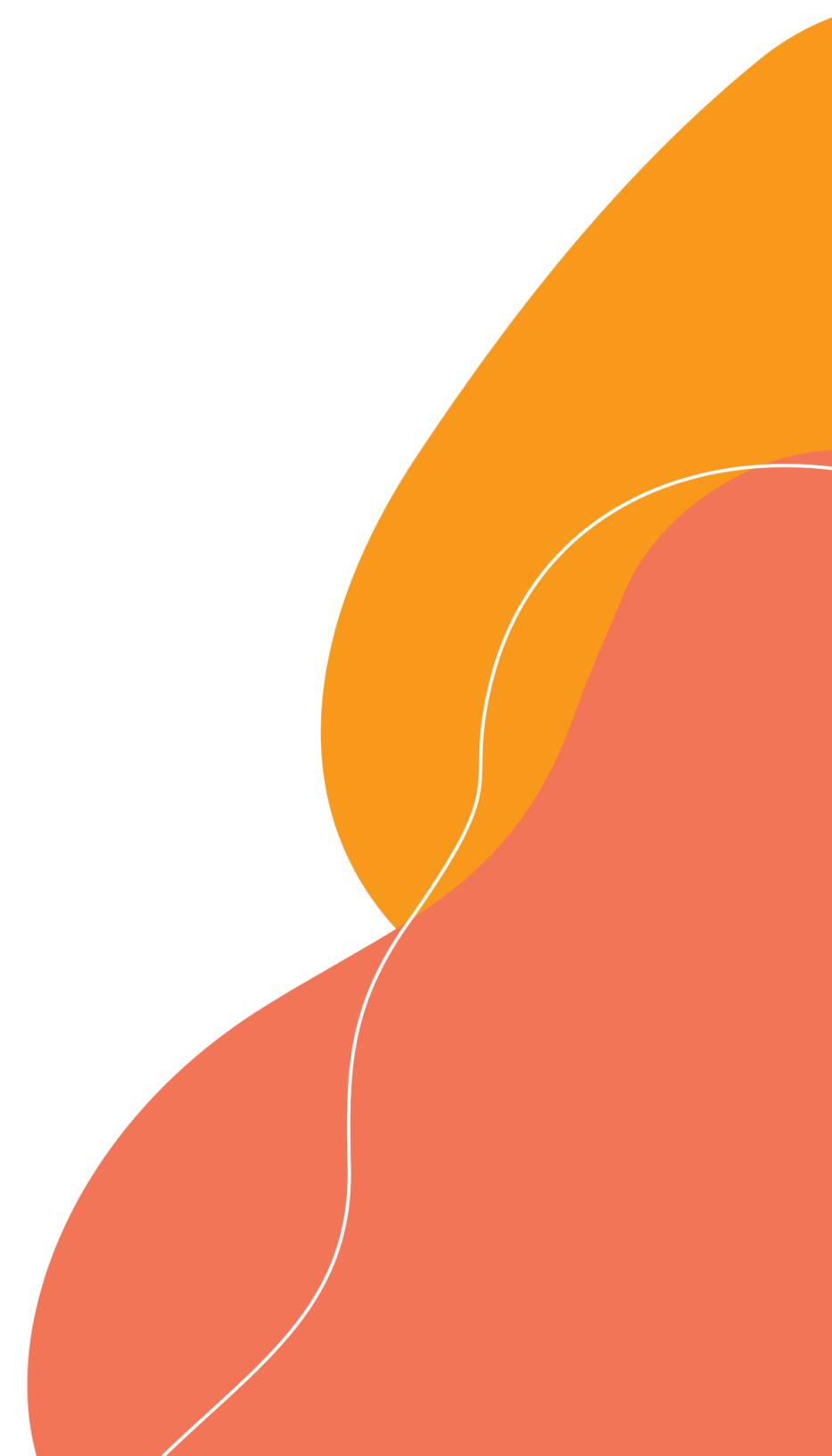
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# GROUP QUESTIONS

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- What program interventions have you used in your previous work to engage men in prenatal care?
- What were some of the key elements that made these activities successful?
- What were some of the challenges you faced and how did you address these?



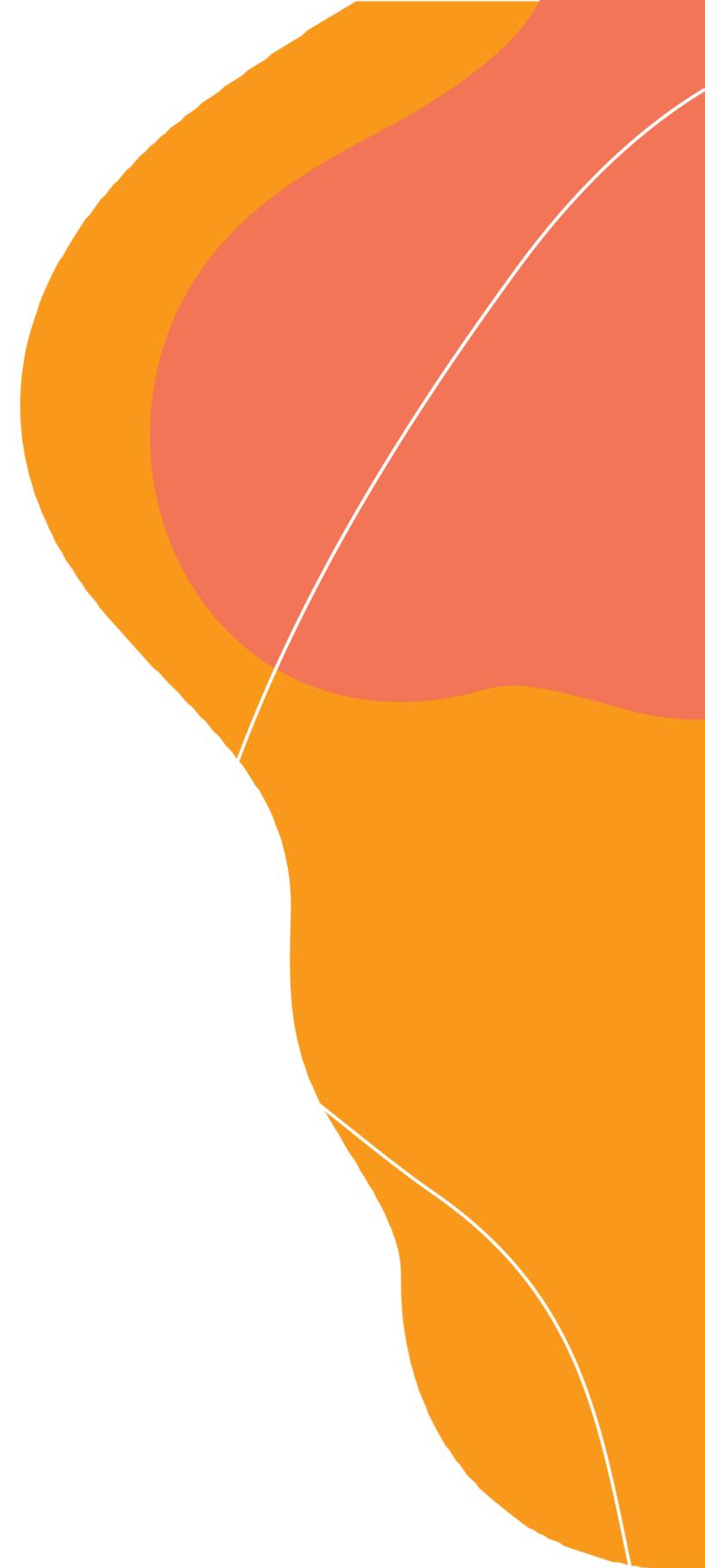


CASE STUDIES

# GROUP QUESTIONS

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- How might the policy in the case study work in your context or country? If you already have a similar policy, discuss lessons learned from the study.
- How could policies on this issue be further strengthened or amended to include a stronger focus on men and gender equality?



# CONCLUSION: KEY MESSAGES

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- Men play an important role in maternal and newborn health as **partners and parents** and can positively influence behaviors within their households (such as increase attendance at prenatal visits) and support the physical and emotional health of their partner.
- When men receive support during pregnancy and delivery, along with their partners, such as through counseling or parental training for fathers, they report **better physical and mental health and fewer problems in their relationship with their partner after birth**. Research also indicates that the more a father is engaged early on, the **stronger the attachment to his baby and development of paternal identity**.

THANK YOU!

**MODULE 3:**  
**GENDER-BASED  
VIOLENCE**

## LEARNING OBJECTIVES

1. Understand forms and causes of GBV
2. Understand role of health care providers in addressing needs of pregnant women experiencing violence
3. Learn skills to respond to clients experiencing GBV



# WHAT GBV MEANS?

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- A form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men (CEDAW)
- A violation of human rights
- A structural issue embedded in unequal gender power
- Reflects and reinforces inequalities between men and women
- Compromises the health, dignity, security, and autonomy of survivors

# TYPES OF GBV?

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- Domestic violence/intimate partner violence:
  - Physical violence
  - Sexual violence
  - Psychological violence (sometimes referred to as emotional violence)
  - Economic Violence
- Femicide
- Online/digital violence
- Sexual harassment at the work place

# KEY TERMS: CAUSALITY

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**Risk factor:** a characteristic of an individual, setting, or society that increases the likelihood of violence occurring

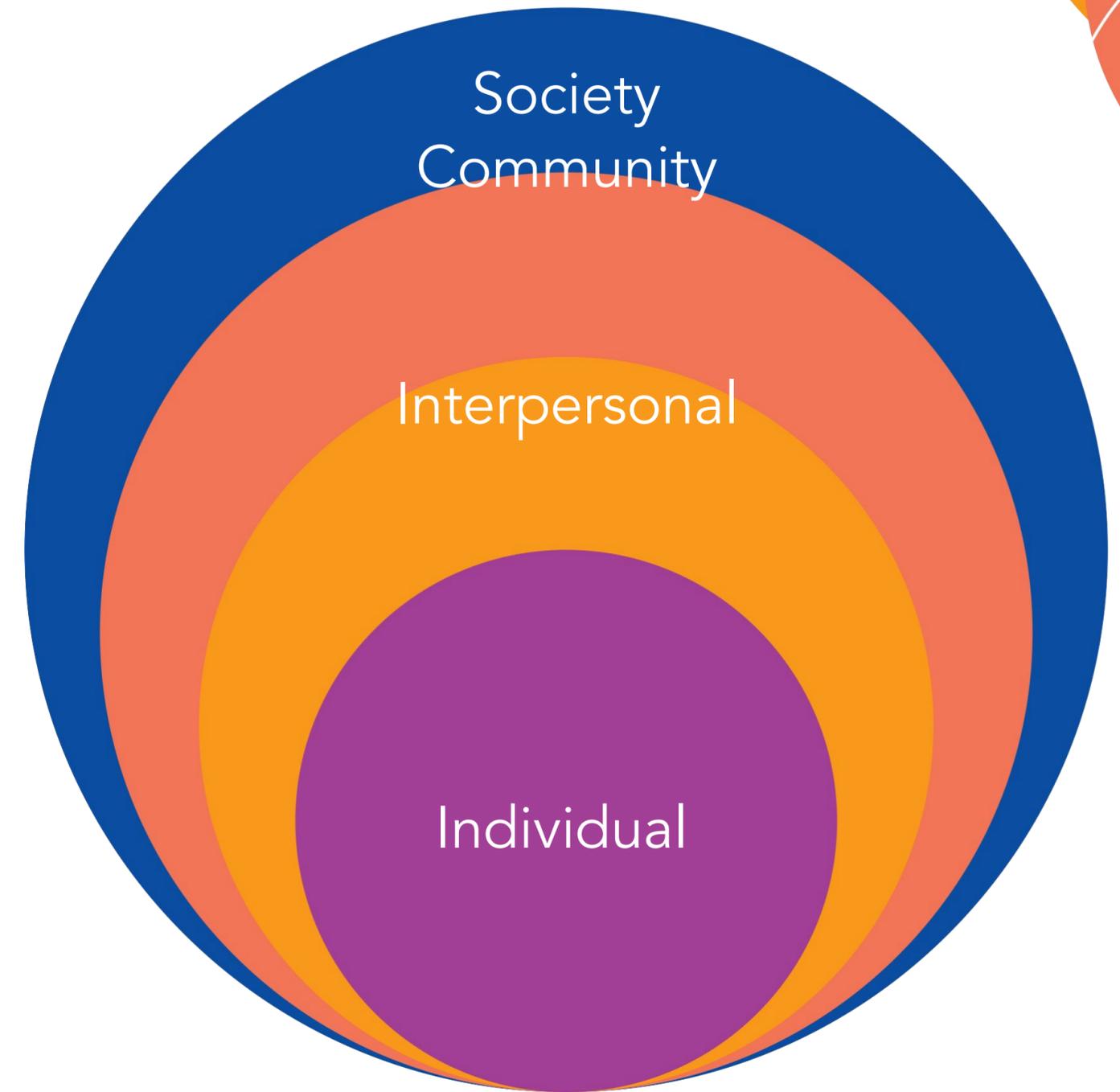
**Protective factor:** a characteristic of an individual, setting, or society that reduces the likelihood of violence occurring

**Situational trigger:** an immediate event or circumstance which can precipitate an incident of violence



# SOCIO-ECOLOGICAL MODEL

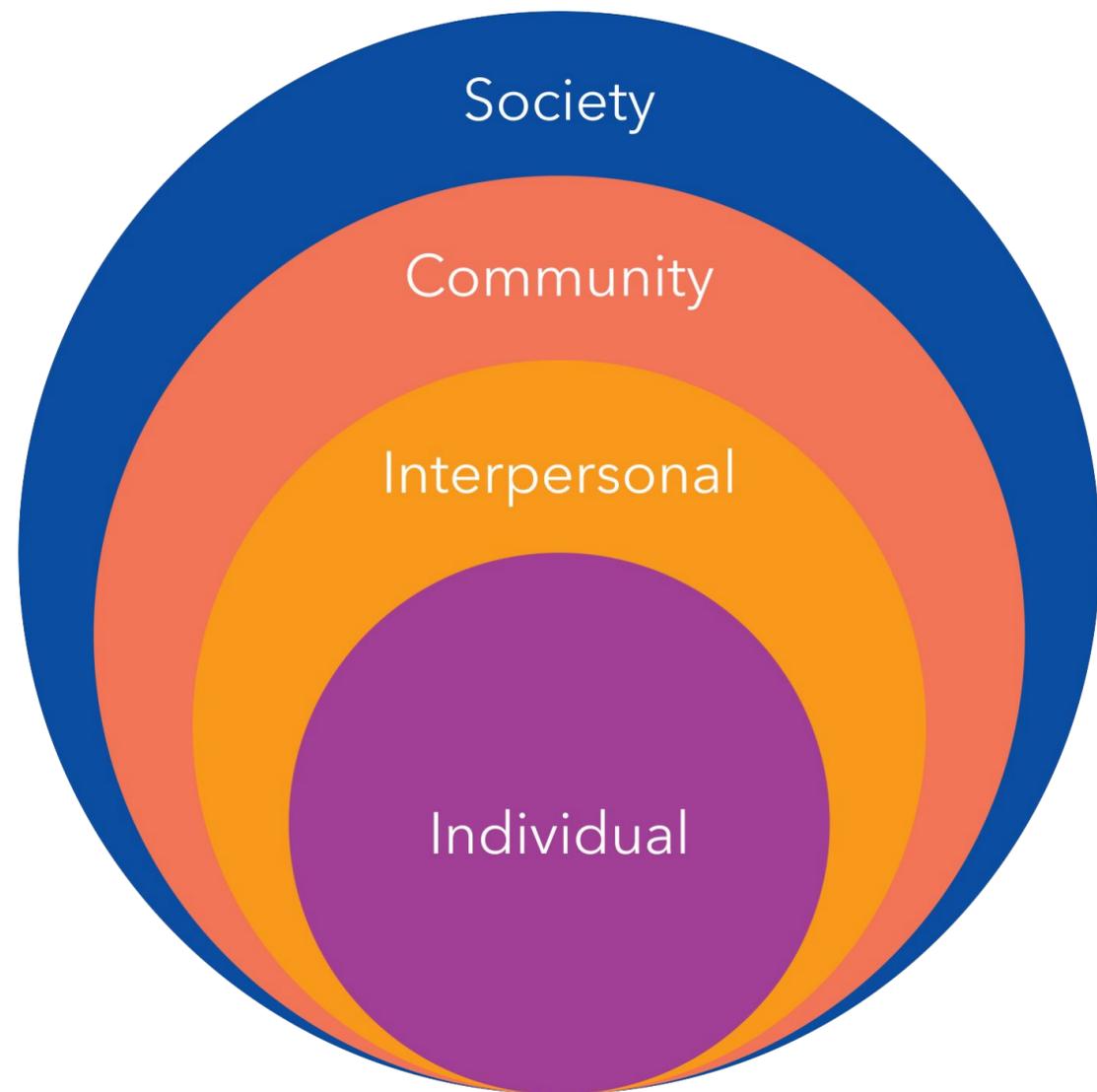
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Source: The Prevention Collaborative  
(2020) Prevention Foundations  
Brief 2: Understanding the causes  
of violence against women.

# SOCIO-ECOLOGICAL MODEL

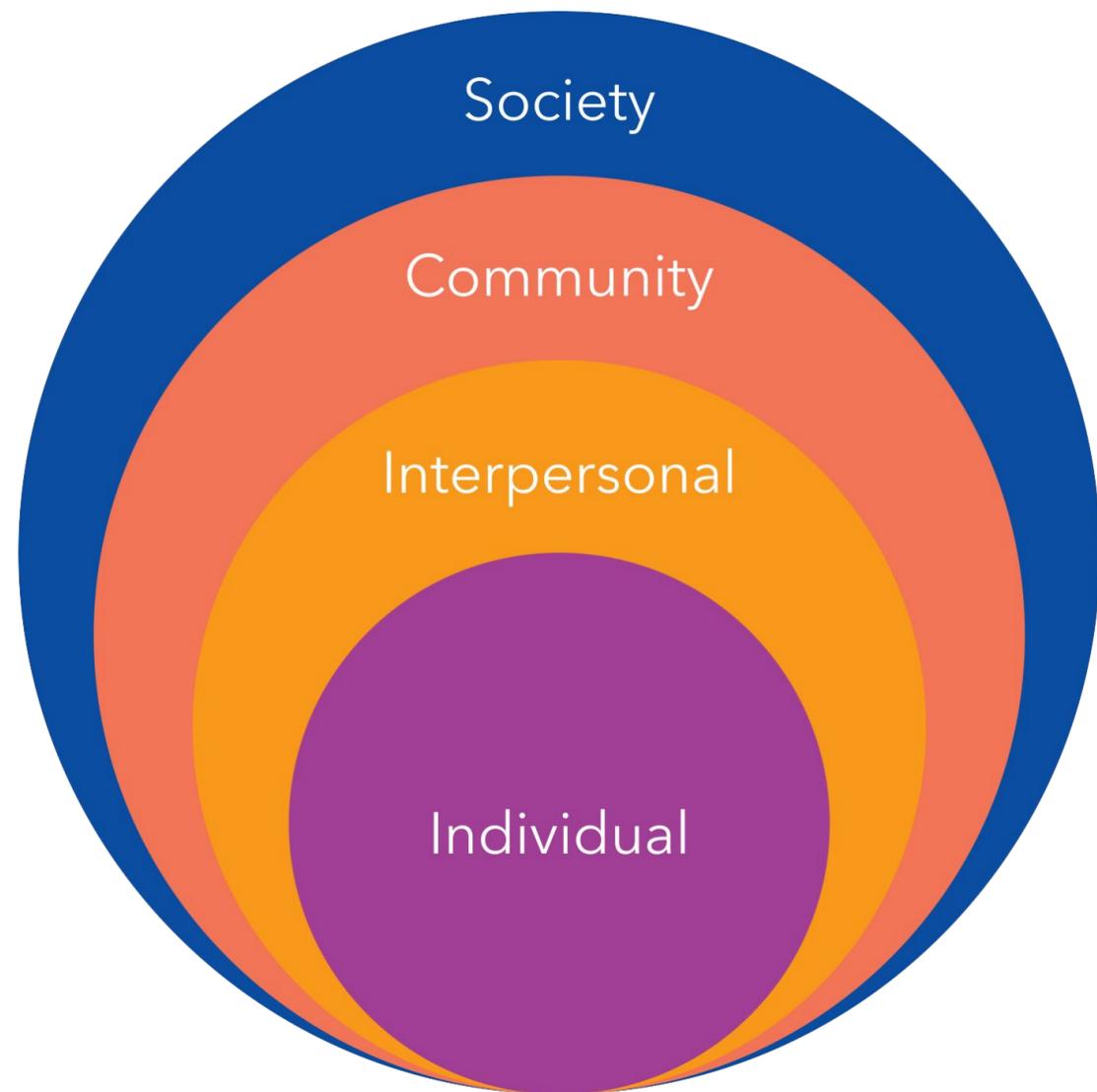
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**Individual:** related to individual attributes, developmental histories, and behaviors can increase the likelihood of men perpetrating violence and women experiencing violence.

# SOCIO-ECOLOGICAL MODEL

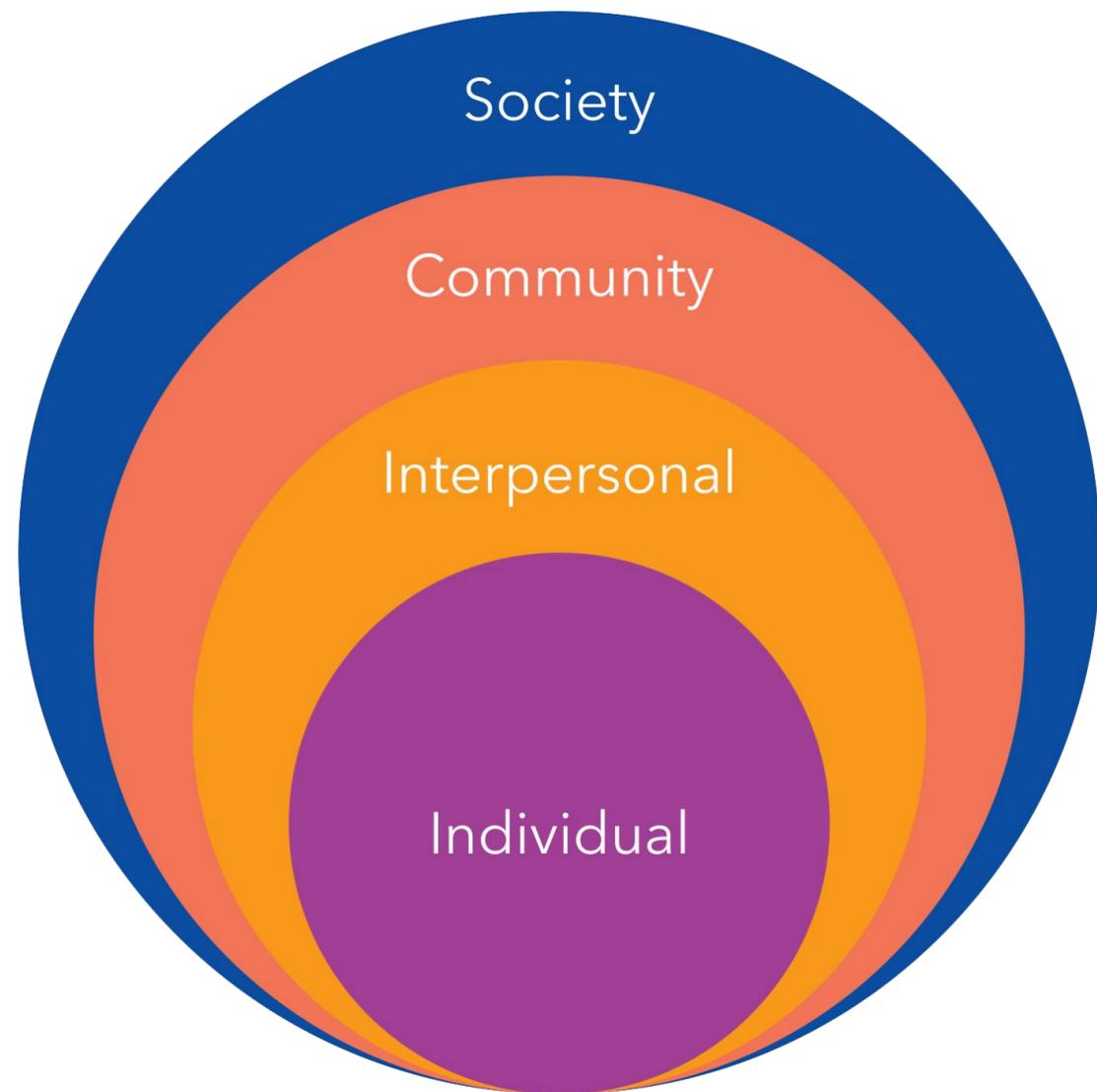
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**Interpersonal:** factors in relationships that increase the risk of IPV. Depending on the setting, this may include intimate partners, family, or peer or friendship networks. In intimate partner relationships, risk factors need to be understood alongside specific situational triggers that can precipitate incidents of violence.

# SOCIO-ECOLOGICAL MODEL

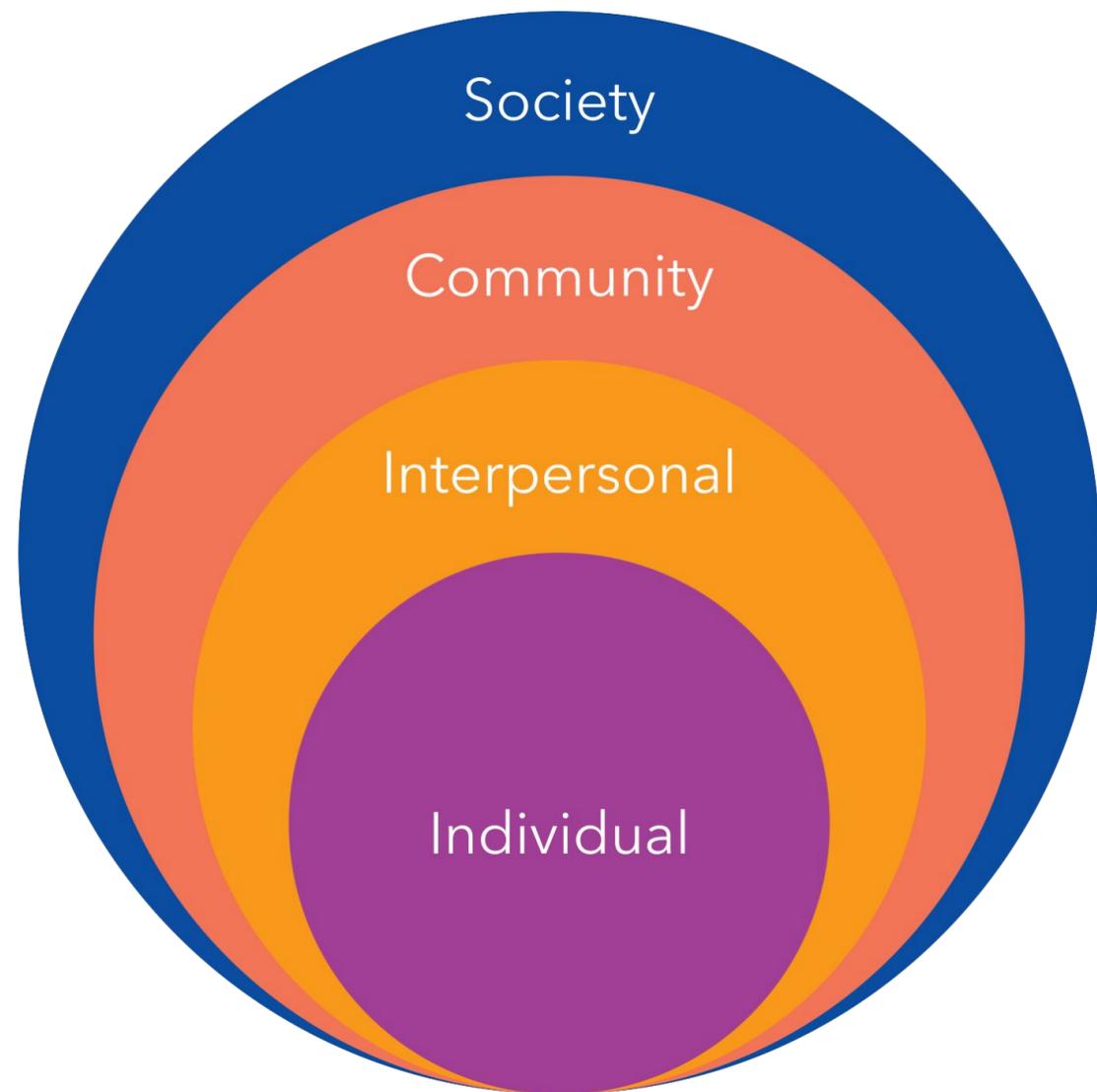
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**Community:** factors in immediate environment that encourage, condone, or create a local enabling environment for men to perpetrate IPV.

# SOCIO-ECOLOGICAL MODEL

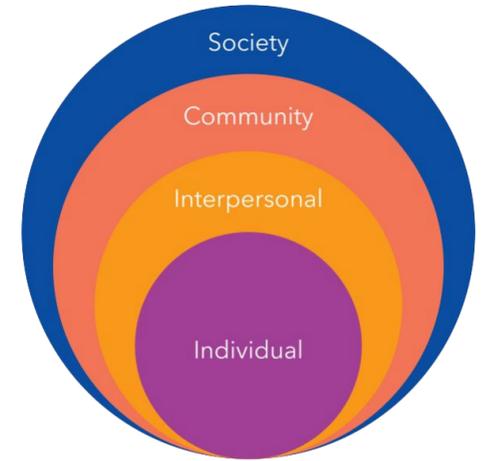
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**Society:** broader environment that either enables or inhibits IPV, including relevant policy and legislative frameworks and economic and cultural influences.

# RISK FACTORS FOR INTIMATE PARTNER VIOLENCE

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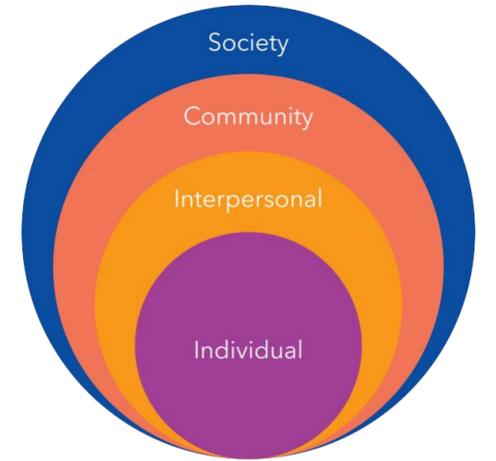


## Societal

- Gender-discriminatory laws / policies
- Other forms of discrimination (e.g. racial, religious)
- Collectivist cultural orientation
- Armed conflict
- Political instability
- Corrosive macro-economic forces

# RISK FACTORS FOR INTIMATE PARTNER VIOLENCE

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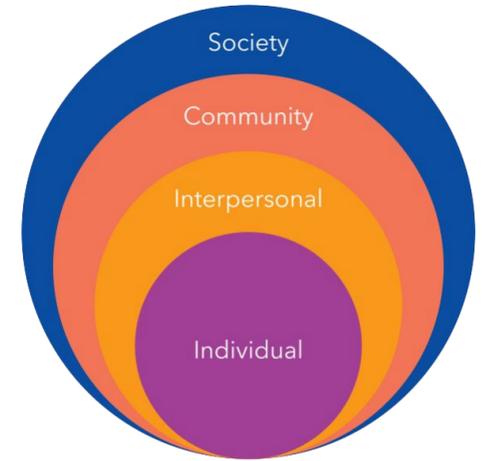


## Interpersonal

- Male dominance in decision-making
- Violence seen as appropriate “discipline”
- Poor communication skills
- High relationship conflict
- Lack of trust / emotional intimacy
- Association with violent and antisocial peers
- Social isolation

# RISK FACTORS FOR INTIMATE PARTNER VIOLENCE

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## Individual woman: (risk of experiencing violence)

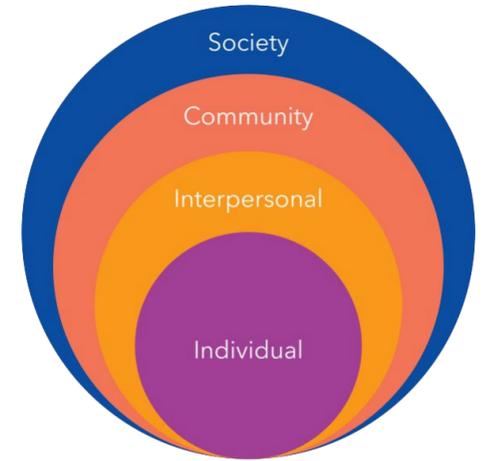
- Age (young women are at higher risk)
- Depression
- Experiencing violence in childhood
- Witnessing violence in childhood
- Attitudes accepting violence / VAW
- Disability
- Low social support

## Factors that increase or decrease risk depending on context:

- Women's employment/ income generation
- Women's asset ownership
- Women's access to credit
- Corrosive macro-economic forces

# RISK FACTORS FOR INTIMATE PARTNER VIOLENCE

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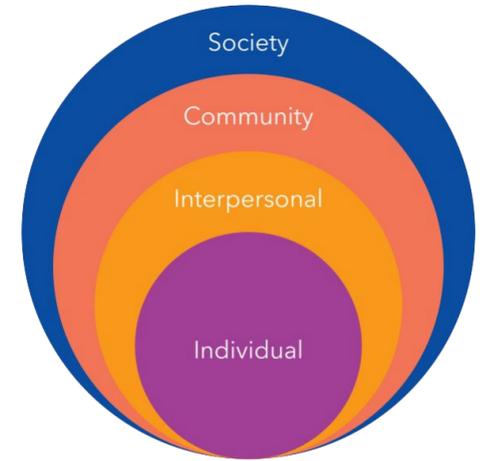


## Community

- Rigid norms around expected male and female roles and behaviours
- Norms condoning male authority over women and children
- Norms linking men's honour to women's behaviour
- Norms accepting VAW
- Norms of family privacy
- Lack of social / legal sanction for VAW
- Local poverty + unemployment

# RISK FACTORS FOR INTIMATE PARTNER VIOLENCE

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Individual man: (risk of perpetrating violence)

- Age (young men are at higher risk)
- Depression
- Experiencing violence in childhood
- Witnessing violence in childhood
- Attitudes accepting violence / VAW
- Gender inequitable attitudes
- Low educational level
- Psychological dysfunction
- Harmful alcohol / substance abuse

# SITUATIONAL TRIGGERS OF IPV

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- Perceived failures to meet gendered expectations
- Refusal of sex, especially in marriage
- Behaviors perceived to threaten family honor
- Accusations of infidelity
- Disagreements over money or resources
- Arguments over alcohol or substance use
- Discord around children's care or behavior
- Intoxication
- Other stressors/shocks

# ESSENTIAL SERVICES AND ACTIONS FOR HEALTH CARE PROVIDERS

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- Identification of survivors of GBV
- First line support
- Care of injuries and urgent medical treatment
- Sexual assault examination and care
- Mental health assessment and care
- Documentation (including medico-legal)



# IDENTIFICATION OF IPV

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## Universal screening is not recommended

- Evidence does not support 'screening'
- Where prevalence is high and referral options are limited, screening brings little benefit to women and overwhelms providers
- However: certain sites, such as antenatal care, mental health, and HIV testing and counseling, may consider screening provided certain requirements are met.

## Clinical enquiry is recommended

- Providers should know when and how to ask about IPV

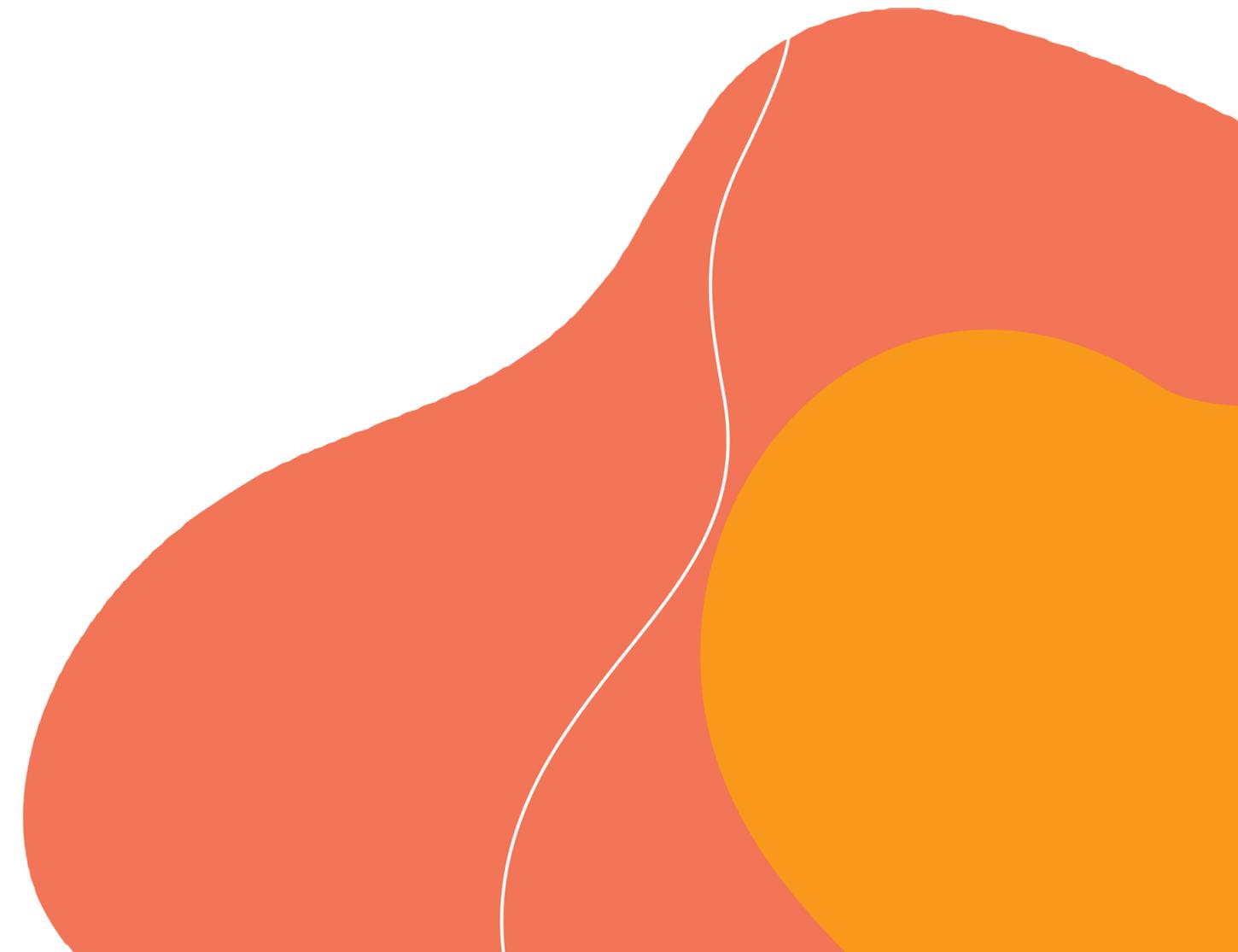
Reference: WHO (2013) Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.

# IDENTIFICATION OF IPV

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## Good practice

- Written information on IPV should be made available in the clinic
  - Posters, pamphlets, leaflets in private areas such as women's washrooms



# WHO ETHICAL GUIDANCE

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- If the clinic decides to put in place routine IPV screenings, the following minimum requirements must be met<sup>1,2</sup>:
  - A protocol or standard operating procedures must be in place
  - Staff must be trained in first-line response
  - Staff must be trained on how to ask questions, minimum response, and beyond
  - Screening must take place in a private setting
  - Confidentiality must be ensured
  - A system for referrals must be in place

Reference:

<sup>1</sup> WHO (2013) Responding to intimate partner violence and sexual violence against women: WHO clinical

and policy guidelines.

<sup>2</sup> WHO (2014) Clinical Handbook on Healthcare for Women Subjected to Intimate Partner Violence or Sexual Violence

# IDENTIFYING IPV – RED FLAGS

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- Ongoing emotional health issues, such as stress, anxiety or depression
- Harmful behaviors such as misuse of alcohol or drug
- Thoughts, plans or acts of self-harm or (attempted) suicide
- Injuries that are repeated or not well explained
- Repeated sexually transmitted infections
- Unwanted pregnancies
- Unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches)
- Repeated health consultations with no clear diagnosis.

# IDENTIFYING IPV – 5 STEPS

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## STEP 1: Review Medical History for Warning Signs of Intimate Partner Violence

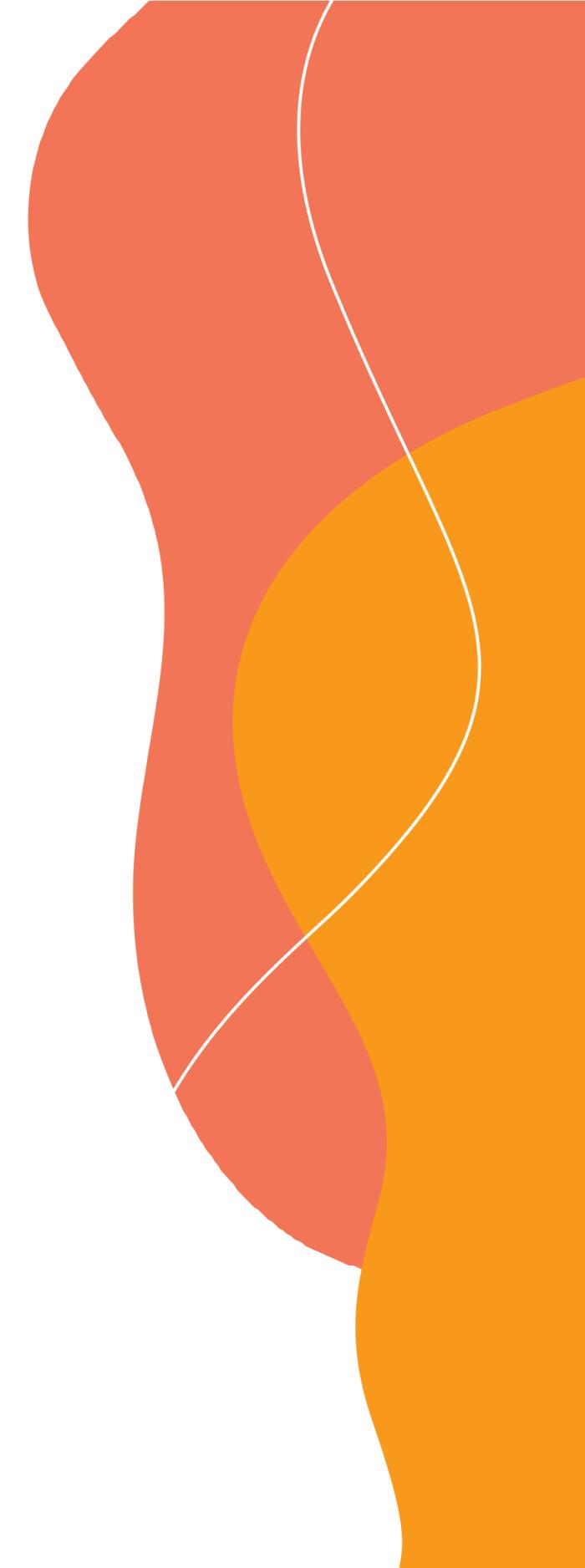
- Previous medical visits for injuries
- History of abuse or assault
- Repeated visits
- Chronic pelvic pain, headaches, vaginitis, irritable bowel syndrome
- History of depression, substance use, suicide attempts, anxiety

# IDENTIFYING IPV – 5 STEPS

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## STEP 2: Review Medical History for Pregnancy-Related Factors

- Unintended pregnancy
- Unhappiness about being pregnant
- Young maternal age
- Single marital status
- Higher parity
- Late entry into prenatal care/missed appointments
- Substance use or abuse (tobacco, alcohol, drugs)



# IDENTIFYING IPV – 5 STEPS

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## STEP 3: Observe Woman's Behavior

- Flat affect
- Fright, depression, anxiety
- Post-traumatic stress disorder symptoms
  - Dissociation, psychic numbing, startle responses
- Over-compliance
- Excessive distrust
- Loss of interest
- Low self-esteem



# IDENTIFYING IPV – 5 STEPS

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## STEP 4: Observe Partner's Behavior

- Being overly solicitous
  - Answering questions for the patient
  - Being hostile or demanding
  - Never leaving the patient's side
  - Monitoring the woman's responses to questions
- 

# IDENTIFYING IPV – 5 STEPS

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## STEP 5: Ask Directly

- Ask questions in private apart from male partner, family, or friends
- Explain issues of confidentiality
- Be aware of mandatory reporting laws in your state and inform the woman of them
- Face to face talk is more effective than written questionnaires
- Ask caring and empathetic questions
- Be prepared to hear your patient's answers

# MANDATORY REPORTING

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- Mandatory reporting of intimate partner violence to the police by the health-care provider is not recommended<sup>1</sup>
- Health care providers are legally required to report any case of violence in majority of countries in the region
- If legislated, health care providers must
  - Understand which mandatory reporting requirements are, reporting mechanisms and investigation procedures
  - Inform the survivor about the mandatory reporting and what can happen after an incident is reported
  - Ensure the safety, dignity and comfort of the survivor

## Reference:

<sup>1</sup> WHO (2013)  
Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.

# FIRST LINE SUPPORT

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1. **Listen** to the woman closely, with empathy, without judging
2. **Inquire** about needs and concerns – emotional, physical, social, and practical (i.e. childcare)
3. **Validate** and show her that you understand and believe her. Tell her she is not to blame.
4. **Enhance safety**. Discuss a plan to protect herself from further harm if violence occurs again.
5. **Support** her by helping her connect to information, services, and social support (this includes referral)

- Often the most important care that you can provide
- Even if this is all you can do, it can make a tremendous difference for your client

# REFERRAL PROCESS<sup>1</sup>

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- Inform the survivor about possibility of referral
- Obtain the consent of the survivor
- Clarify with the survivor what information will be shared and what information will be kept confidential
- Give to the survivor complete and correct information
  - **WHO** – which institution/organization provides services
  - **WHAT** – what sort of assistance they can expect to receive
  - **WHERE** – where exactly is the place, how to get there
- Make the referral according to the survivor's choice
- Ask someone to accompany the survivor to

<sup>1</sup> UNFPA, EEIRH (2020). Health care services provision, part of multi-sectoral response to GBV Standard Operating Procedures.

# RISK ASSESSMENT AND MANAGEMENT

## RISK FACTORS

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- Previous acts/incidents of GBV
- Violent behaviour outside the family
- Separation and divorce
- 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
- Threats
- Extreme jealousy and possessiveness
- Extremely patriarchal concepts and attitudes
- Persecution and psychological terror
- Non-compliance with restraining orders by courts or police
- Possible triggers that may lead to a sudden escalation of violence

# RISK ASSESSMENT AND MANAGEMENT

## MINIMUM SAFETY PLAN

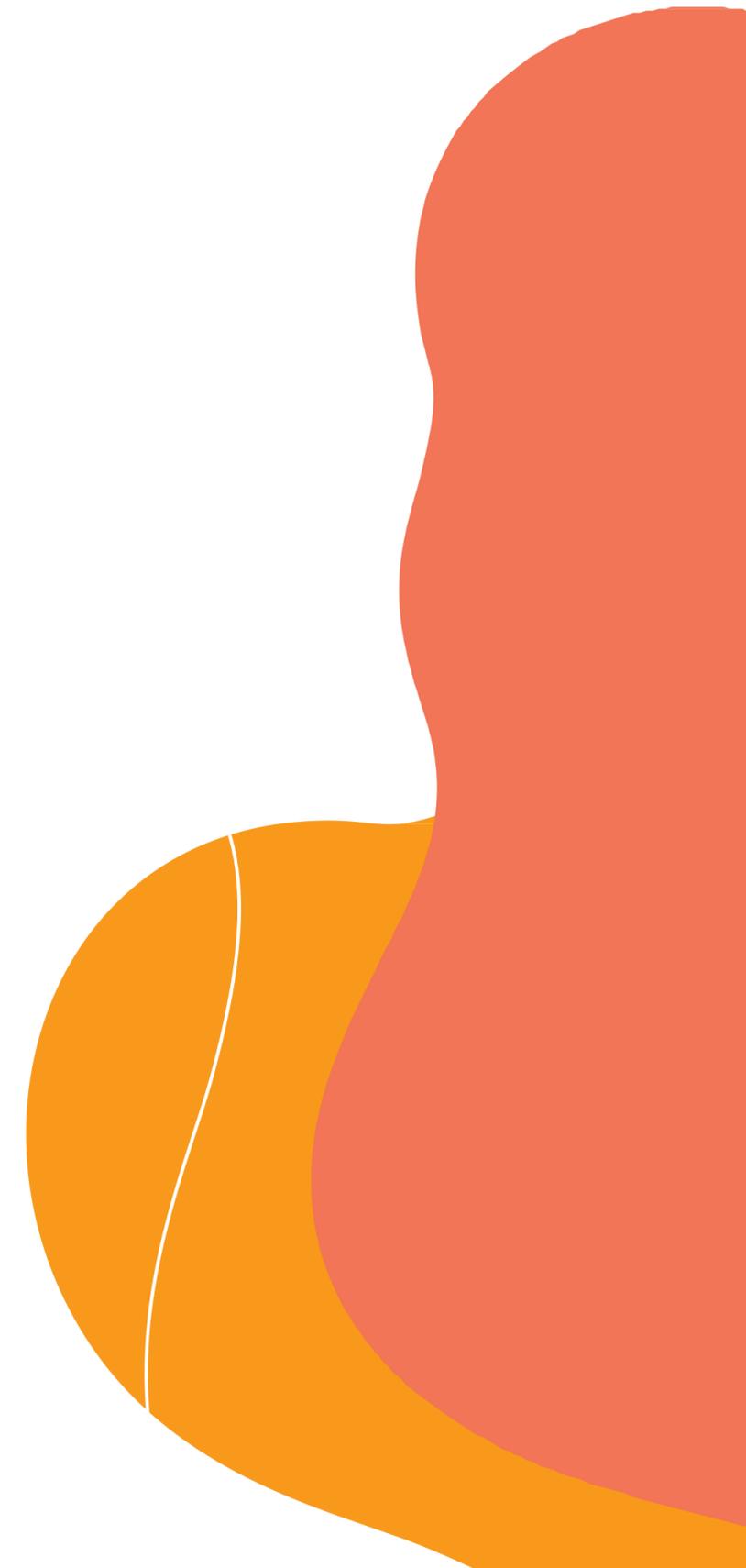
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- Persons that might be called in an emergency situation or who could give shelter
- Neighbours to tell about the violence, and ask them to help if they hear a disturbance in the victim's house
- Practice how to get out of home safely
- Safety bag packed and stored in a place from where can be taken easily in an emergency situation
- Possibility to address for future help to other service providers

# OTHER SERVICES

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- Examine and provide appropriate care
- Treat physical injuries or refer
- Prevent sexually transmitted infections
- Prevent HIV
- Risk assessment and safety planning
- Basic psychosocial support
- Explore the availability of social support



# BARRIERS FACED IN PROVIDING SERVICES

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- Insufficient knowledge about GBV
- Own attitudes and misconceptions about GBV
- Own experience of GBV in the past
- Lack of clinical knowledge and skills in responding to GBV
- Lack of information about available services
- Lack of time
- Worries
- Missing intra-institutional support
- Uncertainties about legal obligations
- Absence of SOPs, policies and protocols

# DO NO HARM PRINCIPLES

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## Safety

It is essential to ensure the safety of the survivor and their family at all times, including their children and people who have assisted them.

## Confidentiality

Respect the confidentiality of survivors and their families at all times by not disclosing any information, at any time, to any party without the informed consent of the person concerned. Ensure the survivor's trust and empowerment.

# DO NO HARM PRINCIPLES

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## Respect

All actions or decisions should be guided by respect for the survivor's choices, wishes, rights, and dignity.

## Non-Discrimination

Survivors should receive equal and fair treatment, regardless of their age, sex, race, marital status, sexual orientation, or any other characteristic.

## Honesty

Survivors should receive honest and complete information about possible referrals for service, be made aware of any risks or implications of sharing information about the situation and have the right to limit the types of information shared and whom it is shared with.

THANK YOU!

**MODULE 4:**  
**INSTITUTIONAL**  
**ASSESSMENT**

## LEARNING OBJECTIVES

1. Conduct a rapid institutional assessment for male engagement
2. Create detailed action plans to increase male engagement
3. Present action plans to leadership



## SESSIONS

1. INSTITUTIONAL ASSESSMENT
2. ACTION PLANNING
3. PRESENTATION TO LEADERSHIP



# SESSION 1: INSTITUTIONAL ASSESSMENT



# FACILITY WALK-THROUGH

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As you walk through your health facility, imagine that you are a man coming for a prenatal visit for the first time. Keeping the man's perspective in mind, assess how the facility would appear to him on the basis of the criteria in the questionnaire.



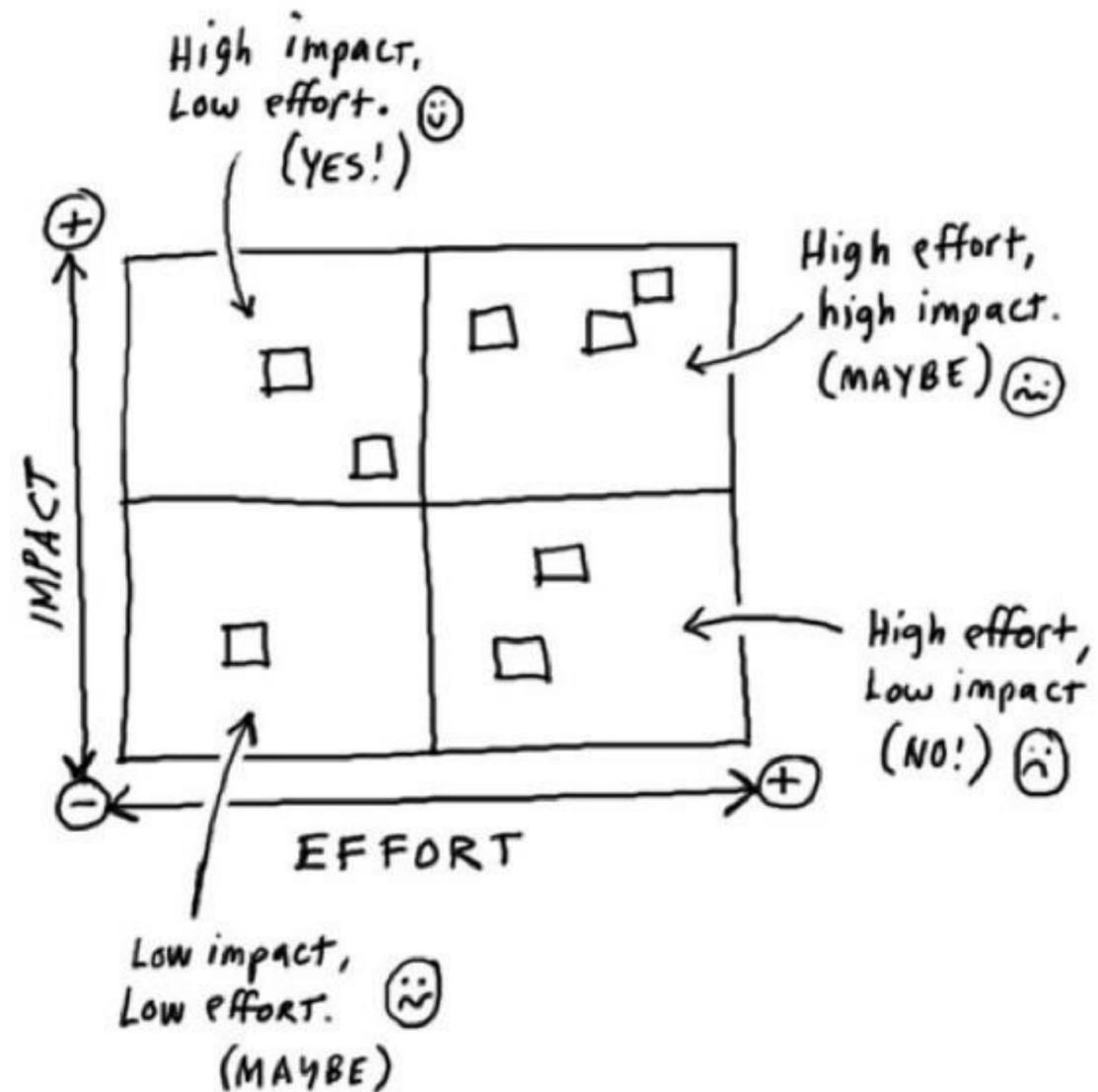
# BRAINSTORMING SOLUTIONS

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- Facility approachability
- Services provided
- Reception area
- Service areas and examination rooms

# PRIORITIZATION EXERCISE

- Most impact
- Least impact
- Most effort
- Least effort



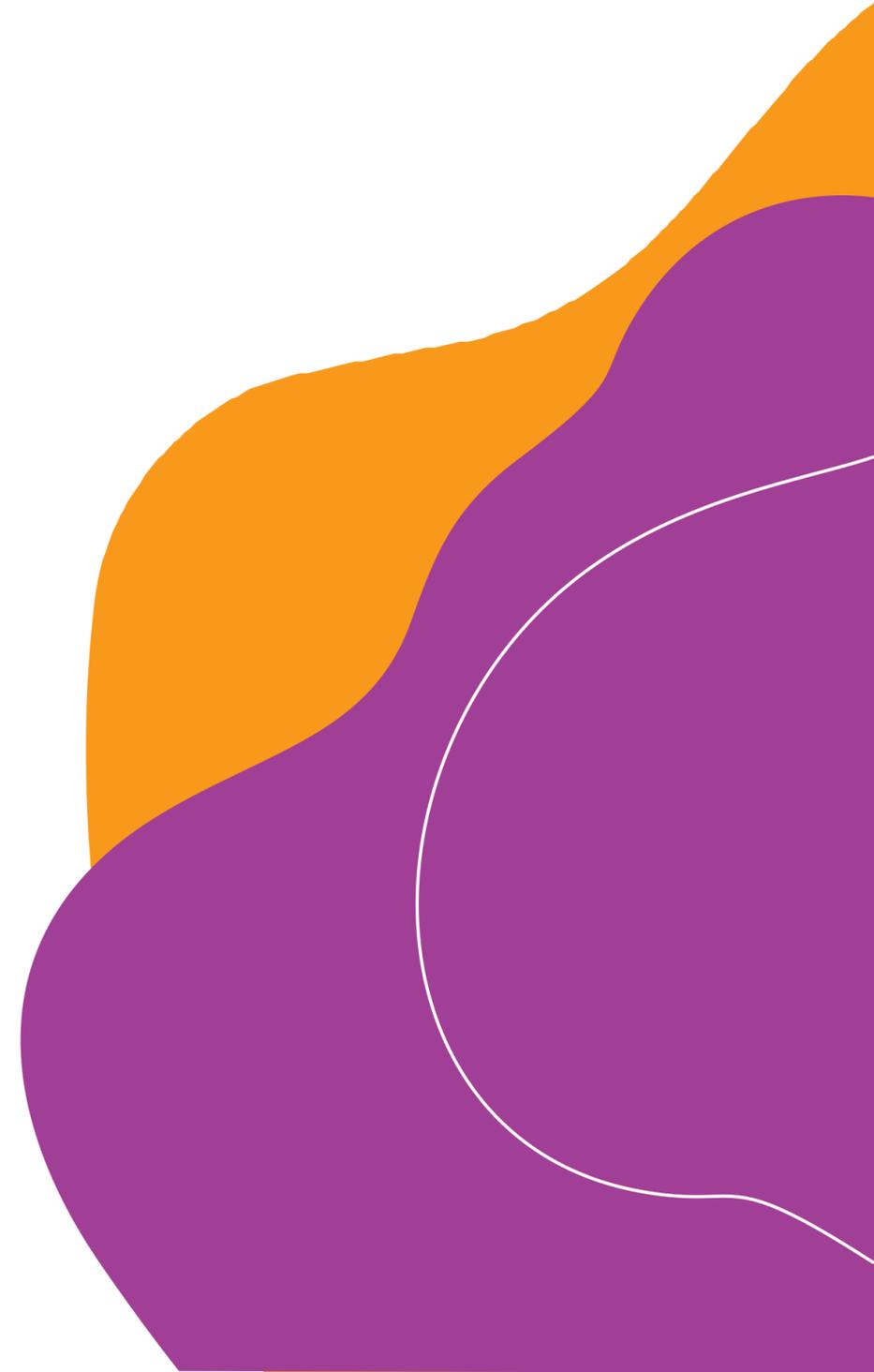
# SESSION 2: ACTION PLANNING



# PRIORITIZATION EXERCISE

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- What is the proposed goal?
- How will this goal help the facility better engage men in prenatal health?
- How do you propose to accomplish this goal?
  - Activities, timeframe, budget, responsibility



# SESSION 3: PRESENTATION TO LEADERSHIP





CONCLUSION  
AND  
EVALUATIONS

THANK YOU!