IMPLEMENT
HEALTH SYSTEM RESPONSE TO GENDER BASED VIOLENCE

TRAINING MANUAL

ON GENDER-BASED VIOLENCE FOR HEALTH PROFESSIONALS

With financial support
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IMPLEMENT – SPECIALIZED SUPPORT FOR VICTIMS OF VIOLENCE IN HEALTH CARE SYSTEMS ACROSS EUROPE | JUST/2014/DAP/5361*

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LAMORO AGENZIA DI SVILUPPO

BGRF bulgarian gender research foundation

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TRAINING MANUAL

ON GENDER-BASED VIOLENCE FOR HEALTH PROFESSIONALS

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1. BACKGROUND

Health care systems in Europe remain a key but underutilized entry point through which victims of gender-based violence (GBV) can be identified and supported. Health care professionals are in a position to break the silence and offer critical care to women and children who are victims of violence and suffer its health consequences for many years. Furthermore, they are often the ones who have the most contact with survivors. Yet health professionals often fail to identify patients experiencing abuse, and thus only treat the presenting complaints and miss an opportunity to provide the link to specialised GBV services. Other health professionals do not have the infrastructure or legal support to provide the necessary care. It is critical that health professionals play a key role in ensuring that the health care system responds to GBV and protects women's health and rights, and this can only be done by **directly connecting the health care system to the specialized support services**. IMPLEMENT, a European Commission (EC) co-funded project to establish capacity building within the health settings of six European countries (Austria, Bulgaria, Germany, France, Italy, Romania) aims to strengthen the specialised support for victims of gender-based violence in health settings. The project aims to better meet the needs of survivors of GBV by securing a strong connection between the health system and women's specialized services.

1.1 Acknowledgements

This manual has been prepared jointly by AÖF staff Kelly Blank, and guided by project facilitator Mathilde Sengölge and project coordinator Maria Rösslhumer, in addition to feedback and input from all IMPLEMENT partners (Marc Nectoux, Sonia Abluton, Ulrike Janz, Marion Steffens, Diana Rus, Daniela Gorbounova), trainers (Gene Feder, Medina Johnson) and Advisory Group Members (Sabine Bohne, Carol Metters, Pascale Franck, Leo Pas). IMPLEMENT would like to acknowledge that this training manual, and the IMPLEMENT project as a whole, is made possible by support from the European Commission. The manual is adapted from the UNFPA-WAVE (Women against Violence Europe) Training Manual "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia". Therefore, this training manual uses many of the modules, chapters, handouts, and tables used in the UNFPA-WAVE Manual, in addition to information supplied by other sources, listed in section 1.3 as well as in citations. The IMPLEMENT project is based on the best practice examples from Austria (Victim Support Groups) and the UK (IRIS). See pages 35 and 36.

1.2 The Implement Project

OBJECTIVES

"IMPLEMENT: Specialized Support for victims of violence in Health Care Systems across Europe", under grant agreement JUST/2014/DAP/5361, began on 1 October 2014 and has a duration of 24 months. The objectives of the project are:

- Identify the strengths and weaknesses of the existing health system infrastructure related to the provision of obstetrical or emergency care for victims–including a discussion with health care managers in each country and integrating existing materials/resources already in place within the countries
- Identify existing national legal frameworks with regards to provision of care for victims in the health setting
- Provide one train-the-trainer seminar to empower six violence prevention advocates **(GBV advocates)** and six health care professionals **(clinical leads)** to implement health care capacity building seminar(s) and one follow-up seminar in each of the partner countries to empower obstetric or emergency care teams to improve support to victims of GBV
- Promote sensitization and advocacy initiatives at the health sector policy level to promote legal support for victims in health settings in the partner countries–includes identifying

the legal frameworks that exist currently at the national level in the EU with regards to provision support victims of GBV in health settings
- Enhance staff training and referral networks to advocacy measures for institutional change at the policy level
- Develop and implement an effective communication and dissemination plan to ensure maximum exposure of project activities and results to key target audiences and relevant stakeholders across the EU, including best practice sharing with the WAVE network and targeting medical conferences

SETTINGS

The primary setting for IMPLEMENT is within the health facilities of six partner EU countries. Table 1 lists the national partners responsible for coordinating with the health facilities and GBV organizations.

Table 1: LIST OF IMPLEMENT PARTNERS

Name	Country	Organization
Maria Rösslhumer	Austria	AÖF
Genoveva Tisheva	Bulgaria	BGRF
Marc Nectoux	France	Psytel
Ulrike Janz	Germany	GESINE
Marion Steffens	Germany	GESINE
Sonia Abluton	Italy	Lamoro
Diana Rus	Romania	BBU

TARGET GROUPS

The beneficiaries of the project are patients who receive emergency or obstetric care as victims of GBV, and the health professionals (doctors, nurses, midwives) who provide medical assistance.

The project target group include: GBV advocates who provide frontline assistance to victims; obstetric/emergency health professionals within clinical teams who are not equipped to assist victims of GBV with their specialized needs; management and front-line staff; and health sector policy makers, for example ministries, and federal and local level entities responsible for health, who are responsible for allocating the resources and institutional measures for specialised support for victims in the health setting.

DELIVERY

The IMPLEMENT website can be found at: gbv-implement-health.eu

A train-the-trainer seminar was conducted in Vienna, Austria on 21–22 May 2015 by two specialized trainers from the United Kingdom, who trained selected health care professionals and violence prevention advocates (one clinical lead and one GBV advocate from each partner country) to then establish capacity building into health facilities in the six partner EU countries.

1.3 Primary Sources for the Manual

This IMPLEMENT Training Manual is adapted from the **UNFPA-WAVE Training Manual** "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014)[1], in addition to information from:

[1] http://eeca.unfpa.org/publications/strengthening-health-system-responses-gender-based-violence-eastern-europe-and-central

- **Fundamental Rights Agency (FRA)** "Violence Against Women: An EU-Wide Survey" (2014)[2]
- **PRO TRAIN Project** "Improving Multi-Professional and Health Care Training in Europe - Building on Good Practice in Violence Prevention" (2007-2009)[3]
- **World Health Organization (WHO)** "Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines" (2013)[4]
- **Identification and Referral to Improve Safety (IRIS)** Training Materials, University of Bristol (2015)[5]
- **UNICEF** "Handbook for Coordinating Gender-based Violence Intervention in Humanitarian Settings" (2010)[6]
- **Women Against Violence Europe (WAVE)** "WAVE Report 2014" (2014)[7]

Table 2: LIST OF IMPLEMENT TRAINERS AND ADVISORY GROUP MEMBERS

Name	Country	Organization	Position
Gene Feder	UK	IRIS	Trainer
Medina Johnson	UK	IRIS	Trainer
Sabine Bohne	Germany	University of Osnabrück	Advisory Group Member
Carol Metters	UK	IRIS	Advisory Group Member
Pascale Franck	Belgium	Province of Antwerp	Advisory Group Member
Leo Pas	Belgium	EUROPREV	Advisory Group Member

1.4 Structure of this Manual

This Manual is divided into two sections; section I is the training manual which consists of eight chapters, and section II is the training appendix, with 23 elements for the training sessions and a fundamental reference tool.

SECTION I – TRAINING MANUAL

Chapter 1 provides background information and practical guidelines to support programmes in strengthening health system responses to GBV, as relevant to the IMPLEMENT training. **Chapter 2** "GBV Core Concepts" provides a brief overview of the causes, dynamics and consequences of GBV, definitions of 2 IMPLEMENT roles (clinical lead and GBV advocate), as well as definitions of violence against women, examples of GBV against women, the prevalence of physical and sexual violence throughout the six partner countries, statistics of women who contacted organizations or services after serious incidents of violence since the age of 15, and finally the chapter addresses the role of health professionals in the response to GBV. **Chapter 3** "Identifying GBV" outlines the different steps of a health care provider's intervention in a presumed case of GBV, including how to sensitively ask questions and respond, the signs, symptoms and behaviors of GBV which women survivors may express or feel, the role of universal screening vs. case-finding, key communication skills, and the process for undertaking a medical examination and providing medical care. **Chapter 4** "Documenting GBV" outlines the ways in which the health sector can document GBV, including recording and classifying injuries, how and what should be documented, and the process of taking photos as evidence and documentation. **Chapter 5** "Risk Assessment and Safety Planning" discusses the necessary steps to take in terms of risk assessment and safety planning in cases of GBV, including confidentiality and disclosure regarding cases with children, and understanding

2 www.health-genderviolence.org/
3 www.pro-train.uni-osnabrueck.de/index.php/TrainingProgram/HomePage
4 http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf
5 http://www.irisdomesticviolence.org.uk/iris/
6 www.unicef.org/protection/files/GBV_Handbook_Long_Version.pdf
7 www.wave-network.org/sites/default/files/01%20WAVEREPORT_2014.pdf

the risk factors of violence. **Chapter 6** "Referral Pathways" addresses referral pathways for survivors of GBV, highlighting issues including the relevant professionals, necessary steps for referring survivors to a service provider, the establishment of effective referral systems and descriptions of women's support services, which are crucial in referral pathways. **Chapter 7** "Multi-Sectoral Cooperation" describes the importance of multi-agency training and cooperation, with sections taken from both the PRO TRAIN manual by Daphne (Module 5), as well as the UNICEF Manual "Handbook for Coordinating Gender-based Violence Intervention in Humanitarian Settings". Finally, **Chapter 8** "Evaluation and Closing" contains the evaluation form for the training.

SECTION II – TRAINING APPENDIX

The purpose of the training appendix is to provide trainers with ready-made and user-friendly material to deliver trainings to health care professionals within the EU. Trainers are encouraged to adapt the training sessions to the learning needs of their specific target group. This appendix includes training presentation slides, handouts, exercises and role-plays, as well as a fundamental reference tool titled "Health Sector Response to Victims of Gender-based Violence" which will be distributed to professionals.

2. GENDER-BASED VIOLENCE: CORE CONCEPTS

The Council of Europe Convention on preventing and combating violence against women and domestic violence, also known as the Istanbul Convention (2011), is a groundbreaking European convention that is based on the understanding that violence against women is a form of GBV that is committed against women because they are women. The Convention has a strong focus on prevention, protection, prosecution and monitoring.[8] One of the key components of preventing violence against women is to train professionals who come in close contacts with victims.

Violence against women is gender-based and is "both a cause and consequence of unequal power relationships between men and women"
(UNFPA-WAVE, p. 17)

GBV violates a number of women's rights, including the right to life, the right to not be subject to torture or to cruel, inhuman or degrading treatment or punishment, the right to equal protection under the law, the right to equality in the family, or the right to the highest standard attainable of physical and mental health.[9] GBV against women and girls is one of the most widespread violations of human rights, with a significant impact on physical, psychological, sexual and reproductive health. GBV is a structural problem that is deeply embedded in unequal power relationships between men and women, and includes all forms of sexual harassment and exploitation.[10] It is important to note that GBV also includes violence perpetrated against men and boys, for instance, boys may become subjected to sexual abuse by family members or trafficked for the purpose of sexual exploitation. There are also instances where men have become survivors of domestic violence. However, because of the unequal distribution of power between men and women, women and girls constitute the vast majority of persons affected by GBV, with the majority of perpetrators being male.[11]

According to the representative 2014 Fundamental Rights Agency (FRA) study surveying violence against women in all Member States in the European Union (EU), one in three women (33%) within the European Union have experienced physical and/or sexual violence since the age of 15 years, and 8% of women have experienced physical and/or sexual violence in the 12 months prior to the survey interview. This means that approximately 13 million women in the EU have experienced physical violence, and 3.7 million women in the EU have experienced sexual violence within twelve months prior to the survey.[12]

8 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 17.
9 Convention on the Elimination of all Forms of Discrimination Against Women (1992).
10 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 18.
11 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 19.
12 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 21.

2.1 Definitions of Gender-Based Violence

Gender-based violence (GBV) and violence against women (VAW) are often used together or interchangeably, since most violence against women is gender-based, and most gender-based violence is perpetrated by men against women and girls. Below are definitions related to gender-based violence and this training manual, as well as brief definitions of the two important roles within IMPLEMENT: the clinical lead and the GBV advocate.

The most common forms of physical violence involve pushing or shoving, slapping or grabbing, or pulling a woman's hair. (FRA, p. 21)

VIOLENCE

Gender-based Violence (GBV)

"violence that is directed against a woman because she is a woman, or that affects women disproportionately"[13]

Violence against Women (VAW)

"(...) a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of women's full advancement. [...]Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men"[14]

(...) constitutes a violation of human rights and a form of discrimination against women. It means all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"[15]

Domestic Violence and Abuse (DVA)

"Any incident or pattern of incidents of controlling[16], coercive[17] or threatening behavior, violence or abuse between those aged 16 or over who are or have been, intimate partners or are family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional. It also includes 'honor'-based violence and forced marriage"[18]

Intimate Partner Violence (IPV)

"behavior by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors. (It) covers violence by both current and former spouses and other intimate partners"[19]

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13 Committee on the Elimination of Discrimination Against Women, General Recommendation No. 19, Violence Against Women (1992).

14 Declaration on the Elimination of Violence Against Women (1993), Preamble.

15 Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (2011), Article 3.

16 „Controlling behavior is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independences, resistance and escape and regulating their everyday behavior." UK Home Office, "Information for Local Areas on the change to the Definition of Domestic Violence and Abuse" (2013), p. 2.

17 „Coercive behavior is: an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim." (UK Home Office, "Information for Local Areas on the change to the Definition of Domestic Violence and Abuse" (2013), p. 2.

18 UK Home Office, "Information for Local Areas on the change to the Definition of Domestic Violence and Abuse" (2013), p. 2. www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf.

19 WHO, London School of Hygiene and Tropical Medicine, South African Medical Research Council, "Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence" (2013).

SERVICES & SUPPORT

Case-finding

Also known as clinical enquiry, "is asking women presenting in health care settings based on clinical conditions, the history and (if appropriate) examination of the patient"[20]

First-line Support

"refers to the minimum level (primarily psychological) support and validation of their experience that should be received by all women who disclose violence to a health care provider or other provider, such as the GBV advocate. It shares many elements with what is being called 'psychological first aid' in the context of emergency situations involving traumatic experiences"[21]

Forensic Examination

"medical examination conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion."[22] The primary aim of a forensic examination is to collect evidence that may help prove or disprove a link between individuals and/or between individuals and objects or places.[23]

Referral System

"a comprehensive institutional framework that connects various entities with well-defined mandates, responsibilities, and powers into a network of cooperation, with the overall aim of ensuring the protection and assistance of survivors, to aid in their full recovery and empowerment, the prevention of GBV, and the prosecution of perpetrators"[24]

Universal Screening

Also known as routine enquiry, is routinely asking women presenting in health care settings about exposure to GBV[25]

IMPLEMENT ROLES

Clinical lead

A clinical lead is health professional employed within the pilot setting who works closely with the GBV advocate in providing appropriate support and referrals to GBV survivors. Their role is to support and empower other health professionals.

GBV advocate

A GBV advocate is an individual who works within a women's organization or agency (such as a women's shelter), which provides support for women survivors. She works closely with the clinical lead in providing appropriate support for women survivors of GBV, and ensures the survivor receives the appropriate support and if necessary, provides further referrals.

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20 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 67.
21 WHO "Responding to Intimate Partner Violence and Sexual Violence Against Women" (2013), p. vii.
22 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 81.
23 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 81. Also cited in WHO, "Guidelines for Medico-legal cares of Victims of Sexual Violence" (2003).
24 UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 88.
25 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 67.

2.2 Forms of GBV Against Women

GBV encompasses a wide range of acts, including physical, sexual, psychological and economic violence. Therefore, it is important for health professionals to understand and recognize the full range of acts that may constitute GBV (see Table 3).[26]

Table 3: FORMS OF GENDER-BASED VIOLENCE[27]

Physical violence	Physical force that results in bodily injury, pain, or impairment. The severity of injury ranges from minimal tissue damage and broken bones, to permanent injury and death. Acts of physical violence include: ▸ Slapping, shoving, pushing, punching, beating, scratching, choking, biting, grabbing, shaking, spitting, burning, twisting of a body part, forcing the ingestion of an unwanted substance ▸ Using household objects to hit or stab a woman, using weapons (knives, guns)
Sexual 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, in any setting, including, but not limited to home and work.[28] Acts of sexual violence can include: ▸ Rape, or other forms of sexual assault ▸ Unwanted sexual advances or sexual harassment (including demands for sex in exchange for job promotion or advancement or higher school marks or grades) ▸ Trafficking for the purpose of sexual exploitation ▸ Forced exposure to pornography ▸ Forced pregnancy, forced sterilization, forced abortion ▸ Forced marriage, early/child marriage ▸ Female genital mutilation ▸ Virginity testing ▸ Incest
Psychological violence (emotional violence)	An action or set of actions that directly impair the woman's psychological integrity. Acts of psychological violence include: ▸ Threats of violence and harm against the woman or somebody close to her, through words or actions (ex. through stalking or displaying weapons) ▸ Harassment and mobbing at the workplace ▸ Humiliating and insulting comments ▸ Isolation and restrictions on communication ▸ Use of children by a violent intimate partner to control or hurt the woman. These acts constitute both, violence against children, as well as violence against women
Economic violence	Used to deny and control a woman's access to resources, including time, money, transportation, food, or clothing. Acts of economic violence include: ▸ Prohibiting a woman from working ▸ Excluding her from financial decision-making in the family ▸ Withholding money or financial information ▸ Refusing to pay bills or maintenance for her or the children ▸ Destroying jointly owned assets

26 UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 20.
27 UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 20.
28 WHO, "World Report on Violence and Health" (2002), p. 149.

2.3 Understanding the Dynamics of Violence in Intimate Relationships

Women survivors of violence presenting in a health setting often do not disclose their experiences. Negative attitudes towards women in general and towards survivors of violence in particular can inflict additional harm upon women who experience violence and may prevent health professionals from providing adequate medical care.[29] Understanding the dynamics of violent intimate relationships can help health professionals to maintain a supportive, non-judgmental, and validating attitude vis-à-vis survivors of violence, which is an important prerequisite of an effective health system response to GBV.[30]

The **Power and Control Wheel** offers a framework for understanding the manifestations and mechanisms of power and control in an intimate relationship.[31] This model was developed by the Domestic Abuse Intervention Programs in Minnesota, US, weaving in the experiences of women survivors of intimate partner violence who had participated in focus groups. The wheel consists of eight spokes that summarize the patterns of behaviors used by an individual to intentionally control or dominate his intimate partner: using intimidation, emotional abuse, and isolation, as well as minimizing, denying and blaming; using children, male privilege, economic abuse, coercion and threats. These actions serve to exercise 'power and control' – these words are in the center of the wheel. The rim of the wheel is made of physical and sexual violence – this violence holds it all together (see Figure 1).[32]

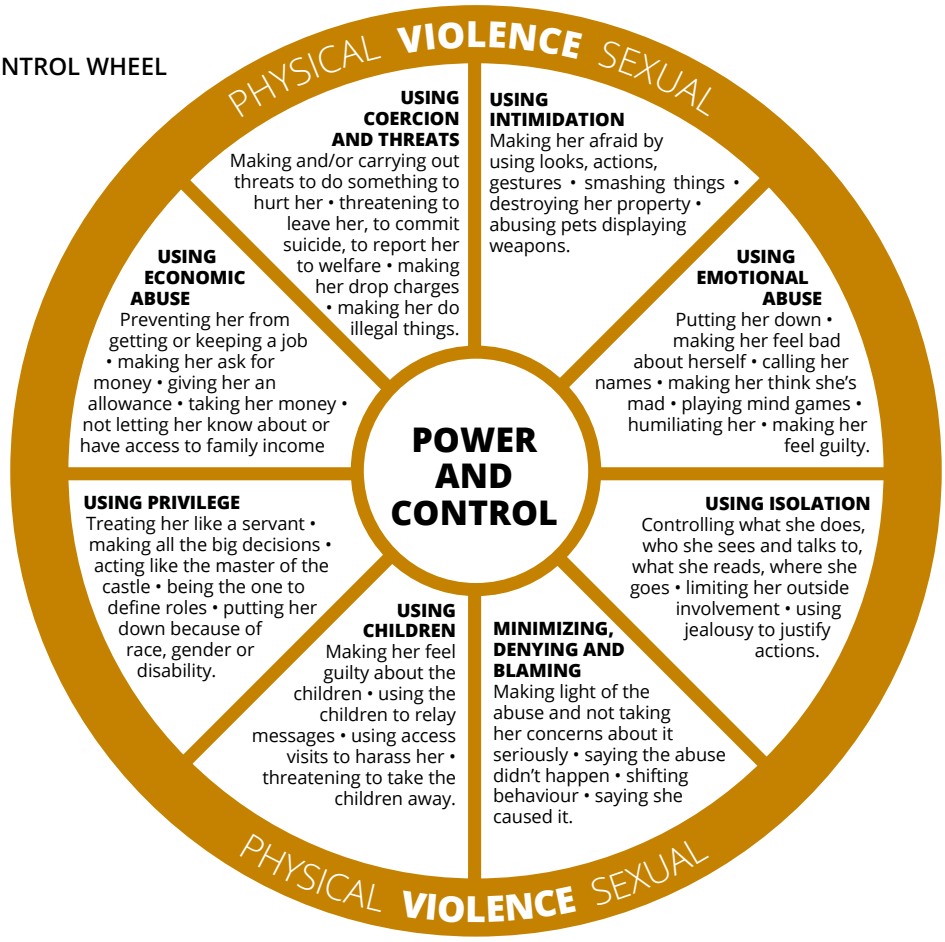
[29] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014) p. 31.

[30] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 31.

[31] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 32. Also cited in WHO, "Integrating Poverty and Gender into Health Programmes, A Sourcebook for Health Professionals Module on Gender-based Violence", (2005).

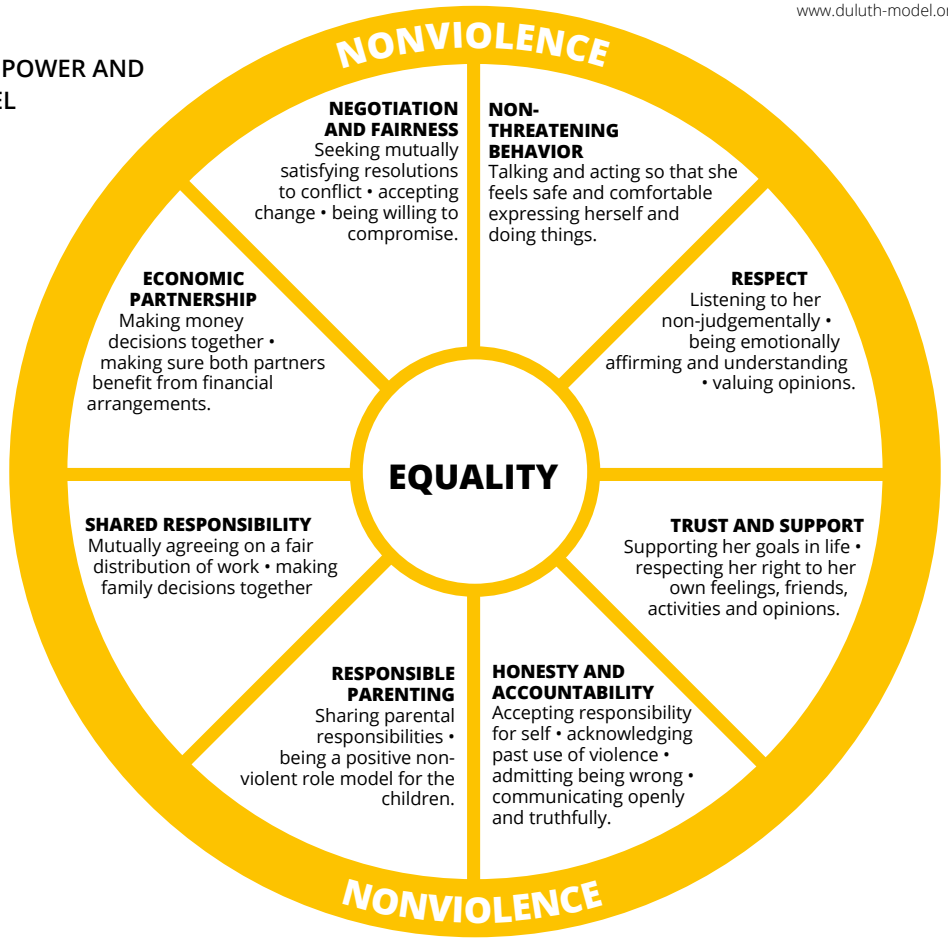
[32] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 32.

Figure 1:
POWER AND CONTROL WHEEL



Adapted from:
Domestic Abuse Intervention Project
Duluth, MN 218/722-2781
www.duluth-model.org

Figure 2:
NON-VIOLENCE POWER AND CONTROL WHEEL



2.4 The Impact of GBV on Women's Health

GBV can impact all aspects of women's health – physical, sexual, and reproductive, mental and behavioral health. Health consequences of GBV can be both immediate and acute, as well as long-lasting and chronic; negative health consequences may persist long after the violence has stopped.[33]

GBV CAN RESULT IN THE FOLLOWING OUTCOMES:[34]

- **Death** – fatal outcomes as immediate result of a woman being killed by the perpetrator, or as a long-term consequence of other adverse health outcomes, (for example, mental health problems resulting from trauma can lead to suicide, alcohol abuse, HIV infection or cardiovascular diseases)
- **Reduced life expectancy** – the World Bank estimates that rape and domestic violence account for 5% of the healthy life years of life lost to women age 15 to 44 in developing countries
- **Physical Harm** – Injuries, functional impairments, permanent disabilities
- **Risky Health Behaviors** – Alcohol and drug use, smoking, sexual risk-taking, self-injuring behavior
- **(Psycho)-Somatic Consequences** – Chronic pain syndrome, irritable bowel syndrome, gastrointestinal disorders, urinary tract infections, respiratory disorders
- **Reproductive Health Consequences** – Pelvic inflammatory disease, sexually transmitted diseases, unwanted pregnancy, pregnancy complications, miscarriage/low birth weight
- **Psychological Consequences** – Post Traumatic Stress Disorder, depression, fears, sleeping disorders, eating disorders, suicidal thoughts, and low self-esteem

2.5 The Impact of GBV on Children

"73% of mothers who have been victims of physical and/or sexual violence by a partner indicate that at least 1 of their children has become aware of such violence taking place"
(WAVE Report 2014, p. 10)

The impact of GBV on children, particularly of domestic violence and abuse, is harmful. Children can be affected by violence committed against their mothers, and they themselves can be abused by the perpetrator, which can often be their fathers or stepfathers.[35] Findings from the survey conducted by the Fundamental Rights Agency (FRA) EU highlight the connection between childhood violence and victimization as adults. In order to interrupt the cycle of violence, it is crucial to support children who are experiencing or witnessing domestic violence against their mother. "This is also important for prevention, since…children are often aware of the violence against their mother."[36]

Additionally, **"children who are exposed to…violent behavior towards the mother are more likely to grow up to be perpetrators or victims themselves."**[37] Children who witness violence are more than observers: "they grow up in an atmosphere of fear, exercise of power, helplessness and insecurity…and stress."[38] Additionally, children may be directly impacted by domestic violence by enduring similar violence. The likelihood of children suffering life-long consequences of childhood domestic violence are high: boys are more likely to grow up to be perpetrators, while girls are more likely to suffer violence.[39] It is essential that children are given help and support in dealing with their experiences of violence.

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33 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 39.
34 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 40.
35 WAVE, "Away from Violence: Guidelines for Setting up and Running a Refuge" (2004), p. 14.
36 WAVE, "WAVE Report 2014" (2014), p. 10.
37 WAVE, "Away from Violence: Guidelines for Setting up and Running a Refuge" (2004), p. 14.
38 Domestic Violence Intervention Center Vienna, "Parent's Rights or Child Protection? Experience Concerning the new Act ion Family Matters in view of Domestic Violence" (2013), p. 4.
39 WAVE, "Away from Violence: Guidelines for Setting up and Running a Refuge" (2004), p. 14.

SYMPTOMS OF CHILDREN EXPOSED TO VIOLENCE (non-exhaustive list):[40]

- Sleeping and eating disorders
- Bed-wetting
- Speech disorders
- Withdrawal
- Behavioral disorders
- Aggression
- Depression
- Difficulties at school
- Suicidal thoughts or acts

Around one third (30%) of women who experienced sexual victimization in a former or current partnership report experiences of childhood sexual violence (FRA, p. 121)

Table 4, taken from the 2014 FRA survey on violence towards women in Europe,[41] demonstrates the percentage of women who have disclosed experiences of childhood physical, psychological, and/or sexual childhood abuse before the age of 15. The table below demonstrates that in the 6 IMPLEMENT partner countries, one-third to one-quarter of women report having been a victim of violence before the age of 15. There are also slight differences in reported experiences of childhood abuse, as Austria reported 5% experience of sexual violence, compared to 28% of women surveyed in Bulgaria. These differences in numbers may also relate to the issue of under-reporting and cultural, societal, and political differences in general awareness around the issue of child abuse.

Table 4: REPORTED CHILDHOOD EXPERIENCE OF VIOLENCE[42]

Country	Physical Violence	Sexual Violence	Psychological Violence	Any Violence
Austria	27%	5%	9%	31%
Bulgaria	28%	28%	5%	30%
France	33%	20%	14%	47%
Germany	37%	13%	13%	44%
Italy	25%	11%	9%	33%
Romania	23%	(1)	4%	24%

2.6 Prevalence of Physical and Sexual Violence

Table 5 displays findings from the FRA survey, indicating the percentage of women who have disclosed experiences of physical and sexual violence by current partners, previous partners, and/or non-partners since the age of 15.[43] It is clear that physical and sexual violence are prevalent throughout Europe and these statistics reflect only the reported cases. The EU (28) average for prevalence of physical and/or sexual violence by any partner and/or non-partner since the age of 15 is 33%[44]; this is similar to the prevalence within the IMPLEMENT partner countries, however Austria is below the EU average with 20%, while Bulgaria is above average at 44%.[45]

40 Domestic Violence Intervention Center Vienna, "Parent's Rights or Child Protection? Experience Concerning the new Act ion Family Matters in view of Domestic Violence" (2013), p. 4.
41 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 123.
42 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 123.
43 data not shown
44 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 123.
45 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 29.

Table 5: WOMEN WHO HAVE EXPERIENCED PHYSICAL AND/OR SEXUAL VIOLENCE SINCE THE AGE OF 15[46]

Country	Current Partner	Previous Partner	Non-Partner	Any Partner and/or non-partner
Austria	3%	15%	12%	20%
Bulgaria	11%	38%	14%	28%
France	11%	31%	33%	44%
Germany	7%	24%	24%	35%
Italy	9%	25%	17%	27%
Romania	14%	30%	14%	30%

2.7 The Role of Health Care

The health sector is a critical entry point for identifying GBV, providing medical care to survivors and referring them to other essential services, such as shelters, counseling centers, or specialized medical care. **For many survivors of violence, a visit to a health professional is the first point of contact**,[47] enabling them to access support and care. Therefore, strengthening the capacity of health professionals to identify and support survivors of violence is crucial to the prevention of and response to GBV.

Doctors are often the first point of contact for survivors - women are most likely to get in touch with health care services more than any other service (FRA, p.60).

The European Union Agency for Fundamental Rights (FRA) published a survey in 2014, which documented violence against women throughout the EU. Findings indicate that 1 in 3 victims of physical and/or sexual partner violence, and 1 in 4 victims of physical and/or sexual non-partner violence contacted some sort of service or organization for assistance. The findings demonstrate that only 25% of victims report the act of violence at all, and those that do report are most likely to speak to a health care provider. Police are the next likely to be contacted.[48] It is clear that the health providers, and those working within the health industry, have a key role to play in the overall well-being and immediate assistance to women survivors of violence, whether or not the violence is disclosed by the survivor or not.

THE MOST COMMON REASONS WHY SOME WOMEN DO NOT SEEK HELP ARE:[49]

- They choose to deal with it independently or disclose to someone close to them
- They believe no one can help them
- Their situation was too 'minor' to involve services
- **They were either unaware of services available or that there were in fact no services available**

Since many women survivors of GBV are unaware of support services in the community, it is crucial that health professionals and GBV advocates work closely together in the care pathway to mend this disconnect.

Specialized services are also crucial for women, particularly because many women report feeling ashamed, embarrassed, and blame themselves for the violence they experience. Specialized support services for women survivors of violence can enhance the healing process before, during, and after a visit to health care services by validating their experiences and feelings, being sensitive to their situations, providing a non-judgmental attitude, and ensuring a safe environment. Moreover, there is evidence that GBV advocacy can improve outcomes for survivors.[50]

Therefore, IMPLEMENT intends to specifically improve health care and GBV sector collaboration. By encouraging and enhancing a multi-agency response and cooperation to GBV,

46 RA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p, 28.
47 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 60.
48 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 60.
49 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 66.
50 Ramsay J, Carter Y, Davidson L, Dunne D, Eldridge S, Feder G et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. Cochrane Database Syst Rev 2009;(3):CD005043.

the needs of survivors can be met more effectively and sensitively. As demonstrated in this manual, IMPLEMENT outlines the ways in which multi-agency cooperation in dealing with GBV can be successfully established in the partner countries through various means, but in particular through improved communication and an effective referral pathway between health settings (clinical lead) and women's organizations (**GBV advocate**). For more information on multi-sectoral cooperation, see Chapter 7.

Health professionals must be trained in how to ask about abuse, respond appropriately, and offer referrals to a specialist GBV service.

The 2014 FRA survey provided the percentage of women in the EU who contacted police or other services after experiencing some form of physical and/or sexual violence. These figures, found below in Table 6, demonstrate that of all the services, women are most likely to contact a doctor or health care facility, followed by the police and hospital. Reasons for not contacting an organization vary, however the primary reasons as indicated in the FRA survey are that: women feel they would rather deal with the situation alone or involve someone close to them such as a family member or friend; they feel the situation is too minor or it just never occurred to them to contact an organization for help; they did not know where to turn to; and there were no services available.[51]

Table 6: WOMEN WHO CONTACTED ORGANIZATIONS OR SERVICES AFTER SERIOUS INCIDENTS OF VIOLENCE SINCE THE AGE OF 15 (EU28)[52]

Service	Partner Physical Violence	Partner Sexual Violence	Non-Partner Physical Violence	Non-Partner Sexual Violence
Police	14%	15%	13%	14%
Hospital	11%	12%	9%	12%
Doctor, health center or other healthcare institution	15%	22%	10%	16%
Women's shelter	3%	6%	(0)	(1)
Victim support organization	4%	4%	1%	4%

3. IDENTIFYING GENDER-BASED VIOLENCE

Even though survivors of GBV are more likely than the general population to use health services, they are not likely to spontaneously disclose. When health professionals sensitively enquire if a patient presents with symptoms that can indicate GBV, this can increase the chance of disclosure. Therefore, facilitating a positive disclosure of GBV is an important starting point for any health intervention. Asking about GBV, when done in a professional and supportive manner, can help to break the feelings of isolation, guilt, and shame that survivors of violence may experience, and also help to convey the message that help is available and that she may use it if she feels ready.[53]

87% of women would find it acceptable if doctors ask about violence when patients exhibit certain injuries (FRA, p. 69)

3.1 Universal Screening vs. Case-Finding

In health settings two approaches are used to facilitate the disclosure of gender-based violence: universal screening and case finding. Universal screening is also known as routine enquiry as this approach requires asking all women presenting in health settings about their exposure to GBV. In contrast, case-finding (also known as clinical enquiry) refers to asking

51 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 66.
52 FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 65.
53 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 66.

women about GBV if they present with certain clinical symptoms, history and (if appropriate) examination of the patient.[54]

Universal Screening: also known as routine enquiry, is routinely asking women presenting in health care settings about exposure to GBV.

Case-finding: also known as clinical enquiry, is asking women presenting in health care settings based on clinical conditions, the history and (if appropriate) examination of the patient.[55]

According to a recent WHO study, 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. This can in turn have a major impact on the women patients, who may choose to disclose during universal screening, only to be met with no effective action taken.

Case-finding, which is based on selective and careful clinical considerations, is found to be the most effective, particularly when health staff is specially trained in how to best respond and refer. IMPLEMENT is a good example in this regard, and is following WHO's recommendation, of "enhancing provider's ability to respond adequately to those who do disclose violence, show signs and symptoms associated with violence, or are suffering from severe forms of abuse." [56]

Universal screening is therefore not recommended; although this method increases rates of identification, it has neither reduced subsequent violence nor led to benefit for women's health. Instead, case-finding is advised; health professionals should ask about exposure to violence when assessing conditions that may be caused or complicated by violence, in order to improve diagnosis/identification and subsequent care.[57]

However, universal screening might be considered in specific circumstances:

- Women presenting with mental health symptoms and disorders (depression, anxiety, PTSD, self-harm/suicide attempts) due to the strong correlation between mental health disorders among women and intimate partner violence
- HIV testing and counseling, since intimate partner violence may affect the disclosure of HIV status, or jeopardize the safety of women who disclose, as well as their ability to implement risk-reduction strategies
- Antenatal care, due to the dual vulnerability of pregnancy and also taking into account the possibility of follow-up in antenatal care[58]

3.2 Symptoms, Signs, and Behaviors of GBV

The following are indicators that a female patient may have experienced violence in the past or currently is experiencing violence, as well as symptoms related to experiencing GBV. It is important to keep in mind that **none of the signs, symptoms, or behaviors listed below automatically indicates that a woman has experienced GBV. They should raise suspicion and prompt health professionals to talk to the woman in private and ask her**

[54] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 67.
[55] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 67.
[56] WHO, "Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines" (2013), p. 19.
[57] WHO, "Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines" (2013), p. 18.
[58] UNFPA-WAVE, ("Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 67.

if she has experienced violence. Even if she chooses not to disclose at this time, she will know that the professional is aware of the issue and she might choose to approach the care provider at a later time to disclose.[59]

CLINICAL CONDITIONS ASSOCIATED WITH GENDER-BASED VIOLENCE:[60]

- Depression, anxiety, PTSD, sleep disorders
- Suicidal thoughts/attempts or self-harm
- Alcohol and other substance abuse
- 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 infection
- Repeated vaginal bleeding and sexually transmitted infections
- Unexplained chronic pain
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system, for example headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner/ husband or accompanying adults in consultations

BEHAVIORS ASSOCIATED WITH GENDER-BASED VIOLENCE:[61]

- Injuries inconsistent with explanation of cause
- 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
- Multiple injuries at different stages of healing
- Woman appears frightened, overly anxious, or depressed
- 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

3.3 Barriers in the Health Care System in Addressing GBV

There are many reasons which may prevent women who experienced GBV from accessing healthcare and disclosing violence to health professionals. Even though these barriers operate at the levels of partner relationships, families and the wider community and therefore require interventions beyond the health system, health professionals nevertheless need to be aware of them, in order to be able to provide effective care and referrals to relevant service providers, such as shelters, crisis centers or counseling centers. These organizations may assist women in addressing some of these barriers, for instance through providing accommodation, legal counseling or other support.[62]

[59] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 68.
[60] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 67.
[61] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 68.
[62] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 182.

BARRIERS FACED BY WOMEN SURVIVORS IN ACCESSING HEALTH SERVICES AND DISCLOSING VIOLENCE:[63]

- **Shame, guilt, and the feeling to be solely or partly responsible for the violence suffered:** A woman who experienced violence from an intimate partner may be convinced that she can stop the violence if she obeys the perpetrator's wishes and "betters" herself.
- **Fear of reprisals from the perpetrator**: Women who live in violent relationships may fear an escalation of violence and further threats, as violent partners usually forbid women to talk about the violence with any other person and threaten with further violence.
- **Fear of stigma and social exclusion** by their families and communities.
- Social isolation and the feeling of having to deal with the experienced violence all by themselves.
- **Long-term experiences of mistreatment** that can damage women's self-confidence and self-esteem to such an extent that the search for and the acceptance of support becomes difficult.
- **Lack of safe options** for their children and fear of losing child custody.
- Fear of drawing attention to irregular **immigration status** or of losing status following separation from a violent spouse.
- **Lack of realistic options** (ex. for financial resources, housing, employment or safety).

OTHER BARRIERS FACED BY WOMEN CAN AND SHOULD BE ADDRESSED BY HEALTH CARE SYSTEMS, INCLUDING THE FOLLOWING:[64]

- **Lack of physical access** to health care services for women living in remote areas;
- **Fear of negative responses** from service providers and of being blamed for not separating from the abusive partner, in particular when the woman has received inappropriate and victim-blaming responses from other service providers in the past;
- **Not knowing which steps health care professionals will take**, for instance whether police will be informed or whether the perpetrator will be approached;
- **Language and cultural barriers** faced by migrant women and women belonging to ethnic minorities; and
- **Situational aspects** of the counseling and treatment situation, such as inappropriate physical conditions of the facility or insensitive behavior of doctors and nursing staff.

BARRIERS FACED BY HEALTH PROFESSIONALS IN PROVIDING EFFECTIVE SERVICES TO SURVIVORS OF GBV:[65]

To provide effective support for survivors of violence, health staff must understand the dynamics of GBV, and be aware of the available support services and the relevant protocol and procedures already in place.

- **Insufficient knowledge about causes, consequences and dynamics of GBV**: If health professionals do not ask about or do not recognize symptoms of GBV, they may misdiagnose survivors or offer inappropriate care.
- **Own attitudes and misconceptions** about GBV that may result in perceiving intimate partner violence as a private matter or blaming the survivor for the violence.
- **Own experiences** of GBV in the past.
- **Lack of clinical skills in responding to GBV**: As a consequence, health professionals may be reluctant to ask about GBV, so as to avoid "opening Pandora's box". Lack of knowledge and skills may also put the patient's safety, life and wellbeing at risk, for instance when health professionals express negative attitudes to a patient who has been raped or by discussing a woman's injuries in a way that can be overheard by a potentially violent spouse waiting outside.
- **Lack of information about existing support services** and appropriate professional contacts, which could serve as basis for referral.

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63 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 182.

64 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 182.

65 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 182.

- **Lack of time for medical care**, as well as inadequate funding of counseling. It may be difficult to estimate how time-consuming a conversation would be and health professionals are worried about having to cut back on the time needed for other patients.
- **Missing intra-institutional support** such as standardized protocols, documentation forms or staff training on dealing with survivors of GBV.
- **Uncertainties about legal obligations**, such as confidentiality rules or reporting obligations.
- **Absence of standard procedures, policies and protocols** to ensure that health professionals' response to all survivors of GBV follow standards of good clinical care

3.4: Requirements & Criteria for Asking about GBV

When enquiring about GBV, health care facilities and providers need to ensure that a number of minimum requirements are in place, while at the same time ensuring safety during enquiry.[66]

PRIOR TO ENQUIRING, HEALTH PROVIDERS MUST ESTABLISH:[67]

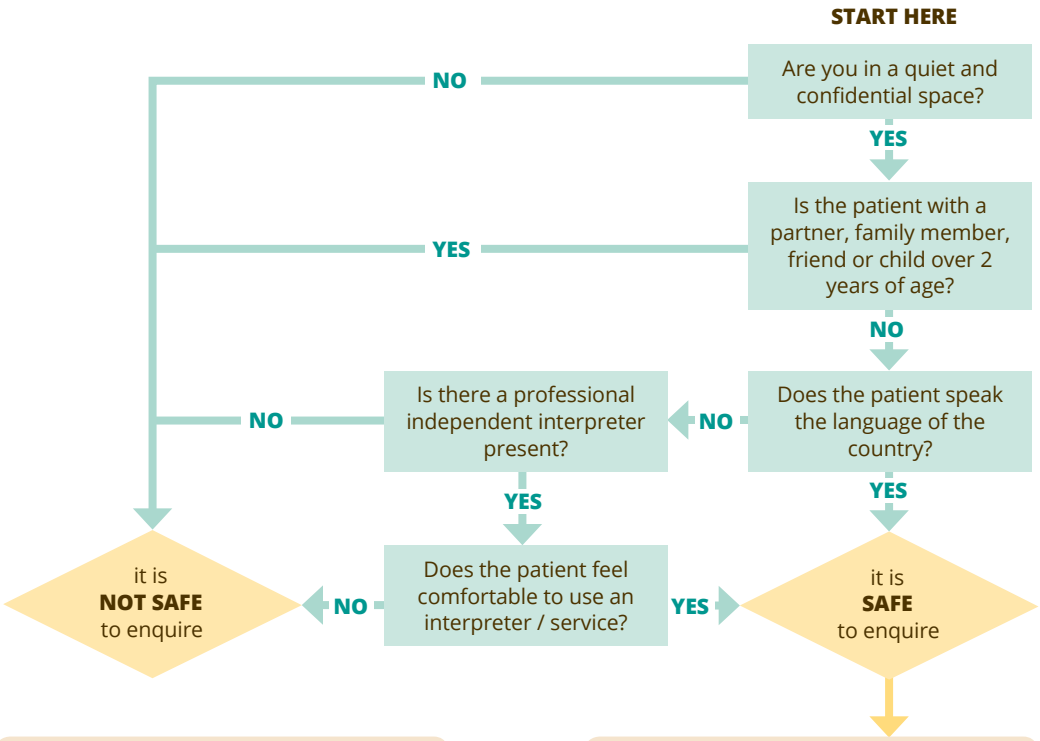
→ A protocol or standard operating procedure is in place to guide the intervention
→ Trained health providers on how to ask and respond to women who disclose
→ Ensured safety, with privacy and confidentiality considerations
→ Aware of and knowledgeable about resources to refer women to

CRITERIA FOR DETERMINING SAFETY DURING ENQUIRY:[68]

→ Private and confidential space
→ Avoid asking about GBV in the presence of a family member, friend, or child over 2 years
→ Ensure the presence of a professional interpreter, for women who are migrants, refugees, or belong to an ethnic minority and do not speak the local language
→ Avoid using family members as interpreters

66 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 68.
67 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 68. Also cited in WHO, "Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines" (2013), p. 19.
68 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 68.

Figure 3: IS IT SAFE TO ENQUIRE ABOUT GENDER-BASED VIOLENCE? [69]



EXPLAIN CONFIDENTIALITY

Information may be shared if:

- The patient gives consent
- There is a statutory duty to share information (ex. court order)
- It is in the best public interest (including safeguarding children)

You will not inform the partner about the discussion around GBV

HOW TO ASK ABOUT GBV

- Take the initiative to ask about violence
- Explain confidentiality
- Use eye contact and be aware of body language
- Use supportive comments and avoid passive listetning
- Show a non-judgemental and supportive attitude
- Reinforce that GBV cannot be tolerated
- Be patient, and do not pressure patient to disclose
- Emphasize that there are options and resources available

If the health care provider is: in a quiet and confidential space, alone, speaks the languge of the patient, or agrees to the interpreter being present, it is safe to enquire. At this point, it is important to ***explain confidentiality****.*

3.5 How to Ask about GBV

Asking a woman if she has experienced GBV can be challenging for health professionals. This section is intended to help increase the knowledge and confidence of health professionals in asking about GBV. Once it is determined safe, as outlined above in section 3.4 and Figure 3, health professionals can begin enquiry.[70]

[69] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 69. (IMPLEMENT updated this figure for purposes of this manual).

[70] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 70.

RECOMMENDATIONS AND TIPS FOR COMMUNICATING WITH SURVIVORS OF GBV:[71]

- **Take the initiative to ask about violence**, but do not ask about violence in the presence of a partner, family member, or friend.
- **Explain that the information will remain confidential** (and inform about any limitations)
- **Use eye contact** and focus all attention on her
- **Be aware of body language** (pay special attention to your tone of voice, and the ways in which you sit, hold your head and rest your arms, which all convey a particular message to the woman about how you perceive the situation)
- **Avoid passive listening and non-commenting** – demonstrate that you are actively listening
- **Show a non-judgmental and supportive attitude**, and validate what she says – avoid questions that may imply blame, such as questions that begin with "why"
- **Reinforce that GBV cannot be tolerated** and is never okay, and reassure that her feelings are normal
- **Be patient** with the survivor of GBV, keeping in mind that they are in a state of crisis and may have contradictory feelings
- **Do not pressure her to disclose**, and explain to her that she can come back for further assistance
- **Emphasize that violence is not her fault**, and that the perpetrator is responsible for his behavior
- **Use supportive statements** such as "I am sorry that this happened to you", which may encourage the woman to disclose more information
- **Emphasize that there are options and resources** available
- When beginning to ask about GBV, start by using an **introductory question**, which explains to the patient that GBV affects many women and impacts women's health

When asking about GBV, use effective body language, active listening, eye contact, and supportive language.

EXAMPLES OF **INTRODUCTORY QUESTIONS** DURING ENQUIRY:[72]

1. "From my experience, I know that abuse and violence at home is happening to many women. It is happening to you?"
2. "We know that many women experience abuse and violence at home and that it impairs their health. I wonder if you ever experienced violence at home?"
3. "Many of the patients I see are dealing with abusive relationships. It can be frightening and feel uncomfortable to talk about this. Have you ever experienced violence or abuse from your partner?"

EXAMPLES OF **DIRECT QUESTIONS** DURING ENQUIRY:[73]

1. "I am concerned that your symptoms may have been caused by someone hurting you. Has someone been hurting you?"
2. "From our experience we know that patients can get this kind of injury from a physical attack. Has this happened to you?"
3. "Has your partner/ex-partner or an adult family member humiliated or threatened you?"
4. "Are you afraid of your partner, ex-partner or an adult family member?"
5. "Have you been forced to have sex when you did not want to?"
6. "Has your partner ever tried to restrict your freedom or keep you from doing things that were important to you?"

It is also helpful to display written information and materials on GBV in health care settings, which can help encourage women to speak about violence.

[71] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 70.
[72] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 71.
[73] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 71.

FIRST-LINE SUPPORT

When a woman discloses violence, health providers should offer immediate first-line support. If they are unable to do so, they should ensure that someone else (within their health setting or an easily accessible service) is immediately available to provide first-line support.

Along with support and validation, first-line support requires that health professionals are patient, do not pressure women to talk about their experiences, and ensure that women are given information and access to resources
(WHO, "Responding to Intimate Partner Violence and Sexual Violence Against Women", p. 3)

First-line support "refers to the minimum level (primarily psychological) support and validation of their experience that should be received by all women who disclose violence to a health care provider or other provider, such as the GBV advocate. It shares many elements with what is being called 'psychological first aid' in the context of emergency situations involving traumatic experiences". [74]

GUIDELINES AND ELEMENTS FOR PROVIDING WOMEN-CENTERED CARE: [75]

- Be non-judgmental, supportive, and validating
- Provide practical care and support that responds to her concerns, but does not intrude
- Ask about her history of violence, listen carefully, but do not pressure her to talk (care should be taken when discussing sensitive topics while interpreters are involved)
- Help her access information about resources, including legal and other services that she might think helpful
- Assist her to increase safety for herself and her children, where needed
- Ensure the consultation is conducted in private and informing the limits of confidentiality
- Provide or mobilize social support

3.6 Undertaking a Medical Examination and Providing Medical Care

Following disclosure of GBV, health professionals should undertake a medical examination, if appropriate, and provide medical care. Throughout the entire process of medical examination and care, health providers need to take into account that survivors of sexual violence are often in a heightened state of awareness and very emotional after an assault. While the compassion of service providers may support the process of emotional recovery from sexual assault, conversely, inappropriate comments by police, doctors or other persons may contribute to patient distress during the examination and hinder long-term recovery.[76]

HISTORY AND EXAMINATION

Informed consent is one of the most important elements to obtain from a patient before beginning the examination and documentation.

Health professionals first need to **obtain informed consent** from the patient on all aspects of the consultation. This means explaining all aspects of the consultation to the patient, so that she understands all her options and is able to make informed decisions about further management. In particular, health professionals need to point out any limitations of confidentiality, such as any legal obligations to report GBV to the police or other authorities. If required by national legislation, the health professional needs to ask the patient to sign or mark the consent form. Examining a person without her consent may result in criminal prosecution of health care professionals. Further, in some jurisdictions, the results of an examination conducted without the consent of the patient cannot be used in legal proceedings.[77]

The next step is to take a **history**, recording events to determine what interventions are appropriate. This should include a detailed **description of the assault** or the emotional violence or coercion, its **duration**, whether any weapons were used, as well as **date and time** of the assault.[78]

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74 WHO, "Responding to Intimate Partner Violence and Sexual Violence Against Women" (2013), p. vii.
75 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 210. Also cited in WHO, "Responding to Intimate Partner Violence and Sexual Violence Against Women" (2013), Recommendations 1, 10, 12, 24.
76 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 73.
77 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 74. Also cited in WHO, "Guidelines for Medico-Legal Cares of Victims of Sexual Violence" (2003).
78 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 74.

IN CASES OF SEXUAL VIOLENCE, THE FOLLOWING INFORMATION SHOULD BE ADDED:[79]

- the time since assault and type of assault
- the risk of pregnancy
- the risk of HIV and other sexually transmitted infections (STIs)
- the woman's mental health status[80]

WHEN INTERVIEWING THE PATIENT ABOUT GBV, HEALTH PROFESSIONALS SHOULD:[81]

- ask her to tell in her own words what happened
- avoid unnecessary interruptions and ask questions for clarification only after she has completed her account
- be thorough, bearing in mind that some patients may intentionally avoid particularly embarrassing details of the assault, such as details of oral sexual contact or anal penetration
- use open-ended questions and avoid questions starting with "why", which tends to imply blame
- address patient questions and concerns in a non-judgmental, empathic manner, for instance, through using a very calm tone of voice, maintaining eye contact as culturally appropriate and avoiding expressing shock or disbelief

After taking the history, health professionals should only conduct a complete physical examination (head-to-toe; for sexual violence also including the patient's genitalia) if appropriate:

CHECKLIST FOR PHYSICAL EXAMINATION OF SURVIVORS OF GBV:[82]

- ☑ 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 to have a female doctor (especially in cases of sexual violence)
- ☑ Do not leave the patient alone (ex. 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
- ☑ Include examining 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 permission. Always let her know when and where touching will occur; show and explain the 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
- ☑ Both medical and forensic specimens should be collected during the course of the examination (this should be done by a health care professional trained in forensic medicine)
- ☑ 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

79 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 74.
80 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 75.
81 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 75.
82 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014),p. 215

4. DOCUMENTING GBV

Health providers have a **professional obligation** to record the details of any consultation with a patient. The health professional's notes should reflect what the patient said, as well as what was seen and done by the health provider. These notes should also be kept confidential.

It is not only a professional obligation to record details, but is also important for **medical records**, since medical records can be **used in court as evidence**. Documenting the health consequences may help the court with its decision-making as well as provide information about past and present violence. Lack of coordination between health providers and police/prosecutors can result in evidence getting lost. To this end, it is critical that health provider's understand the links between forensic medicine and criminal justice in order to facilitate women's access to the criminal justice system.

In addition, documentation can alert other health care providers who later attend the patient to her experiences of GBV and thereby assist them in providing appropriate **follow-up care**[83].

4.1 Recording and Classifying Injuries

Health care professionals should carefully describe any injuries assessed. The description should include the type and number of injuries, as well as their location, using a **body map**. Interpretation of injuries for medico-legal purposes is a complex and challenging matter, and requires proven expertise on the part of the practitioners performing it. In practice, clinicians should and pathologists are often being asked by police, courts, or lawyers to determine the age of an injury, how it was produced, or the amount of force required to produce the injury.[84]

Mechanisms for documenting consultations include hand-written notes, diagrams, body charts, and photography. Through the entire process of documentation, health care professionals should ensure the patient's **informed consent**.

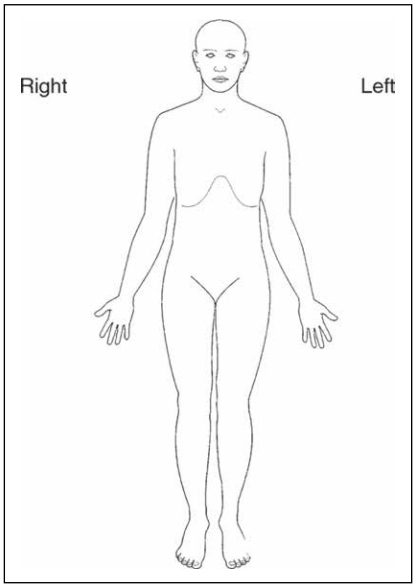
In some countries, health authorities provide standard documentation forms, some of which are obligatory. A sample form for recording consultations with survivors of sexual violence, can be adapted to meet local need and circumstances, and is included in the Appendix.

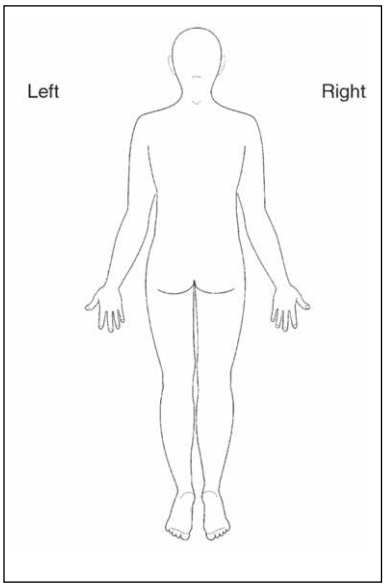
4.2 Documentation of Violence

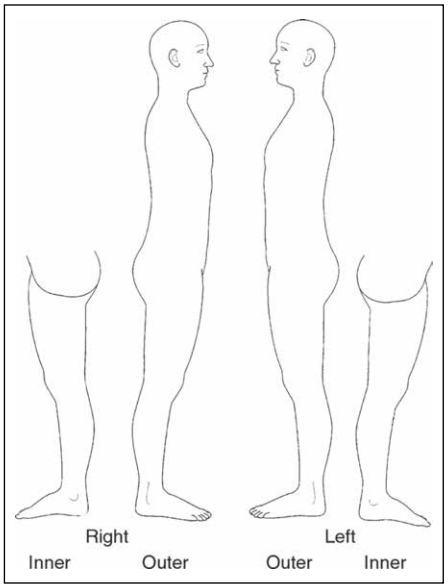
Mechanisms for documenting consultations include hand-written notes, diagrams, body charts, and photography. Through the entire process of documentation, health professionals should ensure the patient's informed consent. In some countries, health professionals provide standard documentation forms. The figures below are examples of body maps which are found in WHO documentation.

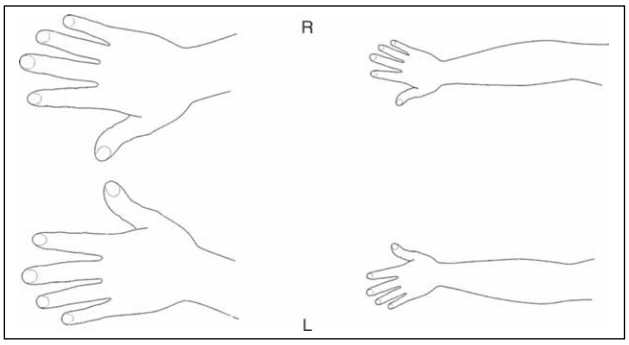
[83] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 79.
[84] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 79.

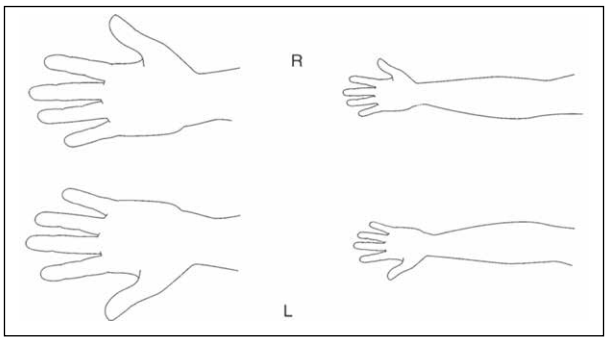
WHO EXAMINATION BODY MAPS [85]

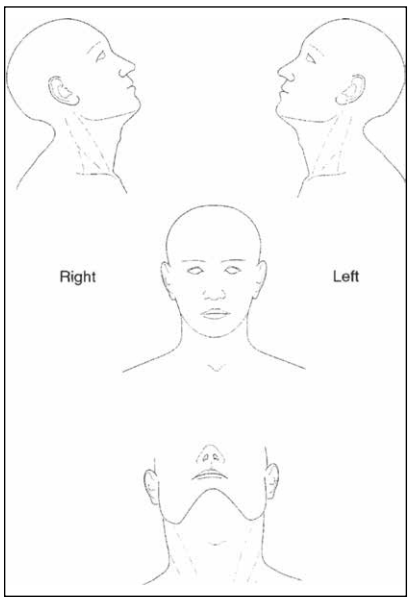


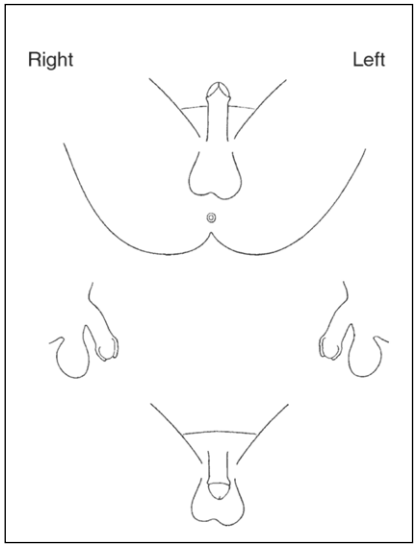


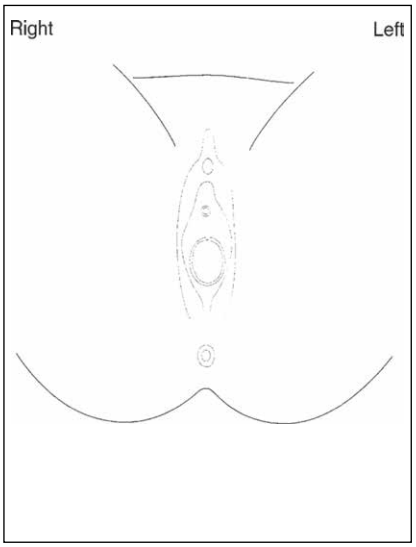












[85] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 293-296.

IN CASES OF SEXUAL VIOLENCE, DOCUMENTATION SHOULD INCLUDE THE FOLLOWING:[86]

- Demographic information (ex. name, age, sex)
- Consent obtained
- History (ex. general medical and gynecological history)
- Account of the assault
- Results of the physical examination
- Tests and their results
- Treatment plan
- Medications given or prescribed
- Patient education
- Referrals given

CHECKLIST FOR DOCUMENTING CASES OF SEXUAL ABUSE:[87]

- ☑ Record the extent of the physical examination conducted, and all normal or relevant negative findings
- ☑ Document all pertinent information accurately and legibly
- ☑ Notes and diagrams should be created during the consultation
- ☑ Notes should not be altered unless this is clearly identified as a latter addition or alteration
- ☑ Ensure that notes are accurate
- ☑ Use the survivors own words in quotes, whenever possible (Use neutral language, such as "Ms. Smith says…" rather than "the patient alleges…")
- ☑ Do not exclude information that is extraneous to the medical facts, such as "it was my fault he hit me because…" or "I deserved to be hit because…"
- ☑ When documenting referrals, the names, addresses, or phone numbers of shelters given to the patient should not be noted, in the interest of the patient's safety

4.3 Photography

Photography is an important tool that should be used by all health providers – specialized and non-specialized in forensic medicine – to document injuries resulting from GBV, as photos are important evidence in possible future criminal proceedings instituted against the perpetrator. When using photography, it is however important to keep in mind that photos may supplement, not replace, the other methods of recording findings mentioned above.

CHECKLIST FOR USING PHOTOGRAPHY TO DOCUMENT FINDINGS:[88]

- ☑ Consider the patient and obtain informed consent: communicate the role of photography and obtain informed consent for the procedure
- ☑ Identification: Each photograph must identify the subject, the date, and the time that the photo was taken, and should be bound with a note stating how many photographs make up the set.
- ☑ Scales: A photograph of the color chart should commence the sequence of photographs. Scales are vital to demonstrate the size of the injury. They may be placed in the horizontal or vertical plane. Photographs should be taken with and without a scale.

[86] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 80.
[87] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 81.
[88] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 80. Also cited in WHO, "Guidelines for Medico-legal cares of Victims of Sexual Violence" (2003).

- ☑ Orientation: The first photograph should be a facial shot for identification purposes. This may not be required if the photographs have been adequately identified. Subsequent shots should include an overall shot of the region of interest, followed by close-up shots of the specific injuries.
- ☑ Chain of custody: This should be logged as for other forensic evidence.
- ☑ Security: Photographs form part of a patient record and as such should be accorded the same degree of confidentiality.
- ☑ Sensitivity: The taking of photos is considered to be inappropriate behavior in some cultures and specific consent for photography (and their release) may be required. Informed consent must therefore be obtained.

4.4 Storage and Access to Patient Records and Information

Patient records and information are strictly confidential. All health providers have a professional, legal and ethical duty to maintain and respect patient confidentiality and autonomy. Records and information should not be disclosed to anyone except those directly involved in the case or as required by local, state and national statutes.

All patient records (and any specimens) should be stored in a safe place. Biological evidence usually needs to be refrigerated or frozen; check with your laboratory regarding the specific storage requirements for biological specimens.[89]

4.5 Forensic Examinations

A **forensic examination** is defined as "medical examination conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion."[90] The primary aim of a forensic examination is to collect evidence that may help prove or disprove a link between individuals and/or between individuals and objects or places.[91]

In all cases involving GBV, **where a criminal offence has been committed**, as in any other criminal investigation, the following principles for specimen collection should be strictly adhered to:

- Collect carefully, avoiding contamination;
- Collect specimens as early as possible, since 72 hours after the assault the value of evidentiary material decreases dramatically;
- Label all specimens accurately;
- Dry all wet specimens;
- Ensure specimens are secure and tamper proof;
- Maintain continuity; and
- Document details of all collection and handling procedures.

Health care workers should be aware of the capabilities and requirements of their forensic laboratory; there is no point collecting specimens that cannot be tested.[92]

ℹ *It is important to note that this information may not be applicable to all health professionals, in particular the clinical lead taking part in the IMPLEMENT project. However, this information may be applicable, depending on the job requirements of the designated clinical lead and/or health professional.*

89 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 83.
90 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 81.
91 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 81. Also cited in WHO, "Guidelines for Medico-legal cares of Victims of Sexual Violence" (2003).
92 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 81.

Table 7: GUIDELINES FOR PROVIDING EVIDENCE IN SEXUAL VIOLENCE CASES: [93]

Writing Reports	Giving Evidence
1. Explain what you were told and observed 2. Use precise terminology 3. Maintain objectivity 4. Stay within your field of expertise 5. Distinguish findings and opinions 6. Detail all specimens collected 7. Only say or write what you would be prepared to repeat under oath in court	1. Be prepared 2. Listen carefully 3. Speak clearly 4. Use simple and precise language 5. Stay within your field of expertise 6. Separate facts and opinion 7. Remain neutral

5. RISK ASSESSMENT AND SAFETY PLANNING

The **safety of patients** who have experienced GBV must be at the center of any health sector intervention to GBV. Isolated occurrences of violence are rare as GBV is often characterized by a pattern of repetitive, coercive control, and immediately after separation, the risk of violence even increases: the majority of murders, attempted murders and acts of serious violence are committed when a survivor attempts to leave violent partners.[94]

Health professionals have an important role to play in offering referral to a GBV advocate linked to specialized support services who will support a victim in risk assessment and safety planning.[95]

5.1 Undertaking a Medical Examination and Providing Medical Care

As a general principle, the more risk factors that apply in a specific case, the higher the risk is that acts of violence will be repeated or that the violence may increase or even escalate.

RISK FACTORS: [96]

- **Previous acts of violence against the woman, the children or other family members, as well as former partners**: Look at the history of abuse, forms and patterns of violence used as well as former convictions or reports to police. Perpetrators who have committed frequent, severe acts of violence (such as using a weapon or strangling the survivor) are particularly dangerous.
- **Previous acts of violence outside the family** (for example against the staff of service providers or authorities), indicate a general tendency to use violence also within the home.
- **Separation and divorce** are times of high risk.
- **Acts of violence committed by other family members** of the perpetrator may be used to control the survivor and result in making it impossible for her to flee.
- **Possession and/or use of weapons**: Legal or illegal possession of weapons increases the risk of armed violence, especially when the perpetrator has used, or threatened to use weapons in the context of earlier episodes of violence.

[93] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 82
[94] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 83
[95] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 83
[96] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 83-84.

- **Abuse of alcohol or drugs** does not in itself cause violence, but may lower the threshold and thus contribute to an escalation of violence.
- **Threats** should always be taken serious. It is wrong to assume that persons who "only" use threats are not dangerous – in fact, severe violence is often preceded by threats. In particular, threats of murder must be taken serious: In many cases of women being killed by intimate partners, they had been repeatedly threatened with murder before being killed.
- **Extreme jealousy and possessiveness**: Perpetrators who kill or severely injure their partners are often possessed by the desire to own and control their partners, sometimes regarding every man around their partner as a rival and constantly accusing her of infidelity.
- **Extremely patriarchal concepts and attitudes**, such as that a woman or girl must obey her husband or father who is the head of the family or comply with rigid concepts of honor and sexuality.
- **Persecution and psychological terror (stalking)**: Many perpetrators are not willing to accept a separation from their partner and try to prevent it by all means, including violence. This may lead to acts of violence and threats committed even many years after a separation.
- **Danger for children**: Children are also at particular risk during separation and divorce. Abuser's aggression against the partner may also extend to the children, and he may take revenge by abusing or killing them. Therefore, safety planning must always include the children.
- **Non-compliance with restraining orders by courts or police** indicate a high-risk situation because it shows that the perpetrator is not willing to change his behavior.
- **Possible triggers** that may lead to a sudden escalation of violence include changes in the relationship, for instance when the woman takes a job against the partner's will, seeks help or files for divorce.

5.2 Undertaking a Risk Assessment

Risk assessment enables criminal justice authorities to decide on actions against the perpetrator. It also enables health professionals and other service providers to support the patient in identifying measures to increase her safety and to raise her awareness of the risk.[97]

QUESTIONS TO ASK WHEN MAKING A RISK ASSESSMENT:

- Is it safe for you to go home?
- What are you afraid might happen?
- What has the abuser threatened?
- What about threats to the children?

[97] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 84.

SPECSS [98]

Clinical leads, health professionals, and GBV advocates may find acronyms useful to memorize key factors or steps in assessing risks. An example used in the UK is "**SPECSS**", which stands for:

SEPARATION/CHILD CONTACT: Leaving a violent partner is extremely risky.
PREGNANCY: (pre-birth and under 1s): 30% of domestic violence and abuse starts in pregnancy
ESCALATION OF VIOLENCE: Previous domestic violence is the most effective indicator that further domestic violence will occur. 35% of households have a second incident within five weeks of the first.
CULTURAL FACTORS: such as language barriers, immigration status, and isolation.
STALKING: Research finds that intimate relationship stalkers use more dangerous stalking behaviors than non-intimate relationship stalkers.
SEXUAL ASSAULT: Where abusers use both physical and sexual violence, victims are at an elevated risk
This list is non-exhaustive.

5.3 Supporting the Patient in Developing a Safety Plan

Safety planning is part of the overall process of risk management, which aims at preventing violence by influencing risk factors and protective factors. Safety planning seeks to improve the survivor's resources – both dynamic (ex. the social environment) and static (ex. the physical environment, such as locks, video cameras, etc.)

Developing a safety plan may help the woman prepare to leave the relationship safely in case the violence escalates. Health facilities are responsible for establishing referral pathways to facilitate further support to help women who are experiencing violence. Support services, such as women's shelters or women's organizations, have the expertise to assist victims. Developing such a safety plan may prove difficult in the case of low-income women, especially those from rural or ethnic minority communities, who may not have the resources to leave the abuser and, in the absence of shelters, may not have access to or even be able to afford temporary stays in hotels or guest houses. In the case of immediate danger and absence of shelters, health facilities may consider offering women short-term stays in the facility.[99]

The checklist below provides further guidance to health professionals, as well as GBV advocates, when developing a safety plan together with the patient.

CHECKLIST FOR GBV ADVOCATES IN DEVELOPING A SAFETY PLAN WITH A SURVIVOR OF VIOLENCE: [100]

- ☑ Identify one or more neighbors you can tell about the violence, and ask them to help if they hear a disturbance in your house
- ☑ Are there any friends or relatives you can trust and who could give you and your children shelter for a few days?
- ☑ Decide where you will go if you have to leave home and have a plan to get there, even if you do not think you will need to leave.

98 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 85.
99 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 85.
100 UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 86.

- ☑ If an argument seems unavoidable, try to have it in a room or an area that you can leave easily.
- ☑ Stay away from any room where weapons may be available.
- ☑ Practice how to get out of your home safely. Identify which doors, windows, elevator, or stairwell would be best.
- ☑ Have a packed bag ready containing spare keys, money, important documents and clothes. Keep it at the home of a relative or friend, in case you need to leave your home in a hurry.
- ☑ Devise a code word to use with your children, family, friends, and neighbors when you need emergency help or want them to call the police.
- ☑ 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.
- ☑ Remember, you do not deserve to be hit or threatened.

6. REFERRAL PATHWAYS

Health professionals are often the first point of contact for survivors of GBV. Therefore, they are well positioned to identify GBV and provide survivors with medical care, and also to refer them to other necessary services. This may include referrals to other health professionals within the same or at another health facility, for example, to mental health care providers or HIV specialists, and referrals to other services, such as shelters or organizations providing psychosocial or legal counseling. In turn, health care professionals may also receive referrals of women survivors, for instance from police, shelters or other health care professionals.[101]

It is the role of clinical leads and health professionals to ensure that survivors of violence are referred to a designated GBV advocate for further support.

The IMPLEMENT project aims to develop or strengthen the referral pathway between the health setting and support services. The health professional receives training on identification of GBV and has established a referral pathway to a GBV advocate. The GBV advocate will be based in a specialized women's services already in place in the given country, and ensure an appropriate referral pathway for the survivor. If there are no specialized women's services in place in the country in question, it is the role of the health professionals to encourage the establishment of regulations to support women victims of GBV within their health facility.

6.1 Referral Pathway Core Concepts

Women who have experienced GBV have multiple and complex needs. This includes medical care, safe accommodation, psychosocial counseling, police protection and/or legal advice, just to name a few; this list is non-exhaustive, as there are numerous additional factors to consider, such as financial aspects, child protection, etc. Therefore, an effective response to GBV requires a comprehensive set of services. Since it is virtually impossible for a single organization to provide all services in the required quality and specialization, a multi-sectoral response that coordinates the services by all relevant service providers helps to ensure the availability of comprehensive support for survivors of GBV. An important prerequisite for the design and implementation of effective referrals is the existence of an institutionalized care pathway.

Partners in a referral network usually include different government departments, women's organizations, community organizations, medical institutions and others. There is also the possibility of self-referral, where a woman approaches an agency herself. As a principle of good clinical practice, referrals should happen with the consent of the woman concerned.

[101] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 87.

However, in some cases, it may be justified that referrals by a family member or an agency occur without the woman's consent, in cases where her life is at risk, like high risk of suicide, threat of being killed or child marriage.[102]

Referral mechanisms may operate at different levels - national, regional and/or municipal/community. Local and/or regional referral mechanisms should be grounded in national laws and/or policies.

6.2 Referral Pathway Benefits

When the clinical lead, health professionals, and GBV advocate guide a survivor through a referral system, it enables the survivor to access further comprehensive and specialized care and support, tailored to her individual needs. From the perspective of health professionals, the establishment of a clear and simple referral route benefits both the health professionals and the survivor, and does the following:

- **offer relief to their daily work load**, as they can count on support provided by other referral partner agencies;
- **increase the confidence of health professionals to ask about violence**
- **enables them to adequately act upon the identification of a survivor of GBV**, keeping in mind that the existence of a system of referring survivors to further services constitutes a minimum requirement for health professionals inquiring about GBV.[103]

In practice, the support of GBV advocates is beneficial because clinical leads and health professionals are often confronted with the reality of limited time and resources in busy clinical settings.

EFFECTIVE REFERRALS REQUIRE THAT HEALTH PROFESSIONALS:[104]

- → **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 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 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 survivor does not give consent

[102] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 87.
[103] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 90.
[104] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 251.

COMPONENTS OF EFFECTIVE REFERRAL SYSTEMS:[105]

- **A joint understanding of the purpose of the partnership** that all partners can subscribe to and are willing to commit resources to. The joint vision should describe in no more than one sentence what the partners want to achieve.
- **A workable structure that fits into more general local structures and consists of a strategic group** that is mandated to define targets for and in consultation with partner agencies, **and an operational arm** that is supported by thematic sub-groups. Strategic direction and operational delivery need to be supported by effective resources and accountability mechanisms.
- **A joint strategy**, describing strategic aims and indicators for their achievement, **accompanied by an operational action plan** that defines key outcomes and outputs planned, the persons responsible for producing the outputs, a timeline, budget, and a system of review and quality control.
- **The involvement of strategic leaders** at the strategic direction level, **middle managers** with access to staff at the operational delivery level, and **front-line staff** at the level of sub-groups who implement plans and are consulted on possibilities for action. NGO representatives need to be part of this process.
- The action plan must be matched by **adequate personal and financial resources**.
- **While the coordinator plays a facilitating role, it is the participating agencies' activities that make the partnership work.**
- **Training of all professionals involved** that challenge existing myths and aim to develop skills and confidence in staff, reflecting the local context, procedures and services available. Partners should contribute to developing key messages for training and involve managers and supervisors in training, both as participants and co-trainers.
- **Developing a useful dataset** to implement and monitor the partnership. This includes agreeing on a basic dataset to support the strategy, agreeing on aims and indicators and regularly reviewing data from the partner agencies during partnership meetings.
- **The existence of policies, protocols and standard operating procedures** to support sustainability and accountability of the partnership.

Developing a care pathway requires more than just having a referral in place. It requires commitment, close partnership, and constant activity and awareness around protocols, policies, trainings, and available support networks.

IDENTIFICATION & REFERRAL TO IMPROVE SAFETY (IRIS)[106]

24 general practices in London and Bristol:

- → Training of health professionals and administrative staff
- → Establishment of simple referral pathway to specialist domestic violence service provider
- → Technical support to practice teams

Evaluation: compared to 24 control practices

Results: intervention practices showed

- → 3 times higher identification rate
- → 6 times more referrals received (compared to control practices)

[105] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 251.
[106] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 252.

BEST PRACTICE EXAMPLE FROM AUSTRIA: VICTIM SUPPORT GROUPS IN HOSPITALS

In 2011, the Austrian Health Facilities Act established "victim protection groups" in hospitals. The law specifies that separate groups are to be set up for children survivors of violence and adult survivors of domestic violence. Two main purposes of these victim protection groups are early identification of violence and sensitization of health care providers on domestic violence. The groups should be composed of at least two doctors specialized in accident surgery and gynaecology/obstetrics, as well as nurses and health care professionals specialized in psychological and psychotherapeutic care. This law transformed already existing practices into a legal obligation. In the General Hospital of the City of Vienna (AKH), not only was a victim protection group set up in 2011, but rules of procedure were also adopted to further specify the groups' aims and tasks: follow advice to health care professionals in contact with survivors of domestic violence; sensitize health care professionals; develop standardized procedures and guidelines for interventions; organize trainings; and coordinate the different departments and case conferences. Although victim protection groups are widely welcome and successful, there remain some challenges, for instance: provision of adequate human and financial resources; making trainings on GBV mandatory for all health care professionals; and effective cooperation both internally and with external stakeholders, such as shelters, police, or general practice doctors.[107]

6.3: Specialized Women's Support Services

GBV experts working within the specialized women's support services are crucial in the referral pathway and are a key asset to the health sector. They are experienced and specially trained in understanding GBV, providing critical support, and collaborating with the police.

Participation of women's organizations in the multi-sectoral response to GBV is of particular importance. These organizations often possess long-standing experience in the response to GBV. Further, because of their mandates as direct and specialized service providers they are well positioned not only to provide many services themselves, but also to accompany survivors throughout the entire process. They complement, but cannot be replaced by, general support services offered by public authorities.

Specialized women's support services for survivors of GBV may provide a broad range of services, including in particular women's shelters, women's helplines, women's centers, providing various types of non-residential support, as well as services specialized for survivors of sexual violence. These organizations might serve survivors of GBV more broadly, or concentrate on survivors who have experienced specific forms of violence (such as intimate partner violence, trafficking or sexual violence) or belong to specific groups (such as migrant women, adolescent girls or sex workers).[108]

Table 7: EXAMPLES OF WOMEN'S SUPPORT SERVICES[109]

Women's helplines	May be the first contact point for survivors to receive information about available services and legal options. Therefore, helplines, which are widely-advertised public numbers that provide support, crisis interventions and referrals to face-to-face services such as shelters or the police, provide an important cornerstone of a multi-sectoral response to GBV. Women's helplines should operate 24/7, be free of charge and anonymous, and serve survivors of all forms of GBV. All women in the country should have access to a helpline, so at least one national helpline should exist and provide support in all the main languages spoken in country, at least for a considerable amount of hours per week.

[107] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 65.
[108] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 91.
[109] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 20.

Women's shelters Are specialized in providing immediate and safe accommodation to women survivors of violence and their children. Furthermore, they provide comprehensive support and empowerment to help survivors to deal with their traumatic experience, to regain their self-esteem and to lay the foundations for a self-determined life. Shelters should be accessible 24/7. They need to apply special safety precautions, which includes risk assessment and safety planning in each individual case, keeping locations secret and technical security of the building in order to protect clients and staff, but also neighbors from violent attacks by perpetrators. Shelters should be available in a sufficient number in the country. A commonly referred benchmark is one family place per 10 000 inhabitants. An important part of the work provided by shelters is follow-up or after-case support, in order to assist women and girls in their reintegration after leaving the shelter. This requires consideration of existing risks, the client's income generation and livelihood skills, alongside other factors. The reintegration process should be well managed, ensure safety to the woman and her children, and subsequently monitored by the caseworker.

Women's centers in some countries, also referred to as "women's crisis centers" or "women's counseling centers") encompass all women's services that provide non-residential support of any kind (psychosocial counseling, legal or other information and advice, practical support, court accompaniment, etc.) to women survivors of GBV and their children. These organizations play an important role in countries or regions where women's shelters do not exist. Moreover, they provide advocacy and counseling to women that might not need accommodation but require other specialist support and advocacy.

Sexual assault support centers Specialized support services for survivors of sexual violence are necessary in light of the traumatic nature of sexual violence, requiring a particularly sensitive response by trained and specialized staff. These services include immediate medical care and trauma support, complemented by medium- and long-term psychological counseling, as well as immediate forensic examinations to collect evidence needed for prosecution. It is a good practice to carry out forensic examinations regardless of whether the matter will be reported to the police and to offer the survivor the possibility to have the samples taken and stored, so that the decision as to whether or not to report the rape can be taken at a later date.

Specialized support services for survivors of sexual violence may not exist in all countries in the EU. Where they do not exist, it is of particular importance that health professionals, particularly gynecologists and forensic doctors, are trained to provide the required immediate medical care and trauma support.[110]

[110] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 93.

GENERAL SUPPORT SERVICES

General support services refer to help funded and offered by public authorities, which provide long-term help and are not exclusively designed for the benefit of survivors only but serve the public at large. Besides health services, this includes housing, financial support and other social services, employment services, public education or child welfare. These services are complemented by women's support services, which have specialized in providing support and assistance tailored to the needs of survivors of GBV. In particular, health and social services are often the first point of contact for survivors of GBV and therefore should be adequately resourced to respond to their long-term needs. The Council of Europe Istanbul Convention (2011) Explanatory Report states in Article 20 that staff members should be trained on the different forms of GBV, the specific needs of survivors and how to respond to them in a supportive manner.

POLICE AND JUDICIARY

Police and the criminal justice system are responsible to investigate and prosecute cases of GBV that constitute criminal offences under the respective national laws and to determine the criminal liability of the defendant. In some countries, police have the legal mandate to issue and enforce restraining orders. Civil courts decide on divorce and child custody proceedings and, in some countries, can issue protection orders that prohibit perpetrators from approaching the survivor. Depending on the circumstances of the individual case, claims for compensation for damages suffered by the survivor as a result of GBV may be decided before civil and/or criminal courts.[111]

In order to enable survivors of GBV to access justice and to de facto enjoy their legal rights, it is necessary to train police officers, public prosecutors and judges on GBV and the response to violence. Further, survivors should have access to appropriate protection, free legal aid and be treated and interrogated in a sensitive, respectful way to avoid the risk of further trauma. Separate waiting rooms in court buildings can help to avoid confrontation with the perpetrator.[112]

7. MULTI-SECTORAL COOPERATION

As a result of the inherent multi-sectoral nature of GBV programming, any GBV efforts must engage a wide variety of actors with different agendas, priorities, and purposes. Regardless of these differences, there are common goals and practices. For instance, it is every agency's responsibility to ensure the survivor's safety, to respond sensitively and with understanding, and to ensure that the appropriate steps are taken to ensure that the survivor receives the necessary support, empowerment, and overall well-being during the assistance process, as well as when following-up.[113]

The problem of violence needs to be recognized throughout health care and social services, including primary health care, specialized health care, as well as various organizations and institutions, in particular women's organizations which specialize in support services. Each of these sectors may need to develop its own model of how best to implement and respond. Policies and protocols help employers to act appropriately and professionally when responding to GBV. It is also critical to establish guidelines for how to handle situations and issues that involve multiple institutional action.[114] Additionally, **"talking about the violence and making it visible is one good way to prevent the violence. Violence prevention should be incorporated into every branch of social services, at all levels of administration, and into**

[111] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 93.
[112] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 93.
[113] UNICEF", Handbook for Coordinating Gender-based Violence Intervention in Humanitarian Settings" (2010), p. 110.
[114] PRO TRAIN, "Improving Multi-Professional and Health Care Training in Europe – Building on Good Practice in Violence Prevention, Health Care Sector, Training Programme" (2007-2009), p. 3.

the missions, policies, and procedures of operational units."[115] Therefore it is important to consistently maintain the commitment of multi-agency coordination when dealing with GBV, particularly because the health sector and the specialized women's support services are separate entities with various needs and outputs, yet are equally important and mutually beneficial in the work to respond to and heal survivors of GBV.[116]

KEY COMPONENTS OF MULTI-SECTORAL COOPERATION[117]

- → Understand the phenomenon of violence and the spiral of violence
- → Recognize the manifestations of trauma
- → Screen everyone routinely about violence
- → Inquire about possible violence and know what to do next
- → Respond to a crisis - take care of security, give out appropriate information, know referrals
- → Conduct follow-up
- → Cooperate with other professionals and experts

Furthermore, it is crucial when fostering collaborative leadership and cooperation that individuals and organizations:[118]

- → Share resources and common goals
- → Exchange information and activities

As Chapter 2 indicates, women survivors are most likely to contact health care services (hospital, doctor, or other health care provider) more than any other service. However, **assistance for survivors must not stop with health providers**. This is why it is crucial that the health care sector and the specialized women's support services work closely to ensure that women receive the best possible help after experiencing GBV, particularly because many women report feeling ashamed or embarrassed after experiencing GBV, which is one reason why they choose not to seek help from other organizations. Through effective multi-sectoral cooperation in responding to GBV, the health sector and specialized women's support services can together combat the victim-blaming and self-blame which hinder many women from seeking further support; furthermore, **successful multi-sectoral cooperation increases the likelihood of women becoming aware of services made available to them in their own community, which helps in awareness-raising and increases the chances of women reporting GBV**. The FRA survey indicates that multi-sectoral cooperation improves the harmonization and effectiveness of data collection. A number of women who are victims of violence contact several services for different reasons: therefore, cooperation is indispensable. The more cooperation and specialized training between the health care sector, police, courts, and women's organizations means the greater likelihood that women will not only become more aware of services available, but also feel more confident in these services capacities to meet their needs.[119]

[115] PRO TRAIN, "Improving Multi-Professional and Health Care Training in Europe – Building on Good Practice in Violence Prevention, Health Care Sector, Training Programme" (2007-2009), p. 2–3.
[116] PRO TRAIN, "Improving Multi-Professional and Health Care Training in Europe – Building on Good Practice in Violence Prevention, Health Care Sector, Training Programme" (2007-2009), p. 5.
[117] PRO TRAIN, "Improving Multi-Professional and Health Care Training in Europe – Building on Good Practice in Violence Prevention, Health Care Sector, Training Programme" (2007-2009), p. 3.
[118] UNICEF, "Handbook for Coordinating Gender-based Violence Intervention in Humanitarian Settings" (2010), p. 110.
[119] FRA, "Violence Against Women: an EU Wide Survey Main Results" (2014), p. 70.

7.1 Roles and Limits of Multi-Agency Cooperation

In effective cooperation, every professional group has its own view of prevention work, which is why it is important to clarify roles, views, and responsibilities of the health providers and the women's organizations working within the field of GBV.

EIGHT STAGES OF DEVELOPING COOPERATION:[120]

1. Creating a shared philosophy of cooperation, along with principles and goals: safety of the victims, responsibility of the perpetrator and avoidance of victim blame
2. Creating agreed-on procedures: sensitivity to the victim's experiences
3. Monitor/track cases to ensure accountability of the professionals: clarify roles of each professional group
4. Coordinating the exchange of information between professionals: developing mutual understanding of confidentiality rules and information
5. Providing resources and services for victims
6. Ensuring sanctions, restrictions, and services for perpetrators
7. Developing actions to prevent harm to children and develop therapeutic work for children's traumatic experiences
8. Ongoing training

7.2 Barriers to Multi-Sector Cooperation

Successful multi-sectoral cooperation in the field of GBV prevention require many elements, such as support of the community and work environments, supervision and leadership of work, education and knowledge (including consistent training), consistent communication between sectors, delegating tasks, accepting limitations of work (including that it is up to the victim to leave an abusive relationship and/or seek help), as well as taking care of yourself and your emotional needs (self-care). Since it can be at times difficult to establish successful and effective multi-sector cooperation, it is important to realize the barriers to its implementation:[121]

- Societal values, norms and attitudes
- Political legislation
- Financial resources
- Stereotypes of GBV
- Quality and quantity of specialized services
- Training of professionals
- Health worker values, norms and beliefs
- Personal conceptions on professionalism and roles
- Education and knowledge of health professional
- Worker's feelings related to violence

[120] PRO TRAIN, "Improving Multi-Professional and Health Care Training in Europe – Building on Good Practice in Violence Prevention, Health Care Sector, Training Programme" (2007-2009), Module 5.

[121] PRO TRAIN, "Improving Multi-Professional and Health Care Training in Europe – Building on Good Practice in Violence Prevention, Health Care Sector, Training Programme" (2007-2009), Module 5.

8. EVALUATION & CLOSING

8.1: Training Evaluation Form[122]

1.	**How do you evaluate the training overall?** ☐ very good ☐ good ☐ not so good ☐ not good				
2.	**What were the three most important things that you learned in this training?** A. B. C.				
3.	**Anything in the course of this training that you found less useful?**				
4.	**Please assess the following aspects of the training (structure, content, methodology).**	**yes, very much**	**somewhat**	**no, rather not**	**not at all**
	The training was well structured.	☐	☐	☐	☐
	There was appropriate time allocated to each module.	☐	☐	☐	☐
	The time for discussion was sufficient.	☐	☐	☐	☐
	The methods were suitable to support my learning.	☐	☐	☐	☐
	The handouts and materials were useful.	☐	☐	☐	☐
	The training was relevant	☐	☐	☐	☐
	The training opened new perspectives to me.	☐	☐	☐	☐
	I learned new skills.	☐	☐	☐	☐
	I now feel more confident to address the issue of GBV in my daily work.	☐	☐	☐	☐
	The training enabled me to learn about experiences and practices from other colleagues/countries.	☐	☐	☐	☐
	The training made me aware of new ideas for cooperation.	☐	☐	☐	☐
	Any comments or suggestions for improving structure, content, methodology of the training?				
5.	**How do you assess the performance of the trainers?**	**yes, very much**	**somewhat yes**	**no, rather not**	**not at all**
	I found the trainers to be knowledgeable.	☐	☐	☐	☐

[122] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p.263-265.

I found the trainers ensured good interaction and exchange with and among participants.	☐	☐	☐	☐
I found the trainers had good presentation skills.	☐	☐	☐	☐
I would recommend the trainers for similar trainings.	☐	☐	☐	☐

Any other comments or suggestions?

6. Any topics about which you would have liked to learn in greater detail?

Any topics that have been missing?

7. How do you assess the overall organization/logistics of the training?

Before the training	**Excellent**	**Good**	**Not so good**	**Bad**
Pre-training information from and communication with the organizers	☐	☐	☐	☐
Travel and accommodation arrangements	☐	☐	☐	☐
During the training	**Excellent**	**Good**	**Not so good**	**Bad**
Accommodation (hotel room)	☐	☐	☐	☐
Training facilities	☐	☐	☐	☐
Interpretation	☐	☐	☐	☐
Coffee breaks, lunches and dinner	☐	☐	☐	☐
Place of training	☐	☐	☐	☐
Location of the venue	☐	☐	☐	☐

Any comments or suggestions for improving the overall organization/logistics?

8. Please provide one example on how the learnings from this training will benefit your work practice.

9. Any other comments or suggestions to help us further improving the training?

Thank you very much for supporting our evaluation!

TRAINING APPENDIX

1. Continuum Exercise [123]

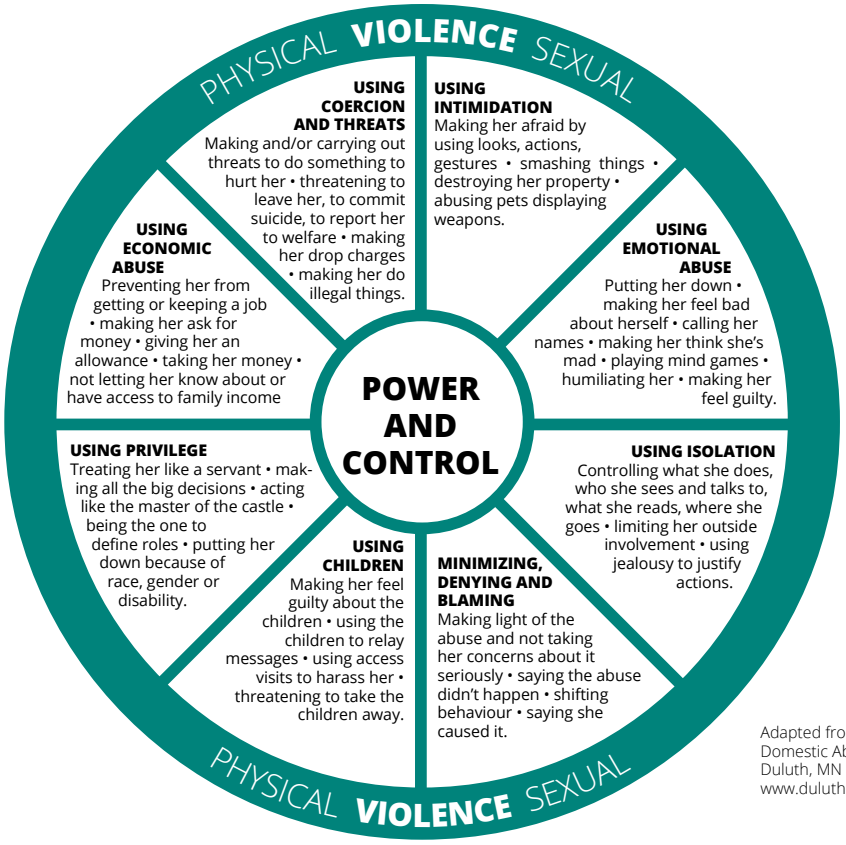
As a group, stand up and listen to the following statements, which will be read out loud by the trainers. One side of the room represents "I strongly agree with the statement", while the other side of the room represents "I strongly disagree with the statement". Participants decide where on the line between strongly agree and strongly disagree they want to position themselves when each statement is read out. The trainer then asks people to explain why they are standing where they are, and invites discussion following each statement.

- She provoked him – she deserved it/asked for it.
- There are many factors to consider before ending an abusive relationship or leaving. It is not helpful to tell a patient that she should "just leave".
- It only happens in low-income/working-class families.
- It is because of his childhood - he grew up in a violent home.
- Domestic violence support services help women experiencing domestic violence and abuse to make choices and explore options. They are not there to rescue people.
- He has a problem controlling his temper and/or he only does it when he's drunk.
- There are many options for women experiencing domestic violence and abuse.
- Women from some communities are passive and conform to male-dominated culture and religion with harsh traditions (that may include wife-beating, maiming, and killing).
- She should stay (or leave) for the sake of the children.
- There is no point in trying to help because the women always go back.

[123] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

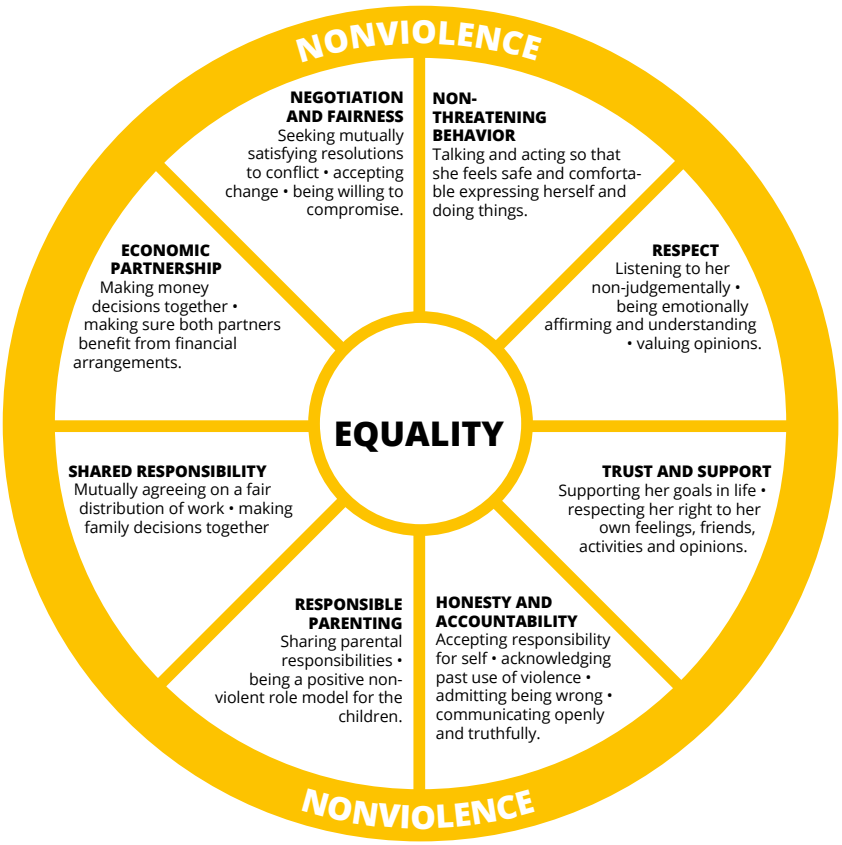
2. Power and Control Wheels

POWER AND CONTROL WHEEL[124]



Adapted from:
Domestic Abuse Intervention Project
Duluth, MN 218/722-2781
www.duluth-model.org

NON-VIOLENCE POWER AND CONTROL WHEEL[125]



[124] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 159.
[125] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

3. GBV & Health IRIS Quiz [126]

1. Over a 5 year period, what percentage of all women aged 16 and above consult with their GP at least once?
a) 10% b) 50% c) 90%

2. Approximately how much does GBV cost the EU in a year?[127]
a) 228 billion EUR b) 928 million EUR c) 528 million EUR

3. How much more likely are women experiencing DVA to use drugs than women who are not experiencing DVA?
a) 2 b) 9 c) 15

4. How much more likely are women experiencing DVA to abuse alcohol than women who are not experiencing DVA?
a) 2 b) 9 c) 15

5. Women who have experienced DVA are how many more times more likely to have depression than those who have not?
a) 2 b) 4 c) 6

6. What's the biggest physical health difference between abused women and non-abused women?
a) More gynecological problems b) More broken bones c) Higher blood pressure

4. Medical Power and Control Wheels Exercise [128]

The group with the power and control wheel must consider how the clinician response can collude with the perpetrator, disempower the survivor, prevent the survivor from seek support, etc. The group should give examples to complete a couple of segments of the wheel, for example, sharing information without consent, suggesting to talk to the abusive partner/family member, etc.

The group with the advocacy wheel should consider how the clinician response can support, assist, and empower the survivor to seek support. The group should give examples to complete a couple of segments of the wheel, for example, listening and giving validation, offering a referral, etc.

Each group should give feedback on a couple of segments each before handing out the completed versions of both wheels.

The wheels demonstrate how important the words are that we use in our response to patients as they can either aid disclosure or unintentionally indicate collusion with the perpetrator, for example, we can all be part of the problem or part of the solution.

[126] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).
[127] WAVE, "Wave Report 2014" (2014), p. 7.
[128] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

5. GP Clinician Experience Case Study – Trish's Story[129]

Dr Trish McQuoney is a senior partner at Air Balloon Surgery in Bristol, a large practice serving over 12,000 patients in a central working class district. The Surgery embraces innovation and since 1996 has received funding as a National Research and Development General Practice. Three years ago, Air Balloon Surgery was invited to take part in a research project developed by the University of Bristol called IRIS (Identification and Referral to Improve Safety of women experiencing domestic violence). The cluster randomized control trial tested the effectiveness of a training and support programme which helps GP surgeries identify and refer patients who are experiencing abuse.

Trish was keen to support the research after working with patients who were living with domestic abuse throughout her career. "We've all come across domestic abuse in our general practice work and hospital work prior to that, so I thought the programme sounded interesting" she says. "But I was also slightly skeptical about the amount of time that the training would take, especially as I felt that we already knew about the issues involved. The entire staff team received training at the same time – from receptionists to General Practitioners (GPs) - so we needed to close down the main functions of the Surgery for an afternoon in order for this to happen."

Despite her initial concern, Trish and her staff team found the training to be extremely useful. The staff were educated to look out for the signs and symptoms which suggest that a patient might be living with domestic abuse. They were also encouraged to find ways of 'asking the question', using role and scenario play. "This was a new approach for us, and like many people we were understandably worried that patients would be upset if we asked them, or would find it intrusive," she affirms. "But the IRIS research team provided plenty of evidence to show that when relevant, patients welcome being asked. This helped our confidence enormously."

Once the team had been trained, a referral system and very simple care pathway was put in place to ensure that disclosing patients were referred to a specialist IRIS advocate educator at Next Link, a local specialist domestic abuse service. Male patients who disclosed abuse were also supported and referred to specialist services. "I believe that in addition to the training, the robust referral system played a key role in making this project a success," she says. "Without this we wouldn't have had the right support in place to be able to positively encourage patients to disclose." Following feedback from the GP practices that were involved in the trial, a new programme for local male perpetrators is also in the process of being set up.

Having been a partner at the surgery for 23 years, Trish thought she knew her patients well. She had treated generations of families from the local area, including children who had grown up to have families of their own. But she describes the whole project as "a complete revelation. By becoming more aware of the signs and symptoms that suggest abuse – long term anxiety and depression, repeat visits to the surgery for minor symptoms, unexplained gynecological problems – I became much more aware of patients who were living with abuse and the negative impact that this was having on their health outcomes. I realized the exact scale and extent of the problem amongst your patient population."

Trish has since identified and referred many women for support. "I've been amazed by some of the disclosures that have occurred," she says. "For example, I'd known one of the patients who disclosed to me for 21 years. In that entire time I had no idea that she was living with a very controlling and psychologically abusive husband, and that this abuse played a key role in her health problems. I've also had women in their sixties and seventies disclose. These women have put up with it for so long, but when offered the right support they are capable of making really brave decisions and changing their lives for the better."

[129] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

As well as adult victims, Trish has also referred a number of teenage girls. "Often these girls present with low self-esteem and depression, and they may not be aware that they're in an abusive relationship as the abuse might not be physical; perhaps their boyfriend is continuously checking up on them by checking their mobile phone calls or messages, or their ex is using Facebook to stalk and psychologically abuse them. In these instances, it can help to have a family GP, a professional that they have known and trusted since childhood, to provide support and refer them to appropriate services, whether that's counseling or a local specialist service."

The IRIS trial found a substantial difference in identification and referral of women experiencing abuse between the 24 intervention and 24 control practices in Bristol and London. Full results will be published before the end of the year.
Victim referrals have increased dramatically at Air Balloon Surgery since the staff got involved in the trial. For Trish, the programme has been an overwhelmingly positive experience. "I'm now convinced that Violence against Women and Children is a major public health problem with long term consequences for women and their families," she says. "As an experienced GP, the whole project has been nothing short of transformational."

6. Patient Experience Case Study – Kim's Story [130]

"The first time I went to see any health service professional was after my partner stabbed me. I left the flat with my leg bleeding heavily carrying my baby in my arms and went straight to the GP, who attended to my wound. I saw him other times I was physically abused, and he documented what happened each time. Eventually, he diagnosed depression, prescribed anti-depressants and referred me to the mental health team. Initially, being told I had depression gave me a feeling of loneliness but at the same time I felt relieved that someone was finally going to listen to me.

I had one appointment with a psychiatrist who referred me to a Community Psychiatric Nurse (CPN). Liz visited me at home but she also treated my abusive partner's father so I felt I could not completely open up to her. She did suggest I had a test for an under-active thyroid as this condition carries the same symptoms as depression. I was positive and prescribed Thyroxine. But being told 'just keep taking your medication' was not enough and left me feeling isolated. After several years of medication, I was referred to a new CPN, Richard. Our relationship was better but still never left me feeling that I was really being helped. I suppose I thought that a professional should know what I needed to make me better and I was disappointed that they didn't. It was about then that I started to use 'speed' as a way of coping with my life. It made me feel happy but more importantly, allowed me to stay awake to prepare for my abusive partner to return home, more often than not, drunk.

Some years later, I ended up being re-referred to the same person. Even then, I felt that I did not get the help I truly needed. I liked Liz and she always made me feel welcome but I also felt that she was always 'too busy' and relied on me getting better through medication rather than offering me some form of therapy. I finished my sessions feeling no better than when I started. My negative thoughts and feelings about mental health services far outweighed my positive ones. I felt that being beaten, threatened and constantly put down by my partner was the cause of my mental health problems. He made me believe I was mental. He told the police, 'I haven't done anything; she is the mad one'. He wore me down to the point that I eventually believed I was mad.

I left my abuser but was still struggling with life. I was having problems with my son who was appointed a Social Worker. She referred us both to the Domestic Violence team for help. For the first time in 20 years, I believed that I was being directed to the place that could finally

[130] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

help me. I was never offered group sessions before. Maybe if I had been, my healing process would have come sooner. It was here that Sue, the group leader, noticed that I had issues. She told me that they could help me. I felt overwhelmed by the caring nature of this lady, that someone finally cared enough to help me. I will be eternally grateful to her and the staff at the domestic violence group forever. I know I have a long and hard journey ahead, but I can finally see a way forward from all the bad in my life".

7. Patient Quotes from IRIS[131]

As a group, discuss the patients below.
What are the key messages from patients about what they want?
What do you think patients want and need?

- *"And you go to the doctors because you're feeling very unwell and they take your blood pressure and give you some blood pressure tablets and I thought, I've got to talk to somebody. And I said, I don't sleep at all. Oh well we'll give you some tablets for that and some tablets for this."*
  (IRIS client – comment on GP)

- *"You suffer with depression and they just take it as a medical thing and not really like there's something behind it."*
  (IRIS client – comment on clinician)

- *"I had my shoulder broken by him...however my boyfriend was with me as a translator so the GP gave me a piece of paper with a certain number where I can go and seek help and I was watching the reaction of my boyfriend."* (IRIS client – comment on clinician)

- *"If they ask you would answer."* (IRIS client –comment on clinicians)

- *"...the only doctor who ever asked...I was just so relieved that somebody just said something. And he gave me the box of tissues and I just sat and cried...and he said, tell me when you're ready, he said, there is somebody out there to help me. I'm not on my own. And if I want help, it's there and not to be ashamed of it. Which I was, really ashamed of it and he said, you're not on your own. We can get you this help. And he did. He really did."* (IRIS client – comment on GP)

- *"I told her. It was like we had finally found the piece of the jigsaw. The GP said that explains it... I mentioned about domestic violence...my GP acted on it straight away."*
  (IRIS client - comment on GP)

- *"Never thought this day would come...I feel stronger to cope...I couldn't have done this without your support and patience, I had a lot to wade through."*
  (IRIS client - comment on advocate)

- *"I just thought, this is it. This is going to help. And I smiled. Yes, you do. You smile inside."*
  (IRIS client - comment on advocate)

- *"I have slowly got my freedom back and am so happy to be making my own decisions, planning my own way in life. This is not just for me, it's for my children and women like me out there."*
  (IRIS client - comment on advocate)

[131] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

8. Patient Experience Case Study – Catherine's Story[132]

Catherine is a 49 year old black Caribbean woman, who is disabled and has 4 adult children.

Catherine was referred to the IRIS programme through her 'domestic violence aware' general practice (all practice staff received IRIS training and on-going support). The IRIS poster was on display in the practice and having seen this poster Catherine spoke to her doctor about domestic abuse. The doctor made a direct referral to the IRIS advocate-educator and Catherine met with the advocate-educator at the surgery and spoke about her ongoing experiences of abuse. Her husband verbally, emotionally and financially abuses Catherine and this has been happening for over 26 years. During the first meeting Catherine described feeling sad, low and said she felt unable to cope.

Catherine was registered at her practice for over 16 years and had never spoken to anyone about the abuse she was experiencing. She had previously been unable to access specialist domestic violence support and it was unsafe for her to visit other services. Catherine's case would also not fit easily into the categories of risk relevant to other local domestic violence services, such as medium and high risk of repeated abuse. Without the IRIS programme, Catherine would not have been able to access support or information about her situation. As the general practice was part of the IRIS programme Catherine was able to easily and safely arrange appointments and meet with the advocate-educator at the practice. The advocate-educator provided a range of practical support, giving information and options for Catherine to consider. The advocate educator also provided consistent emotional support, including key messages around Catherine's disclosures and always discussed the safety of Catherine and her children.

The advocate-educator worked with Catherine for 12 months. For the first two months this involved an appointment once every two weeks, the next two months involved an appointment once every month and for the last eight months an appointment once every two months (each approximately an hour in length). In total the advocate-educator met with Catherine for ten support sessions. Catherine set the frequency of the appointments which contributed to her increasing empowerment in taking decisions about her life. Additional support included a total of approximately five phone-calls and a monthly text.

Catherine remains with her husband and over the 12 month period of support she reports many positive changes in her life;

- Going out on her own and leaving the house at least once every day
- Meeting with a friend/family member each week
- Opening her own bank account
- Setting career goals
- Taking a holiday to visit family
- Having her own time and time with her children
- Beginning a degree
- Getting "my freedom back" and "making my own decisions and planning my own way in life"

Catherine feel's empowered to make decisions for herself and her family, increasing her safety and breaking the cycle of abuse. Catherine reports the feeling of "having her life back" and "feels stronger to cope", she feels less anxious and states she is happy and has self-belief. Catherine also states that she visits her GP less frequently than before.

Catherine's doctor states that since identifying domestic abuse it is as if "a light switch has been turned on". Doctor Smith reports improved health and emotional well-being and many positive changes including increased independence, confidence, self-esteem, achievement

[132] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

of personal goals and "moving incredibly from strength to strength". Catherine's visits to the surgery have reduced by two thirds. Within the 12 months prior to accessing support Catherine visited her doctor once per month and during the 12 months that Catherine has been receiving support through IRIS she has visited her doctor once every 3 months (once a quarter). Doctor Smith reported that as Catherine has a long-term chronic condition (linked to her experience of domestic abuse) she would expect to see Catherine once a quarter. Catherine has also largely reduced her use of medication for both depression and sleeplessness.

Since engaging with IRIS the doctor feels that the practice is better resourced to help Catherine manage her health and that she is getting the support she needs.

In Catherine's words "Encouraging myself that I can do this.....I feel empowered.....I feel proud of me.....thank you for believing in me"

9. Group Exercise: Barriers to Effective Health Services – The Perspective of Survivors and Health Care Professionals[133]

In your working group, please identify barriers to an effective health care response to GBV.

Group(s) working on survivor barriers:

1. Which barriers prevent women survivors of GBV from accessing and receiving health services (survivor barriers)?
2. What can you as a health professional do in your daily work to address these barriers? (2-3 suggestions)
3. What support do you need from the management at your health facility in order to address these barriers?

Group(s) working on provider barriers:

1. Which barriers prevent health care professionals from providing effective care and treatment to patients who have experienced GBV (provider barriers)?
2. What can you as a health professional do in your daily work to address these barriers? (2-3 suggestions)
3. What support do you need from the management at your health facility in order to address these barriers?

Please write your barriers and suggestions on a piece of flipchart paper. You have 20 minutes time for discussions in the group.

Each group should assign one rapporteur who will present the points collected on the flip chart to the group.

10. Role Play 1[134]

Divide into groups of 2: one person acting as patient, the other acting as clinical lead/GBV advocate, and role-play the following according to your role. How would you handle the situation?

[133] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 181.
[134] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

PATIENT

- You are a 34 year old woman with two young children under school age.
- You are attending for a review of your anti-depressant medication, which you have been taking for the last 9 months.
- You are a lawyer working part-time and your husband is a doctor.
- It is a hot day but you are wearing a scarf as you have bruising around your neck following an argument with your husband last night.
- In the past you have had a perforated ear drum, which occurred during your honeymoon (from an assault but you never told anyone).
- You have had two miscarriages.
- You are feeling very low, want more anti-depressants. You feel hopeless and frightened.

HEALTH CARE PROVIDER

- You are new to the practice and have not seen the patient before.
- When reviewing the records you notice that she has a history of a perforated ear drum which occurred during her honeymoon.
- She has a history of two miscarriages.
- When she walks in you notice that she is wearing a scarf, even though it's a hot day.
- She appears tired and anxious.

11. Role Play 2[135]

Divide into groups of 2: one person acting as patient, the other acting as clinical lead/GBV advocate, and role-play the following according to your role. How would you handle the situation?

PATIENT

- You are an 18 year old woman and are 32 weeks pregnant with your second pregnancy, having had a previous termination when you were 15 years old.
- You are attending the GP Surgery as you have had frequent headaches and are not sure why.
- You recently moved out of your parent's house to live with your partner.
- Your partner is always with you, however he waits outside while you go through to see the GP.
- You have been with your partner for just over a year. He does not let you go out on your own, he is intimidating and does not like you talking to other people or seeing your family.

HEALTH CARE PROVIDER

- Your patient is an 18 year old woman.
- The records state 'Patient Pregnant'.
- You have not met her before.
- Record has a note by another GP who saw her mother and says 'mother worried daughter losing weight and seems withdrawn, less confident'.

12. Role Play 3[136]

Divide into groups of 2: one person acting as patient, the other acting as clinical lead/GBV advocate, and role-play the following according to your role. How would you handle the situation?

[135] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).
[136] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

PATIENT

- You are a 30 year old woman visiting the GP/nurse with pain on passing urine and back pain.
- You have 3 daughters, the youngest aged 5.
- You live with your partner (father to youngest daughter), the other girls live elsewhere and have different fathers.
- On Sunday your partner assaulted you (kicked you).
- Your lower back hurts, and you cannot open your bowels because of the pain. You have a bruised coccyx and a tender lumbosacral spine.
- Your partner has assaulted you in the past. You saw the GP 2 years ago with facial bruising following an assault.
- Over the past 4 years you have been seen with chest pain around your breast (GP said 'muscular').
- You have also had hand pain and an ENT referral for earache.
- You binge drink at times to relieve stress and anxiety.
- You smoke.
- You took an overdose when you were 19.
- You are frightened of your partner and want him to leave but he doesn't want to leave his daughter. You think things are getting worse.

HEALTH CARE PROVIDER

- Your patient is a 30 year old woman
- You have not met her before.
- Records show that she has a history of depression, alcohol/drink problem and overdose aged 19.
- In the last 4 years she has been seen with hand pain.
- For ENT referral.
- An episode of chest pain.
- There is one episode of assault with facial bruising 2 years ago.

13. Clinical Enquiry Exercise – Example Questions[137]

Please code these questions as red , amber, or green.
Red means, "This is a terrible question. I would not use this with my patients."
Amber means, "Bits of this question are OK and some of it needs changing."
Please suggest how you would change this question.
Green means, "This question is good and I would use it with my patients."

	🔴	🟡	🟢
The computer is asking me to ask you about domestic abuse. Is this happening to you?			
We know that 1 in 4 women experience domestic abuse in their lifetime. Does your partner or a family member hit, or kick you?			
How are things at home with your husband/partner/family? Has someone hurt you?			
We know that domestic abuse can be a problem for some people. Is this a problem for you?			
Sometimes people with depression/low self-esteem have experienced major life events that cause this and can explain why they feel so low. Living in an abusive relationship can cause this. Might that be happening to you?			
I'm sure this isn't a problem for you...but I have to ask if you are experiencing domestic violence?			
We know women can present with these symptoms when they are being hurt by their husband. Is this happening to you?			

[137] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

14. Documentation Form for Cases of GBV – Example from Austria [138]

Place of examination: Doctor: Tel. Referred by: Beginning of examination:_____ ____:____ (Date) (Time)	**PATIENT:** Date of Birth Tel Address: Other people present:

PATIENT BASIC DOCUMENTATION Height: Weight: Psychological condition during examination:	Patient is: ☐ Right Handed ☐ Left Handed Consciousness: ☐ clear ☐ slightly impaired ☐ clearly impaired ☐ unconscious Impression of: ☐ alcohol ☐ drug consumption
Communication: ☐ fluent ☐ broken ☐ translation necessary ↳ by whom: Dangerous situations for staff ☐ yes ☐ no	

DETAILS ABOUT OFFENSE Location: Time: _____ (Date) _____:_____ (Time) (approx.) duration of the incident: _____	☐ assailent known ☐ assailent(s) unknown How many:
Description of assault, weapons used, details of assault, **subjective disorders**: (Basis for clinical examination and forensic data collection, no suggestive interrogation.)	
Are there **witnesses** of the offense (children, neighbors)?	☐ yes ☐ no ☐ don't know
↳ If yes, are they also concerned/hurt?	☐ yes ☐ no ☐ don't know
Did the survivor try to defend herself?	☐ yes ☐ no ☐ don't know
Did the patient scratch the assailant(s)?	☐ yes ☐ no ☐ don't know ↳ If yes, please wipe the lower surface of the fingernails with wet cotton

[138] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 228-231.

Was force used against the throat (strangle, choking)?	☐ yes ☐ no ☐ don't know ↳ signs of congestion ☐ unconsciousness ☐ deception ☐ loss of urine or stool ☐ pain in the throat, difficulty to swallow
Did the patient consume alcohol, drugs or medication before, during or after the offence?	☐ yes when, what, how much: ☐ no ☐ don't know
Has a similar offence happened before?	☐ yes ☐ no ☐ no answer

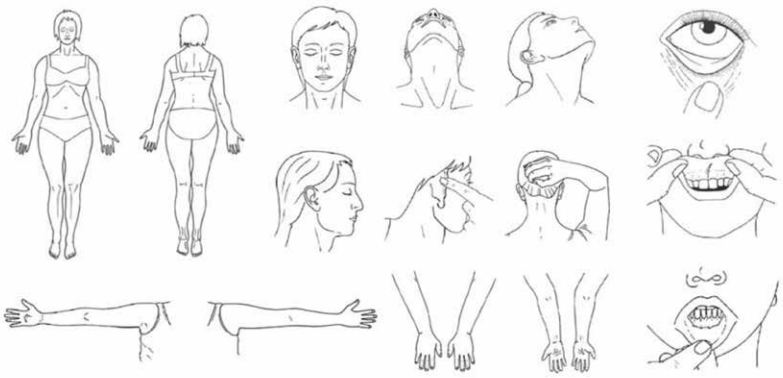
SAVING EVIDENCE		
Damage on clothes (Photo)? Contamination of clothes (blood, soil etc.)? Other traces secured?	☐ yes ☐ no ☐ yes ☐ no ☐ yes ☐ no ↳ which:	Clothing secured ☐ yes ☐ no → Packed separately in paper bags

PHYSICAL EXAMINATION	
HEAD	Hairy skull (palpate, bald spots?):
	Forehead-/temporal region:
	Eyes (incl. conjunctiva):
	Ears (backside):
	Nose (nostrils):
	Cheeks:
	Mouth (lips, teeth, vestibular mucosa):
	Chin:
	Are there **signs of congestion**? ☐ yes ☐ no ↳ ☐ skin of eyelid ☐ conjunctiva ☐ skin behind ears ☐ facial skin ☐ vestibular mucosa
THROAT	Front side:
	Neck:
THORAX	Mammae:
	Anterior rib cage:
	Back:
ARMS	Shoulder:
	Upper arms (even inside):
	Forearms (wrists):
	Hands:
ABDOMEN	
BUTTOCK	
GENITAL AREA	
LEGS	Thigh (inner thighs):
	Lower leg:
	Feet:

▸ Is an apparent pattern of injury visible? ☐ yes ☐ no (grouped or shaped injuries, burns, prints, e.g. shoe print, tire prints, double bruise): ▸ **Gunshot wound** excision of projectile, marked and documented
Provisional medical assessment:
Further measures (e. g. multidisciplinary consultation, psychological counselling, informing police...)
Information about services (shelter, helpline) given? ☐ yes comments:
End of examination: _____ time _____:_____ signature doctor: _____

TRANSMISSION OF EVIDENCE	
Objects (clothing, instrumentalities, projectile, excised tissue etc.):	
Transmitted by: _____ (capital letters) Date and signature: _____,_____	Taken over by: _____ Date and signature: _____,_____
PHOTO DOCUMENTATION	
Was photo documentation made? ☐ yes ☐ no ↳ if „no“, why not: ↳ if „yes“, where archived:	Number of photos taken:

Recommendation for examination and basic documentation:



15. Handout: Risk Indicators & Safety Planning[139]

RISK INDICATORS

A checklist of common indicators of risk, known as **SPECSS+**
(Richards, 2004)

- ☑ **S**eparation – has the survivor recently left/plans to leave? Any child contact issues with perpetrator
- ☑ **P**regnancy – is the woman pregnant now or has she given birth in the last six weeks?
- ☑ **E**scalation – is the abuse getting worse or happening more often?
- ☑ **C**ultural issues/sensitivity/isolation – are there any specific issues
- ☑ **S**talking – is she being harassed or threatened by anyone, particularly a former partner? (includes emails/texts)
- ☑ **S**exual assault – has she reported sexual assault as part of the abuse?
- ☑ **O**ther current risk factors
  - → Suicidal thoughts
  - → Homicidal thoughts
  - → Threats to kill client or other family member(s)
  - → Abuses family pet
  - → Access to weapons
  - → Alcohol/drug use
  - → History of assault

SAFETY PLAN

A safety plan can cover various stages.

Safety in the relationship

- Places to avoid when abuse starts (such as the kitchen, where there are many potential weapons).
- A potential exit from the home if abuse escalates (such as an unlocked window/door)
- People to turn to for help or let know that they are in danger.
- Asking neighbours or friends to call 999 if they hear anything to suggest a woman or her children are in danger.
- Places to hide important phone numbers, such as helpline numbers.
- How to keep the children safe when abuse starts.
- Teaching the children to find safety or get help, perhaps by dialing the local police/safety number.
- Keeping important personal documents in one place so that they can be taken if a woman needs to leave suddenly.
- Letting someone know about the abuse so that it can be recorded (important for cases that go to court or immigration applications, for example).

Leaving in an emergency

- Packing an emergency bag and hiding it in a safe place in case a woman needs to leave urgently.
- Plans for who to call and where to go (such as a domestic violence refuge).
- Things to remember to take, including children's: documents, medication, keys or a photo of the abuser (useful for serving court documents).
- Access to a phone/address book.
- Access to money or credit/debit cards that a woman has perhaps put aside.
- Plans for transport.
- Plans for taking clothes, toiletries and toys for the children.
- Taking any proof of the abuse, such as photos, notes or details of witnesses.

[139] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

Safety when a relationship is over

- Contact details for professionals who can advise or give vital support.
- Changing landline and mobile phone numbers.
- How to keep her location secret from her partner if she has left home (by not telling mutual friends where she is, for example).
- Getting a non-molestation or exclusion or a restraining order.
- Plans for talking to any children about the importance of staying safe.
- Asking an employer for help with safety while at work.

16. Handout: Safety Planning Form Example[140]

Suggestions for increasing safety – in the relationship

- I will have important phone numbers available to my children and myself.
- I can tell _____ and _____about the violence and ask them to call the police if they hear suspicious noises coming from my home.
- If I leave my home, I can go (list four places):
  _____.
  _____.
  _____.
  _____.
- I can leave extra money, car keys, clothes, and copies of documents with
  _____.
- When I leave, I will take _____with me.
- For safety and independence, I can:
  - Keep change for phone calls with me at all times
  - Ensure my phone is charged
  - Use a panic alarm
  - Open my own savings account
  - Alter my routes to/from_____
  - Rehearse my escape route with a support person; and review safety plan on _____(date).
- When the violence begins which areas of the house should I avoid?
  e.g. bathroom (no exit), kitchen (potential weapons) _____.

Suggestions for increasing safety – when the relationship is over

- I can: change the locks; install steel/metal doors, a security system, smoke detectors and an outside lighting system.
- I will inform _____and _____ that my partner no longer lives with me and ask them to call the police if s/he is observed near my home or my children.
- I will tell people who take care of my children the names of those who have permission to pick them up. The people who have permission are: _____, _____and _____.
- I can tell _____at work about my situation and ask _____ to screen my calls.

[140] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

- I can avoid shops, banks, and _____that I used when living with my abusive partner. I can change my route to/from_____.

- If I feel down and ready to return to a potentially abusive situation:

  - I can call _____for support.

  - I can alter the route and/or times _____ appointments at the _____service or attend _____service as an alternative.

- Important Phone Numbers
  - Police_____
  - Helpline _____
  - Friends _____
  - Refuge_____

Items to take checklist

- Identification
- Birth certificates for me and my children
- Benefit books
- Medical cards
- Phone card, mobile or change for a pay phone
- Money, bankbooks, credit cards
- Keys - house/car/office
- Keys to a friend or relative's house
- Medicine, medication or drugs
- Driver's license
- Change of clothes
- Passport(s), Home Office papers, work permits
- Divorce papers
- Lease/rental agreement, house deed
- Mortgage payment book, current unpaid bills
- Insurance papers
- Address book
- Pictures, jewellery, items of sentimental value
- Children's favourite toys and/or blankets
- Any proof of abuse, notes, tapes, diary, crime reference numbers, names and numbers of professionals

In an emergency, always call the police

17. Individual Exercise: Identifying Risk Factors – The Case of Mrs. Y [141]

After another violent attack by her husband, Mrs. Y arrives at the hospital to see medical help for injuries.
Please assess the level of danger faced by Mrs. Y. Which risk factors can you identify in the case study?

Mrs. Y has been married to her husband for one and a half years; for both of them it is the second marriage. Mrs. and Mr. Y live in country A but are originally from country B. Both have

[141] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 242.

children from previous marriages; only the 5-year-old daughter of Mrs. Y lives with them.

Before they got married, Mr. Y was charming and polite to his wife. But soon after the wedding he becomes very controlling and tries to prevent her from visiting her family or going out with friends. He wants her to account for every minute she is out of the house and if she comes back from work later than usual he explodes and accuses her of being a bad wife and "whoring around" with her colleagues.

Mrs. Y does not put up with his behavior and refuses to submit to his "orders". As his controlling behavior and possessiveness get worse, she tells him that she wants to divorce him. From this moment on he starts to threaten that he will kill her if she leaves him; he also threatens to kill her children. Mrs. Y has the citizenship of country A, but Mr. Y does not and depends on her for his visa.

Despite his threats Mrs. Y files a petition for divorce. When he finds out he beats her and threatens again to kill her if she does not withdraw the petition for divorce.

Mrs. Y reports the physical violence and the threats to the police. The police issues an expulsion and barring order obliging Mr. Y to leave the family home for 10 days. Despite the expulsion of her husband Mrs. Y decides to move out of the family home with her daughter because she is very afraid of her husband. She seeks counselling and support from a domestic violence counseling centre; the counselor advises her not to go back home.

Mr. Y continues to be violent; he follows Mrs. Y to her work place, and threatens her there as well. He says that he will kill her and flee to his home country and that her case will be in the newspaper. Mrs. Y calls the police but he flees before they arrive. She reports the threats to the police again; the police informs the prosecutor's office, who however decides not to arrest Mr. Y.

With the support of the domestic violence counseling centre, Mrs. Y obtains a court order that prohibits her husband to come to her home, to her work place or to contact her. But Mr. Y continues to follow and threaten her.

18. Role Play: Safety Planning – The Case of Dilorom[142]

The aim of the role play is to practice the safety planning in a case of GBV and communication with survivors of GBV, according to the principles discussed in training. The role play has 3 parties: Dilorom (a survivor seeking help), a doctor working at the health center, and an observer. Maximum duration of the conversation between the doctor/nurse and the patient: 15 minutes. After the role play, please come back to the bigger group for a feedback round (patient, health care professional, observer), followed by comments from the larger group.

Situation

Dilorom seeks medical help from a health center in her hometown because of chronic stomach pain and sleeping problems. The doctor observes several bruises on her arms and neck. Dilorom reports that her husband repeatedly beats her and sometimes also the children. Several times, he forced her to have sexual intercourse. He also verbally abuses her and threatens to kill her if she leaves him. Dilorom wants to leave but she is afraid of what he would do if she does leave him. Together with her husband and children, she lives with her in-laws. From her husband's parents, she cannot expect any help – they regularly insult her

[142] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 246.

and blame her for her husband's violent behavior. Dilorom asks the doctor what she could do for her safety.

Questions:

- Questions for the person playing the survivor: How did you feel in your role? Was the behavior of the doctor/nurse useful? What could the doctor/nurse have done differently?
- Questions for the person playing the health care professional: How did you feel in your role? What did you handle well? What was the most difficult for you? What could you have done differently? What do you need to do in your work practice to support a patient in safety planning?

Ask the observer to share his/her feedback and observations, then open the discussion to the group.

19. IRIS Referral Example[143]

IRIS REFERRAL FORM

fax: _____

email: _____

phone: _____

Referring clinician

Name: _____

E-mail address: _____

Practice address: _____

Practice phone number: _____

Patient

Name: _____

Address: _____

Date of Birth: _____

Language: ☐ English ☐ Somali ☐ Punjabi ☐ Urdu ☐ Polish

Other language: _____

Please provide a safe telephone number for the patient (or another means by which she can becontacted): _____

_____

Is it safe to leave a message/text this number?

Reason for referral: _____

Date of referral : _____

Number of consultations in last 6 months: _____

Number of prescriptions in last 6 months: _____

[143] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

20. Training Tips Skills Exercise[144]

In a group, provide possible solutions to the scenarios below:

1. You lose your train of thought and forget what you were saying. What do you do?
2. You panic and feel very nervous just as you are about to start a session. What do you do?
3. You don't know the answer to a question. What do you do?
4. A participant disagrees with everything you say and sighs throughout the session. What do you do?
5. Three GPs all ask you a question at the same time. What do you do?
6. You become very flustered and realize you are rambling. What do you do?
7. You realize you have rushed the first 10 minutes and some of the participants are looking disengaged. What do you do?
8. You arrive to be told that you have only 10 minutes in a meeting when previously you had agreed to a 30 minute slot.
9. During a second training session, a clinician says that he has feedback from a patient previously referred to you to say that the service was no help at all.
10. Someone in the training session says that they don't believe that 1 in 4 women can experience DVA. The numbers can't be that high.
11. You arrive at a practice and the receptionist asks loudly who you are, where you are from, and why you want to see the patient you have arranged to meet.
12. You arrive at a practice to meet a patient and the room you have booked is no longer available and there is no other available space.

21. GBV Advocate Exercise – What to do When...[145]

In a group, explain what you would do in the following situations:

1. A woman agrees to meet you but doesn't want to talk when you meet, and sits in silence.
2. A woman is angry and begins to shout at you.
3. A woman tells you that no one can help her, nothing ever changes, and she's had enough.
4. A woman asks if you can speak with her husband and persuade him to speak to the doctor himself.
5. A woman arrives at your meeting but has clearly been drinking heavily.

[144] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).
[145] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

6. A woman brings her 4 and 6 year old children to the meeting with her.

7. A woman arrives and is accompanied by her partner.

8. A woman calls just before you are due to meet, saying everything is OK now and she doesn't need to see you or speak to you again.

22. Self Care Exercise[146]

Participants are asked to individually think about how they look after themselves when working in the field of GBV, and how to avoid vicarious trauma.

The trainer puts up 3 pieces of flip chart paper with the following 3 headings:

- Physical
- Emotional
- Professional

Participants are then instructed to write down the ways in which they look after themselves under each heading. Afterwards, the group opens up for discussion.

[146] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

23. Handout: Action Plan Individual Exercise[147]

ACTION PLAN

Please think of and note down three actions that you are going to take away to work on. Think about what the actions are, whether you need support or resources to address them, and who you can discuss this with.
Put a realistic timeframe on your actions and a date to review them.

Remember to make your actions SMART!
Specific, Measurable, Achievable, Realistic, within a Timeframe

1)

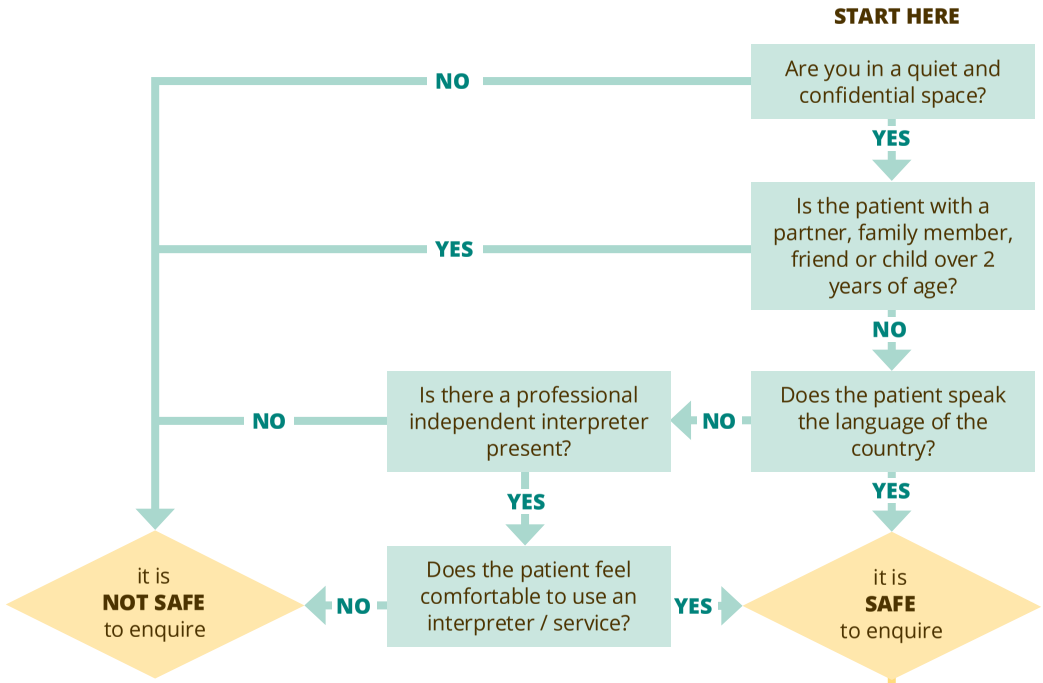
2)

3)

[147] IRIS (Identification & Referral to Improve Safety) © University of Bristol, UK (2015).

HEALTH SECTOR RESPONSE TO VICTIMS OF GENDER-BASED VIOLENCE (GBV)

WHEN IS IT SAFE TO ASK PATIENTS ABOUT GBV?



EXPLAIN CONFIDENTIALITY

Information may be shared if:

- The patient gives consent
- There is a statutory duty to share information (ex. court order)
- It is in the best public interest (including safeguarding children)

You will not inform the partner about the discussion around GBV

HOW TO ASK ABOUT GBV

- Take the initiative to ask about violence
- Explain confidentiality
- Use eye contact and be aware of body language
- Use supportive comments and avoid passive listetning
- Show a non-judgemental and supportive attitude
- Reinforce that GBV cannot be tolerated
- Be patient, and do not pressure patient to disclose
- Emphasize that there are options and resources available

REFERRAL PATHWAY

Name of person referring
Name of referring organization
Contact details of person referring

IMPLEMENT
HEALTH SYSTEM RESPONSE TO GENDER BASED VIOLENCE

EXAMPLES OF INTRODUCTORY QUESTIONS

"From my experience, I know that abuse and violence at home is happening to many women. Is it happening to you?"

"Many of the patients I see are dealing with abusive relationships. It can be frightening and feel uncomfortable to talk about this. Have you ever experienced violence or abuse from your partner?"

EXAMPLES OF DIRECT QUESTIONS

"I am concerned that your symptoms may have been caused by someone hruting you. Has someone been hurting you?"

"From our experience we know that patients can get this kind of injury from a physical attack. Has this happened to you?"

"Has your partner/ex-partner or an adult family member humiliated or threatened you?"

"Are you afraid of your partner, ex-partner or an adult family member?"

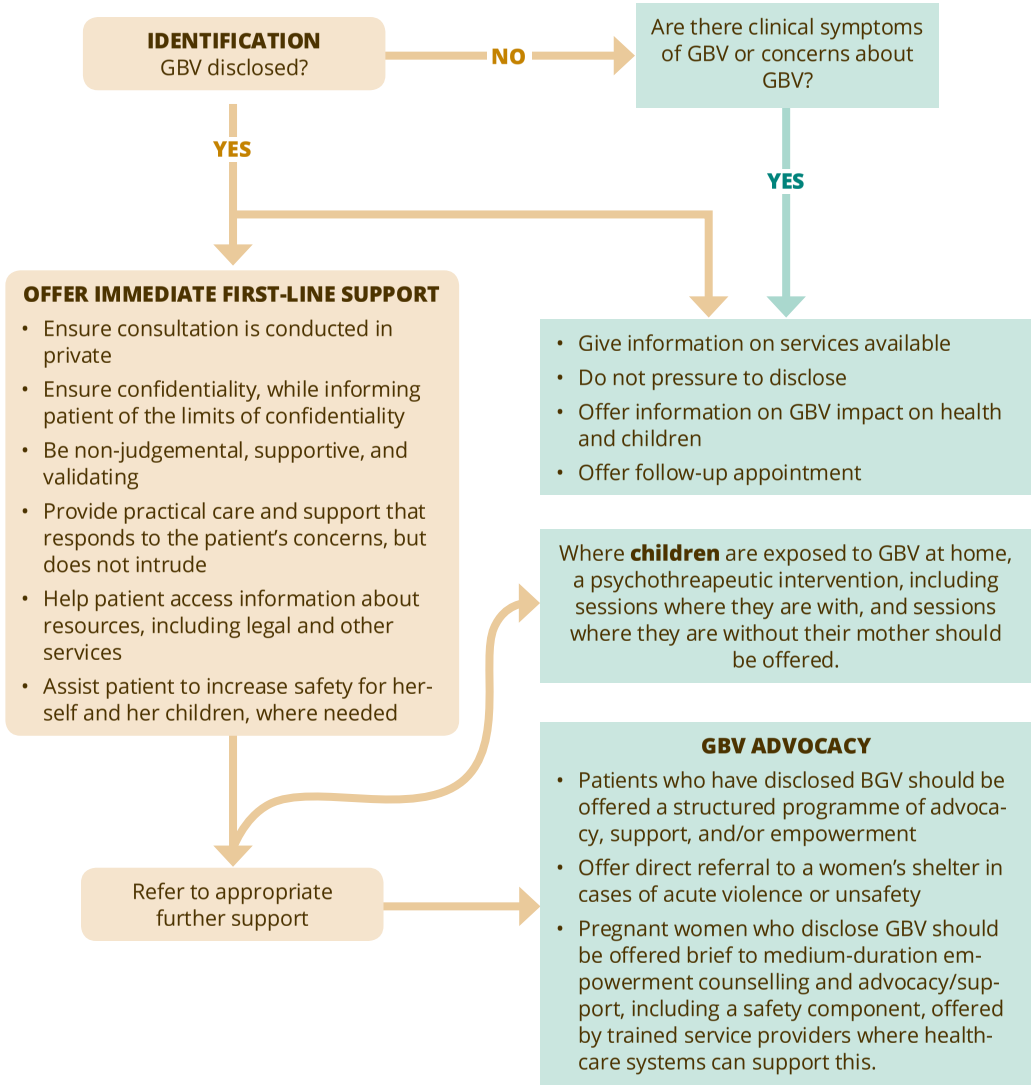
"Has your partner ever tried to restrict your freedom or keep you from doing things that were important to you?"

SECURITY IN THE HEALTH SYSTEM

- Staff is informed about how to proceed in cases of acute violence, including how to ask a woman if she is experiencing GBV in a private setting
- Safety plans for employees
- Information about prevention and support is available and complete
- Discretion in distribution of information is taught to staff, and no information shall ever be given to the perpetrator – ensure confidentiality
- System referral in place

HEALTH SECTOR RESPONSE TO VICTIMS OF GENDER-BASED VIOLENCE (GBV)

CARE PATHWAY FOR GBV



WHAT SHOULD BE DOCUMENTED?

- Demographic information (i.e. name, age, sex, children in the household)
- Obtained consent
- History (i.e. relevant medical and gynecological, if appropriate)
- Account of the abuse or violence
- Results of the physical examination (if appropriate)
- Tests and their results (if appropriate)
- Management plan
- Recording of referral or patient declining referral

RED FLAGS ASSOCIATED WITH GBV

- Symptoms of depression, anxiety, PTSD, sleep disorder
- Suicidality or self-harm
- Alcohol and other substance abuse
- Unexplained chronic gastrointestinal symptoms
- Unexplained reproductive symptoms, including 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 of kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Chronic pain (unexplained)
- Traumativ injury, particularly if repeated and with vague or implausible explanations
- Problems with central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

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IMPLEMENT
HEALTH SYSTEM RESPONSE to GENDER BASED VIOLENCE

Session 1
WELCOME & INTRODUCTION

Gene Feder & Medina Johnson
Vienna, 21-22 May 2015

IMPLEMENT
HEALTH SYSTEM RESPONSE to GENDER BASED VIOLENCE

Outlook

- Housekeeping and break time
- Objective of the training
- Background – training materials used

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Group Agreement

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Overview of Day 1

- Group Agreement
- IMPLEMENT Manual and Objective
- Your role in IMPLEMENT
- Gender-based Violence (GBV) Myths
- Definitions - violence against women (VAW)
- Dynamics of GBV
- Identifying GBV
- Barriers in the health system
- How to ask about GBV
- Undertaking a medical exam
- Recording and classifying injuries
- Closing

Overview of IMPLEMENT Training Manual

IMPLEMENT Training Manual

- Divided into 2 sections

I. **Manual**: 8 chapters – information related to training sessions

II. **Appendix**: training exercises, handouts, and presentations

Objective of IMPLEMENT

The main objective is to provide capacity building in 6 European countries (France, Italy, Germany, Bulgaria, Romania, and Austria) **in order to strengthen the support for victims of gender-based violence (GBV) with a focus on intimate partner violence in health settings**.

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IMPLEMENT HEALTH SYSTEM RESPONSE to GENDER BASED VIOLENCE

IMPLEMENT Roles

Role of **clinical lead**

- support and provide training for health team on understanding and responding to GBV
- encourage health team to identify GBV and to effectively respond, record, and assess immediate risk and refer
- provide peer support and maintain effective relationship with health team and GBV advocate

Role of **GBV advocate**

- support and provide training for health team on understanding and responding to GBV
- encourage health professionals to identify and effectively respond to GBV
- build and maintain effective relationship with health team and clinical lead
- provide information, support and advocacy for women who disclose their past or current experiences of GBV

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Session 2
GBV CORE CONCEPTS

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GBV Myths

1. Women allow GBV to happen to them, and if they really want to, they can leave their abusive partners
2. Conflicts and discord are a normal part of any relationship
3. Men and women are equally violent to each other
4. GBV happens only to a certain type of person
5. GBV is caused by substance abuse such as alcohol and/or drugs
6. Women should tolerate violence to keep the family together
7. A man cannot rape his wife

(UNFPA-WAVE, p. 161)

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Gender-based Violence

What is GBV?

Gender-based Violence

Definitions

- violence against women
- domestic violence and abuse
- intimate partner violence & violence from an adult family member
- female genital mutilation
- sexual violence
- forced marriage
- honor-based violence

Gender-based Violence

Forms of violence against women (VAW)

- physical
- sexual
- psychological
- economic
- isolation
- threats
- coercive control

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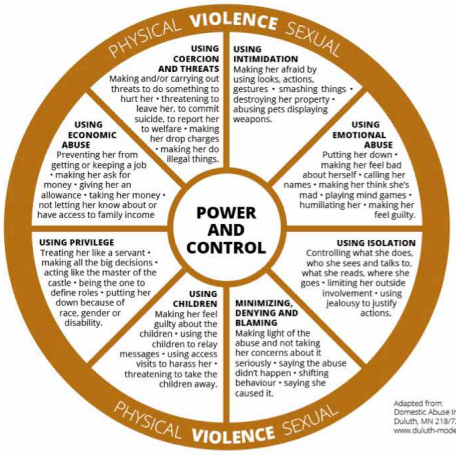
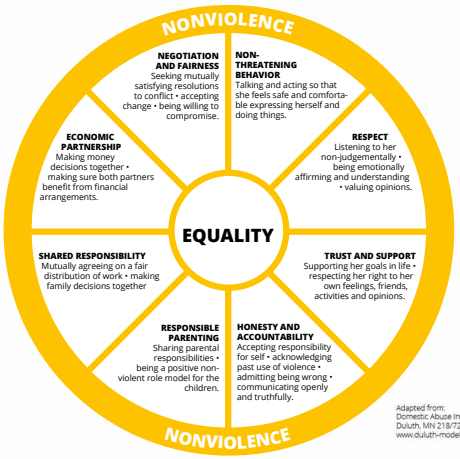
What about gender?

- 89% of people who suffer four or more domestic violence assaults in their lifetime are women (Walby & Allen 2004)
- Violence against women is more frequent and more severe - beaten, choked or raped (Canadian General Social Survey, 2006)
- 38% of women and 7% of men in violent relationships fear for their lives (as above)
- Associated with significant mortality: over 50% of female homicides committed by current or ex-partner compare to 5 % of male homicides. (Krug E et al, 2002)
- Male victims need access to support too

Power and Control Wheel



Non-Violence Power and Control Wheel



Impact of GBV on Women's Health

Gender-based violence can result in:

- Death
- Reduced life expectancy
- Physical harm
- Unhealthy coping mechanisms
  - substance use
  - self-harm
- (Psycho)-Somatic consequences
- Reproductive health consequences
- Psychological consequences

(UNPFA-WAVE, p. 39)

Pooled data from WHO study (2005)

	Unadjusted OR	95% CI	Adjusted OR	95% CI
Self-reported general health: poor or very poor	1·9	1·7–2·1	1·6	1·5–1·8
Difficulty walking in past 4 weeks	2·0	1·8–2·1	1·6	1·5–1·8
Difficulty with daily activities in past 4 weeks	1·9	1·8–2·1	1·6	1·5–1·8
Pain in past 4 weeks	1·8	1·7–2·0	1·6	1·5–1·7
Memory loss in past 4 weeks	2·0	1·9–2·2	1·8	1·6–2·0
Dizziness in past 4 weeks	2·0	1·9–2·2	1·7	1·6–1·8
Vaginal discharge in past 4 weeks	2·3	2·1–2·5	1·8	1·7–2·0
Ever suicidal thoughts	2·4	2·2–2·6	2·9	2·7–3·2
Ever suicidal attempts	3·5	3·0–4·1	3·8	3·3–4·5

Adjusted ORs were adjusted for site, age group, current marital status, and education. *ORs and 95% CI are given for the

Mental Health Consequences

(Howard 2013, *Golding 1999*)

	OR (95% CI)
Depression	**2.8** (2.0 to 3.9)
PTSD	**7.3** (4.5 to 12.0)
Alcohol abuse	***5.6*** *(3 to 9)*
Suicidal thoughts	***3.6*** *(2.7 to 4.6)*

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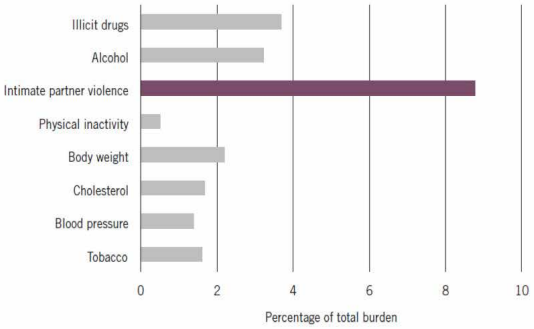
IMPLEMENT HEALTH SYSTEM RESPONSE to GENDER BASED VIOLENCE

Contribution to Disease (VicHealth, 2004)

Figure 2: Top eight risk factors contributing to the disease burden in Victorian women aged 15–44 years



IMPLEMENT HEALTH SYSTEM RESPONSE to GENDER BASED VIOLENCE

Why doesn't she leave?

- Normalization of violence, cultural attitudes and societal expectations
- Discrimination and stereotypes
- Life of woman is threatened
- Woman cannot escape or feels obligation to keep family intact
- Woman feels isolated or is unaware of services available
- Perception of „Honeymoon phases" which are actually part of the abuse
- Limited acccess to justice and health care, language barriers (migrant women)
- Fear she will not be believed
- May not recognize behavior as abuse or believe that alternatives exist
- Woman loves the perpetrator and wants the behaviour to stop

(IRIS Training, Bristol, UK)

IMPLEMENT HEALTH SYSTEM RESPONSE to GENDER BASED VIOLENCE

Impact of GBV on Children I

- 73% of mothers who have been victims of physical and/or sexual violence by a partner indicate that at least 1 of their children has become aware of such violence taking place (WAVE Report 2014, p. 14)
- Children that are exposed to violent behavior towards the mother are more likely to grow up to be perpetrators themselves (WAVE, Away from Violence, p. 14).
- Around one third (30%) of women who experienced sexual victimization in a former or current partnership indicate experiences of sexual violence in childhood (FRA, Violence Against Women, p. 121).

Impact of GBV on Children II

- Domestic violence and abuse (DVA) between parents is the most frequently reported form of trauma for children (Meltzer et al, 2009)
- The mental, emotional and psychological health of children and their social and educational development is affected (Stanley, 2011)
- DVA was a feature of family life in 63% of the serious case reviews carried out between 2009-2011 (Brandon et al, 2012)
- Children - the Adoption & Children Act 2002 definition of harm "including, for example, impairment suffered from seeing or hearing the ill treatment of another"

Reported Childhood Experiences of Violence

Country	Physical Violence	Sexual Violence	Psychological Violence	Any Violence
Austria	27%	5%	9%	31%
Bulgaria	28%	28%	5%	30%
France	33%	20%	14%	47%
Germany	37%	13%	13%	44%
Italy	25%	11%	9%	33%
Romania	23%	(1)	4%	24%

(FRA, Violence Against Women, p. 123)

Why do some women not contact a service for help?

- they choose to deal with it independently or disclose to someone close to them
- they believe no one can help them
- they have had negative experiences of seeking support in the past
- they believe that their situation was too 'minor' to involve services or the threshold of services doesn't include what they are experiencing
- they were either unaware of services available or that there were in fact no services available. (FRA, Violence Against Women, p. 66)

DAY 1

Services which women survivors contact for help

Women who contacted organizations or services after serious incidents of violence since the age of 15 (EU28):

Service	Partner Physical Violence	Partner Sexual Violence	Non-Partner Physical Violence	Non-Partner Sexual Violence
Police	14%	15%	13%	14%
Hospital	11%	12%	9%	12%
Doctor or healthcare institution	15%	22%	10%	16%
Women's Shelter	3%	6%	(0)	(1)
Victim Support Organization	4%	4%	1%	4%

(FRA, Violence Against Women, p. 65)

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Gender-based Violence European Statistics

Main FRA results on the prevalence of physical and sexual violence

- *1 in 3 women* has experienced some form of physical and/or sexual assault since the age of 15 = 62 million women throughout the EU
- *1 in 10 women* has experienced some form of sexual violence since the age of 15
- *1 in 20 women* has been raped since the age of 15

(FRA, Violence Against Women, p. 21)

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Prevalence of GBV in IMPLEMENT Countries

Women who have experienced physical and/or sexual violence since the age of 15:

Country	Current Partner	Previous Partner	Non-Partner	Any Partner and/or non Partner
Austria	3%	15%	12%	20%
Bulgaria	11%	38%	14%	28%
France	11%	31%	33%	44%
Germany	7%	24%	24%	35%
Italy	9%	25%	17%	27%
Romania	14%	30%	14%	30%

(FRA, Violence Against Women, p. 28)

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Role of Health Care

- Provide immediate support (+ forensics), referral to specialist GBV service, ongoing care
- GBV as a public health issue
- 1 in 3 victims of physical and/or sexual partner violence, and 1 in 4 victims of physical and/or sexual violence non-partner violence contacted some sort of service or organization for assistance
- **Women are more likely to get in touch with health care services than any other service**, including the police or social services

(FRA, Violence Against Women, p. 60)

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Session 3
IDENTIFYING GBV

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Survivor's Voices

"…the only doctor who ever asked…I was just so relieved that somebody just said something. And he gave me the box of tissues and I just sat and cried…and he said, tell me when you're ready, he said, there is somebody out there to help me. I'm not on my own. And if I want help, it's there and not to be ashamed of it. Which I was, really ashamed of it and he said, you're not on your own. We can get you this help. And he did. He really did."

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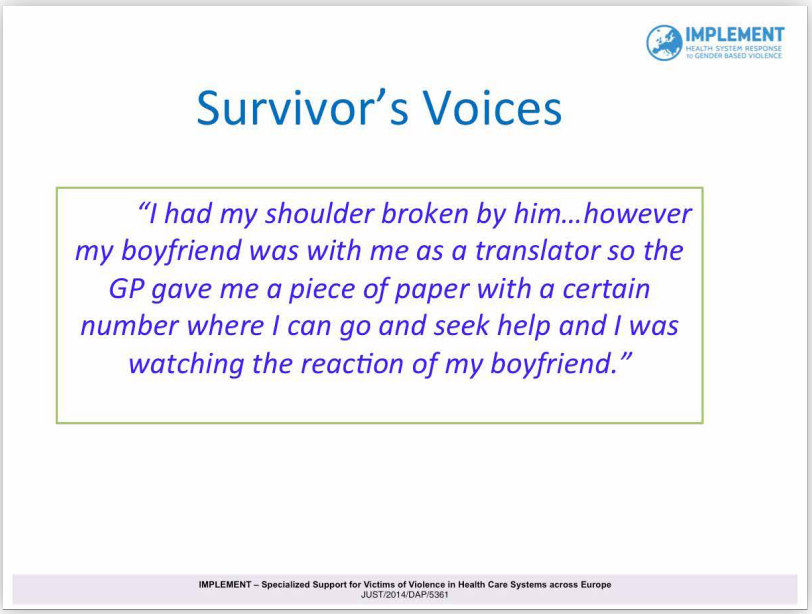
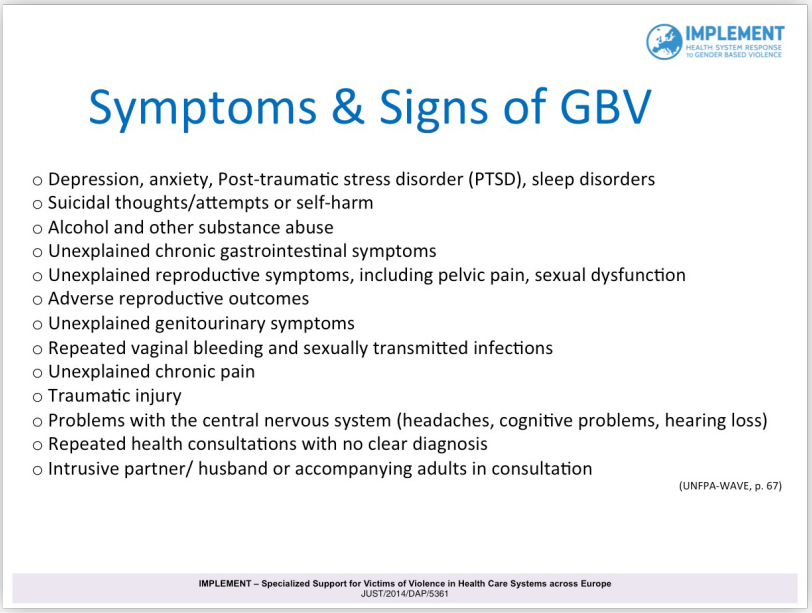
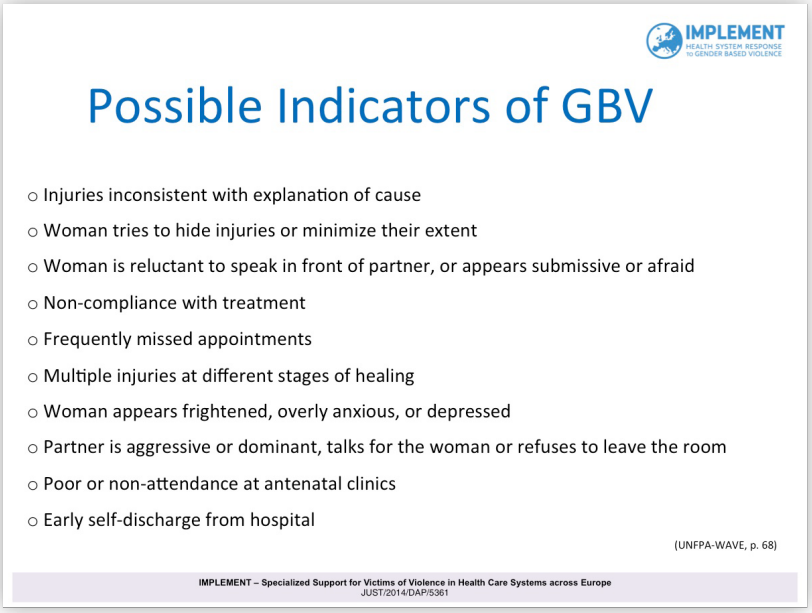






Barriers in the health system in addressing GBV

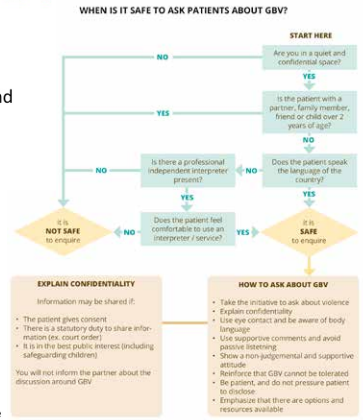
Patients	Health Care Providers
○ Shame, guilt ○ Fear of negative response, being blamed ○ Fear of an escalation of violence ○ Social isolation ○ Lack of safe options for themselves and their children ○ Lack of physical access, especially in remote areas ○ Language and cultural barriers	○ Insufficient knowledge about GBV and incompetent handling of cases ○ Lack of time ○ Lack of institutional support, such as standardized protocols and institutionalized training ○ Own attitudes and misconcpetions about GBV

(UNFPA-WAVE, p. 176).

Requirements for asking about GBV

Minimum requirements when asking:
○ Protocol or standard procedure
○ Health care providers are trained on asking and responding to disclosure
○ Privacy and confidentiality considerations
○ Aware and knowledgeable or resources and referral system (IMPLEMENT Fundamental Reference Tool)

When is it safe?
○ Private and confidential space
○ Woman is alone
○ For women who are migrants, refugees, or belong to an ethnic minority and do not speak the local language, ensure the presence of a professional interpreter (avoid using family members as interpreters) (IMPLEMENT Fundamental Reference Tool)



Clinical Enquiry (Case-finding)

○ It is not safe to ask all women

○ There is no evidence for screening/routine enquiry

○ Ask when women present with certain injuries and conditions

○ Have a low threshold for asking

○ Asking the question makes it OK to talk about GBV

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How to ask

- Take the initiative to ask
  - do not ask in the presence of other people, especially partner
- Confidentiality
- Eye contact
- Body language
- Active listening
- Validation
- Patience
- Supportive statements
- Emphasize resources
- Non-judgemental

(UNFPA-WAVE, p. 70)

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Asking

"From my experience, I know that abuse and violence at home is happening to many women. Is it happening to you?"

"We know that many women experience abuse and violence at home and that it impairs their health. I wonder if you ever experienced violence at home?"

"Many of the patients I see are dealing with abusive relationships. It can be frightening and feel uncomfortable to talk about this. Have you ever experienced violence or abuse from your partner?"

"Are you afraid of someone at home? Has someone hurt you?"

"Some women have these injuries when they are suffering abuse. Has this happened to you?"

"Sometimes people with these symptoms might be having problems at home. How are things at home? Are you ever afraid of, humiliated or hurt by anyone?"

"Does anyone try to control what you do and who you see?"

(IRIS Training Materials, Bristol, UK, 2015)

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Asking

Research shows: women don't start talking about violence, but most react positively to being asked

Raise questions appropriate to the patient's age, culture, and level of tranquility at the time

Avoid technical terms like ‚domestic violence' – women may not know the meaning and therefore not identify with it

(UNFPA-WAVE, p. 200)

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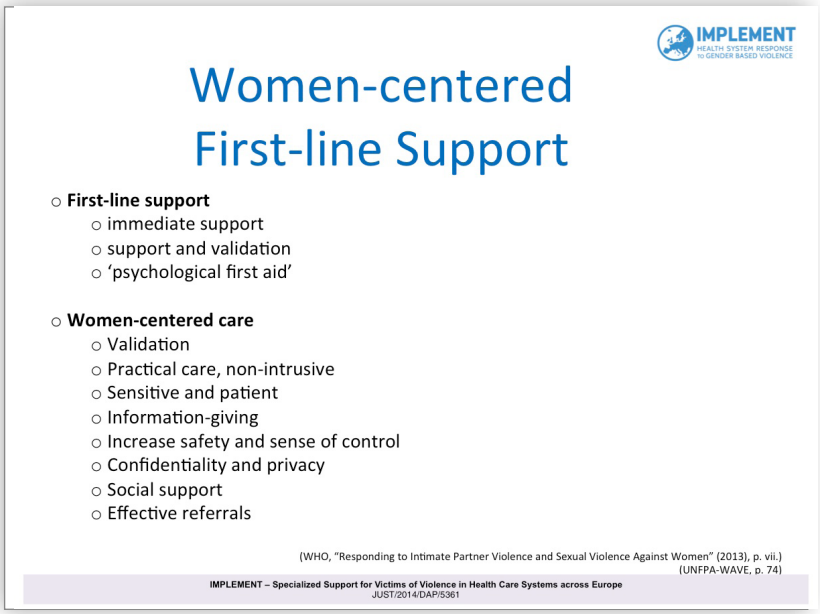
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Women-centered First-line Support
First-line support
immediate support
support and validation
'psychological first aid'
Women-centered care
Validation
Practical care, non-intrusive
Sensitive and patient
Information-giving
Increase safety and sense of control
Confidentiality and privacy
Social support
Effective referrals
(WHO, "Responding to Intimate Partner Violence and Sexual Violence Against Women" (2013), p. vii.)
(UNFPA-WAVE, p. 74)
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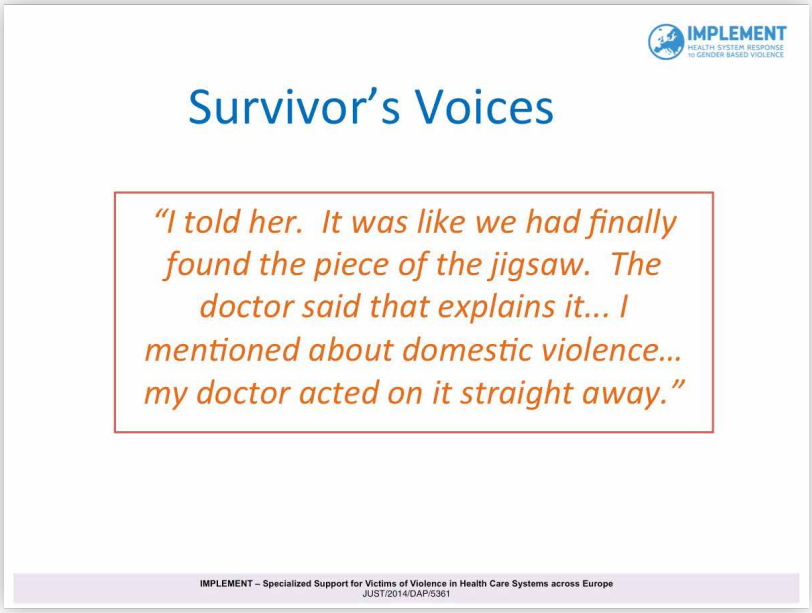
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Survivor's Voices
"I told her. It was like we had finally found the piece of the jigsaw. The doctor said that explains it... I mentioned about domestic violence... my doctor acted on it straight away."
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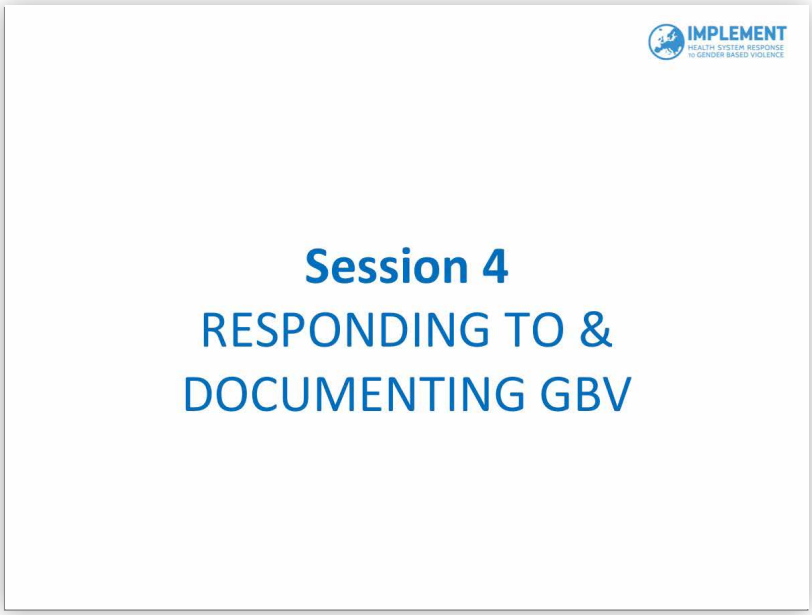
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Session 4
RESPONDING TO & DOCUMENTING GBV

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Responding

Key messages:

"I believe you"

"It's not your fault"

"Support is available"

"Thank you for telling me"

"Everyone has the right to be safe (at home)"

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Use of documentation

Health professional's legal issues	Patient's legal issues	For good clinical care
• professional obligation to record details of any consultation with patient • notes should reflect what patient said, what was seen and done • keep confidential	• medical records can be used in court as evidence • documenting health consequences may help court in decision-making and provide info about past/present violence • lack of coordination between health care and police/prosecutors can cause loss of evidence	• documentation can alert other health care providers, who may later attend to the patient, to her experiences of GBV and thereby assist in providing appropriate follow-up care • GBV is a particular field of violence which requires specialized training

(UNFPA-WAVE, p. 79)

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HEALTH SYSTEM RESPONSE to GENDER BASED VIOLENCE

Recording History

- **Why record?**
- **Informed consent**

1. Obtain informed consent
   - Explain all aspects of consultation
   - Explain limits of confidentiality
   - Ask patient to sign or mark consent form, if required by law

→

2. Take complete medical history
   - the time since assault, and type of assault
   - the risk of pregnancy, STDS, and other STIs
   - woman's mental health status
   - demographic information
   - results of physical examination and tests
   - treatment plan
   - medication
   - symptoms or observed injuries
   - frequency and severity of abuse
   - record consent and action (referrral)

(UNFPA-WAVE, p. 80)

Recording

- **Interviewing**
  - ask her to tell in her own words what happened
  - ask open-ended questions, avoid using „why“
  - avoid unnecessary interruption
  - active-listen
  - validate
  - non-judgemental

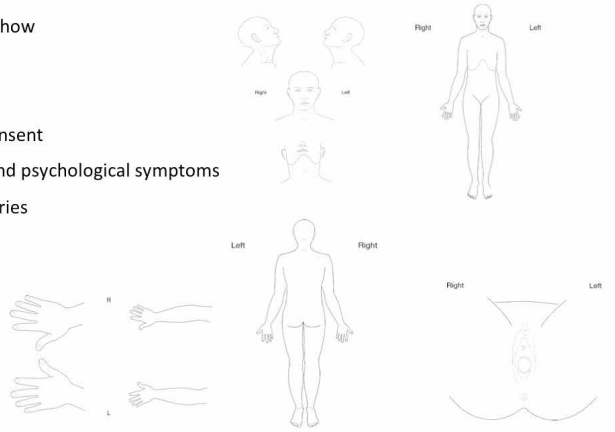
  (UNFPA-WAVE, p. 75)

- **Documenting cases of sexual abuse**

Physical Examination

- Explain and show
- Permission
- Be thorough
- Informed consent
- Emotional and psychological symptoms
- Physical injuries
- Forensics
- Body map

(UNFPA-WAVE, p. 75)



Photography

- Consent
- Identification
- Scales
- Orientation
- Chain of custody
- Security
- Sensitivity

(UNFPA-WAVE, p. 80)

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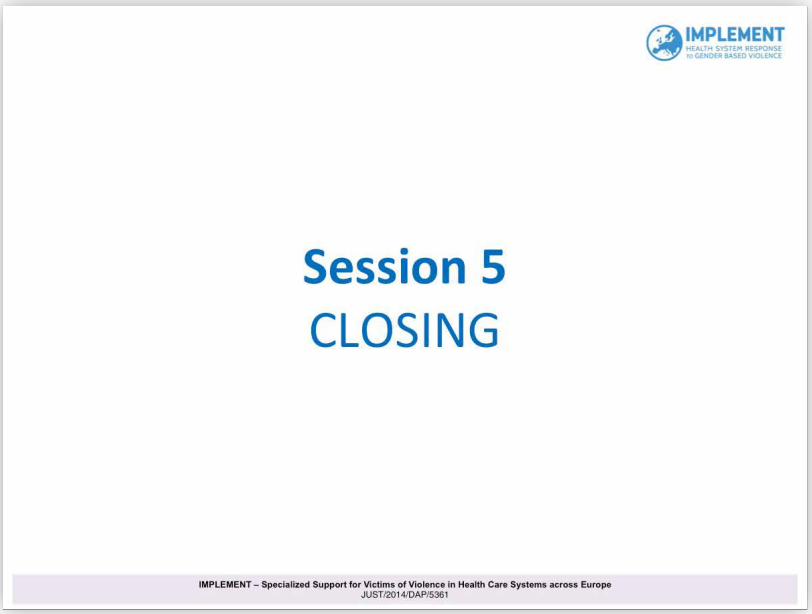

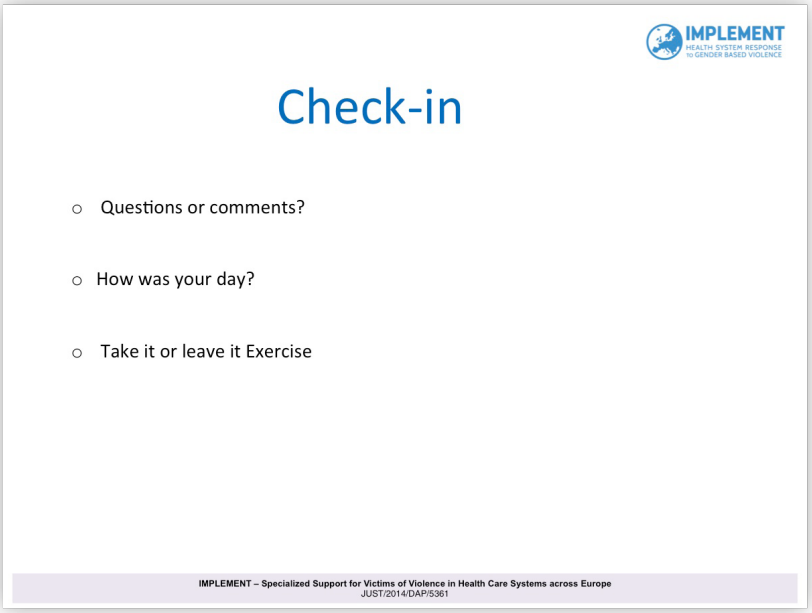

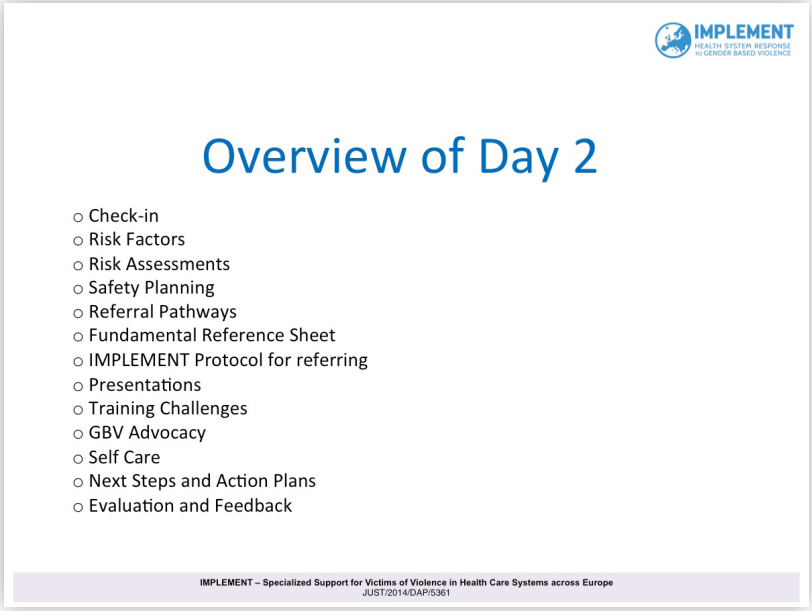

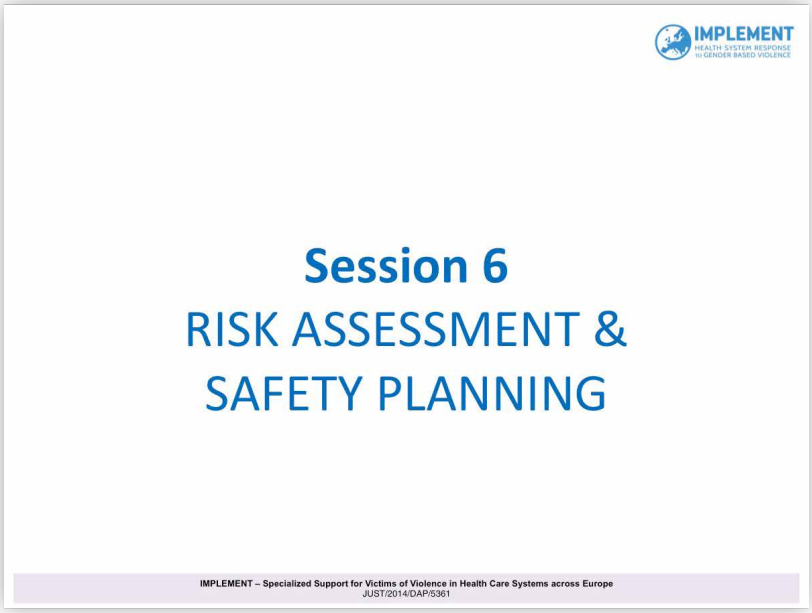

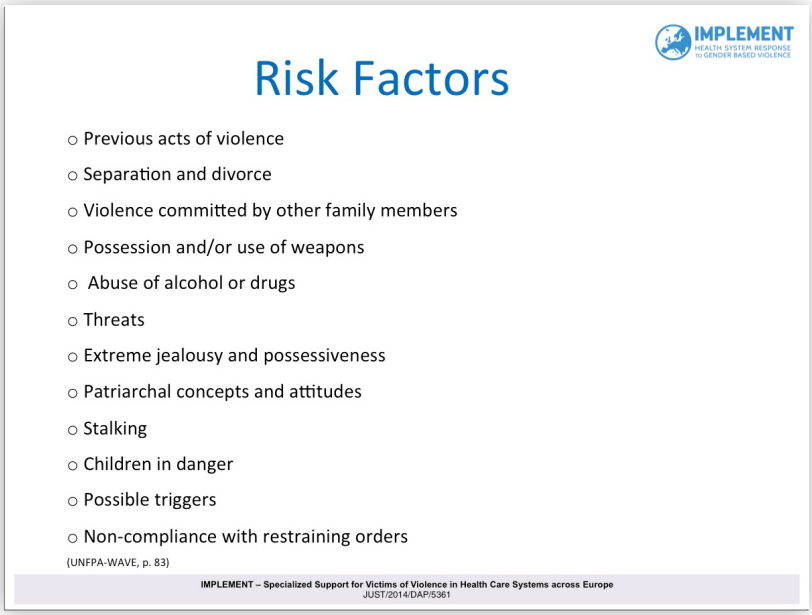

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DAY 2

Risk Assessment Questions

Safety - ask the patient

- "Is it safe for you to go home?"
- "What are you afraid might happen?"
- "What threats have been made?"
- "What about threats to the children, other family members, pets?"

Risk – ask the patient

- "Do you think that he/she will seriously injure you or the children?"
- "Most severe incident?" (most frightened or injured)
- "Are things getting worse?" (frequency, type, severity, escalation)

(IRIS Training, Bristol, UK, 2015)

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SPECSS

Separation/Child Contact: Leaving a violent partner is extremely risky.

Pregnancy: (pre-birth and under 1s): 30% of domestic violence and abuse starts in pregnancy

Escalation of Violence: Previous domestic violence is the most effective indicator that further domestic violence will occur. 35% of households have a second incident within five weeks of the first.

Cultural Factors: such as language barriers, immigration status, and isolation.

Stalking: Research finds that intimate relationship stalkers use more dangerous stalking behaviors than non-intimate relationship stalkers.

Sexual Assault: Where abusers use both physical and sexual violence, victims are at an elevated risk (Laura Richards, 2003)

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DASH

Domestic Abuse, Stalking and Harassment and Honor-based Violence

Risk Assessment

- Form to be filled out by all front line staff in cases of domestic abuse
- Identify risk factors, who is at risk, and decide what level of intervention is required
- Details of children resident at the address should be included
- Record the steps you have taken to ensure the immediate safey of the victim and children
- Ask yourself: „Am I satisfied that I have done all I can?"

www.dashriskchecklist.co.uk/

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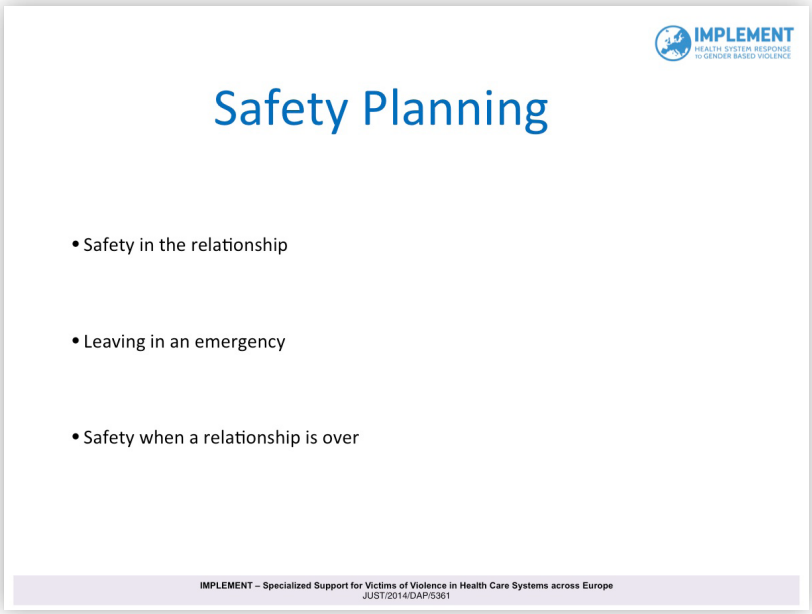
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Safety Planning
• Safety in the relationship
• Leaving in an emergency
• Safety when a relationship is over
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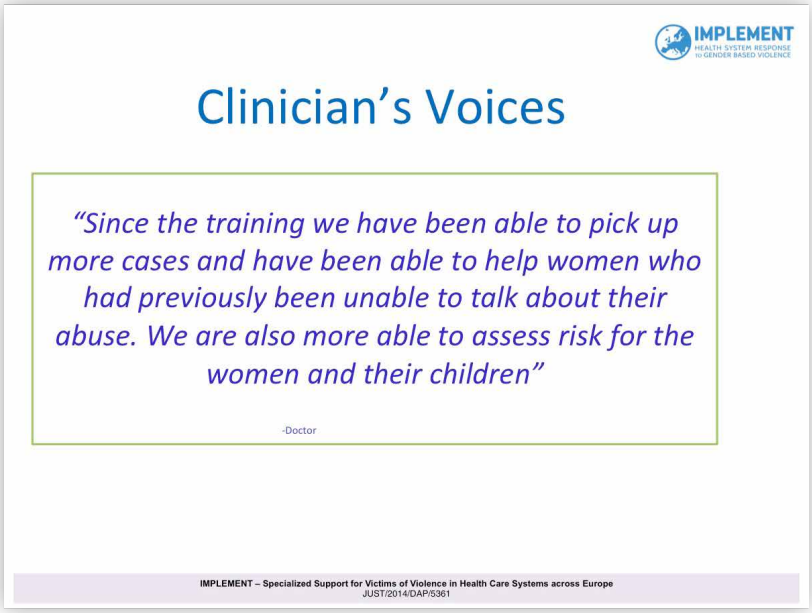
IMPLEMENT
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Clinician's Voices
"Since the training we have been able to pick up more cases and have been able to help women who had previously been unable to talk about their abuse. We are also more able to assess risk for the women and their children"
-Doctor
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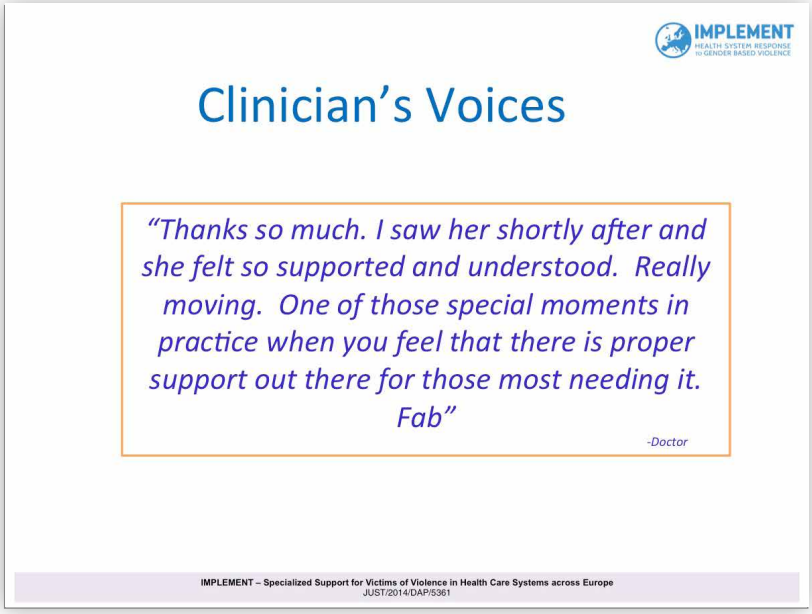
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Clinician's Voices
"Thanks so much. I saw her shortly after and she felt so supported and understood. Really moving. One of those special moments in practice when you feel that there is proper support out there for those most needing it. Fab"
-Doctor
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Referral Pathway

- **What is a referral?**

comprehensive institutional framework that connects various entities with well-defined mandates, responsibilities and powers into a network of cooperation

- aim of ensuring:
  - the **protection and assistance** of survivors, and to aid in their full recovery and empowerment;
  - the **prevention** of GBV;
  - the **prosecution** of perpetrators **(the so-called 3 p's)**

(UNFPA-WAVE, p. 88)

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Referring

- How and when should a referral be made?
- Dos and don'ts, for example: do offer a referral even if it has been declined previously; don't force someone to accept a referral
- Consult Fundamental Reference Sheet
- What is the referral process?
- Your role in the process of referring

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Fundamental Reference Sheet

- For all clinical leads to have in their health care setting as a reference to how to respond to GBV, including:
- Name and contact information of designated referral pathway (GBV advocate)
- Examples of questions (direct/indirect)
- "When is it safe to ask about GBV?" diagram
- What should be documented
- Red flags associated with GBV
- "Care pathway for GBV" diagram
- Elements of ensuring safety and security in the health system

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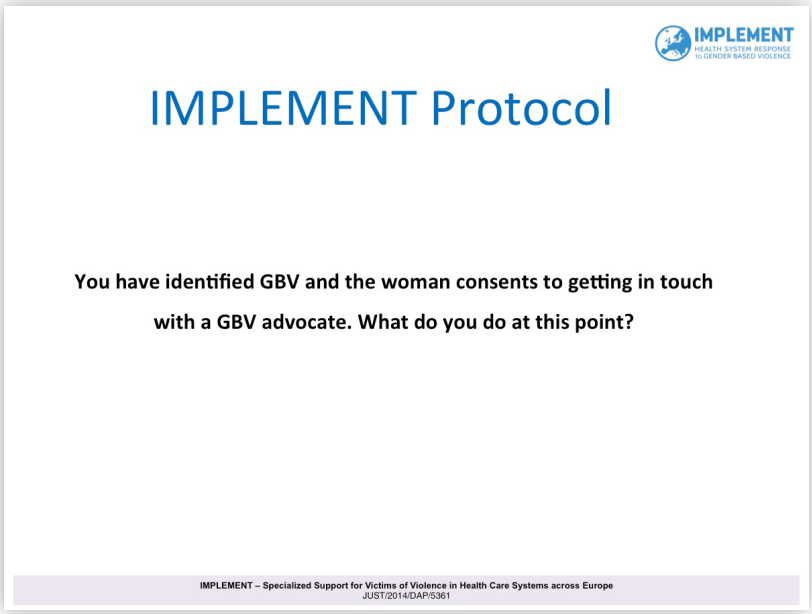
DAY 2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IMPLEMENT Protocol
You have identified GBV and the woman consents to getting in touch with a GBV advocate. What do you do at this point?
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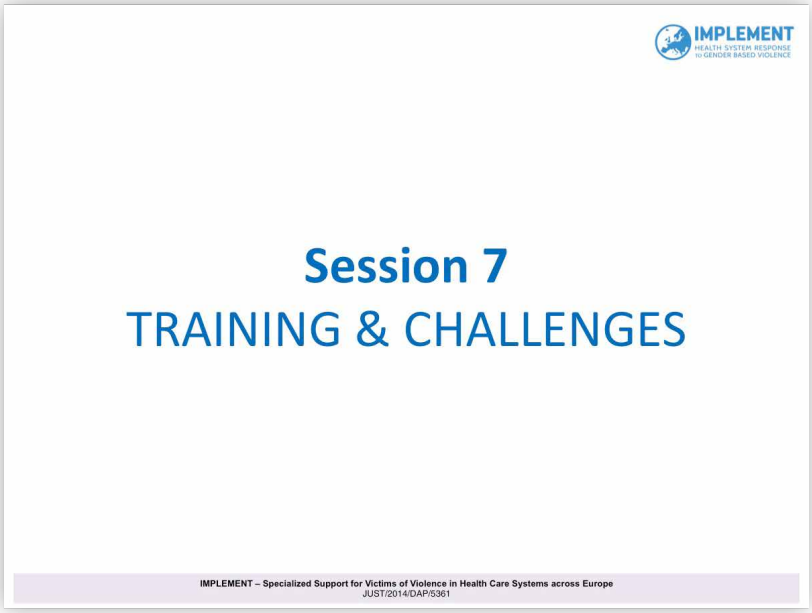
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Session 7
TRAINING & CHALLENGES
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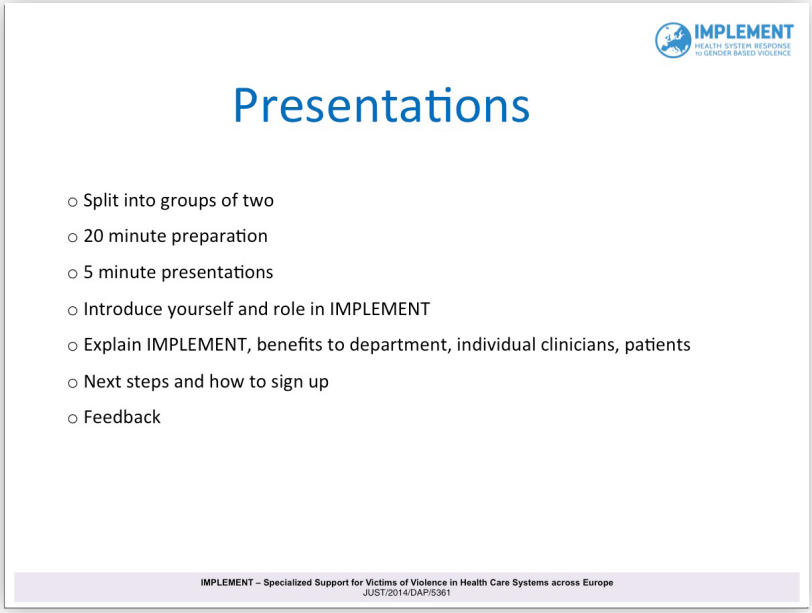
IMPLEMENT
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Presentations
Split into groups of two
20 minute preparation
5 minute presentations
Introduce yourself and role in IMPLEMENT
Explain IMPLEMENT, benefits to department, individual clinicians, patients
Next steps and how to sign up
Feedback
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Training Tips I

○ **Forget something?** Breathe deeply, take a moment, look at notes, carry on

○ **Feel nervous?** Imagine delivering to an interested, engaged audience – cement a positive image in your mind, make eye contact

○ **Don't know the answer to a question?** Pause, think, be honest, and say you will get back to them

○ **Someone disagrees with you?** Accept appropriate challenges and questions, do not take it personally, take a problem-solving approach

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Training Tips II

○ **Everyone asks a question at the same time?** Remind them of the group agreement (one person speaks at a time)

○ **Become flustered?** Look at the slide you are on, check notes, be in the moment (present), continue.

○ **Rushed through, people are disengaged?** Speak more slowly, leave longer pauses in between sentences, drink some water, revisit what you have just covered.

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Session 8
GBV ADVOCACY

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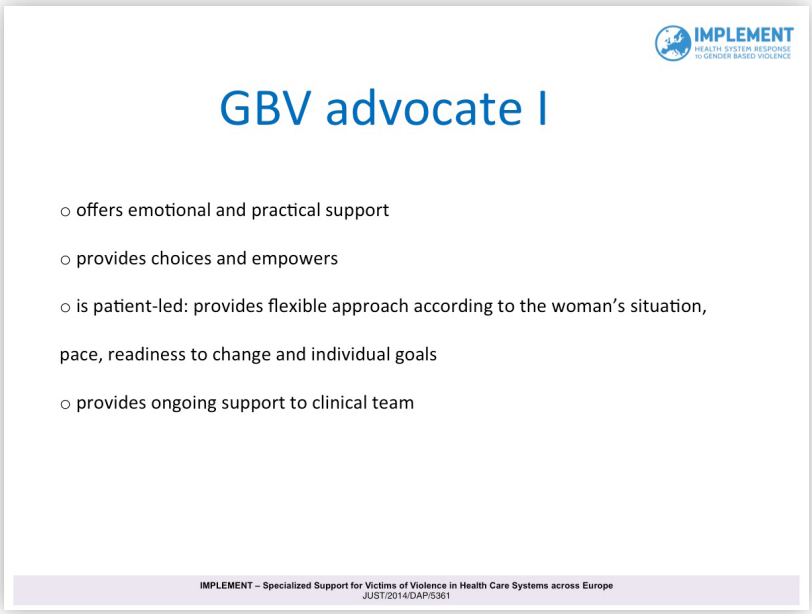
IMPLEMENT
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GBV advocate I
○ offers emotional and practical support
○ provides choices and empowers
○ is patient-led: provides flexible approach according to the woman's situation, pace, readiness to change and individual goals
○ provides ongoing support to clinical team
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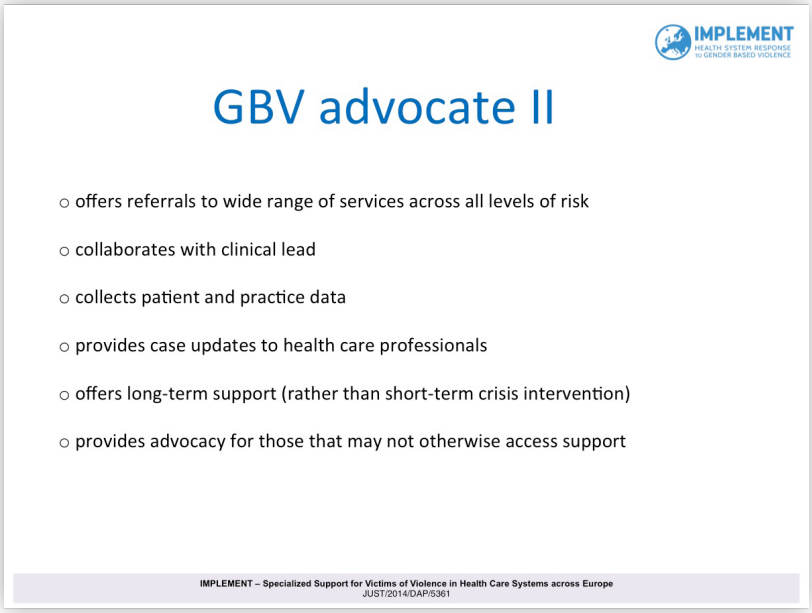
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GBV advocate II
○ offers referrals to wide range of services across all levels of risk
○ collaborates with clinical lead
○ collects patient and practice data
○ provides case updates to health care professionals
○ offers long-term support (rather than short-term crisis intervention)
○ provides advocacy for those that may not otherwise access support
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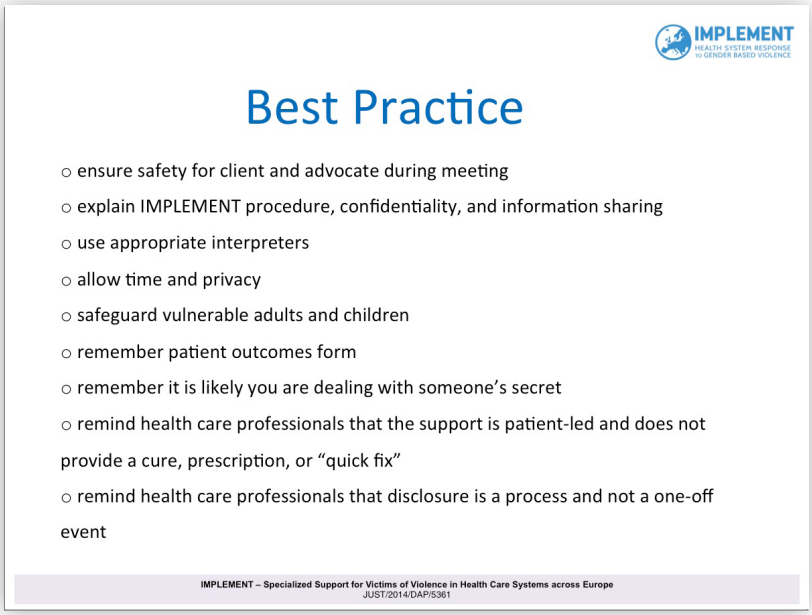
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Best Practice
○ ensure safety for client and advocate during meeting
○ explain IMPLEMENT procedure, confidentiality, and information sharing
○ use appropriate interpreters
○ allow time and privacy
○ safeguard vulnerable adults and children
○ remember patient outcomes form
○ remember it is likely you are dealing with someone's secret
○ remind health care professionals that the support is patient-led and does not provide a cure, prescription, or "quick fix"
○ remind health care professionals that disclosure is a process and not a one-off event
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Self Care

How do you look after yourself while working in the field of GBV?

1. **Physical**: eat regular meals, get enough sleep and rest, exercise, have a holiday
2. **Emotional:** watch a favourite film/listen to a favourite song, let yourself cry and laugh
3. **Professional:** maintain boundaries, go to regular supervision, balance life and work, set limits, take breaks throughout your day

Use the support offered via IMPLEMENT – check in with Gene and Medina

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Next Steps

- contact details of other GBV advocates and clinical leads
- your induction
- regular supervision
- ongoing contact with the IMPLEMENT team
- ongoing contact with Gene and Medina
- individual action plans

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Action Plans

Please think of and note down three actions that you are going to take away to work on.

Think about what the actions are, whether you need support of resources to address them, and who you can discuss this with.

Put a realistic timeframe on your actions, as well as a date to review them.

Remember to make your actions ***SMART***:
Specific, Measurable, Achievable, Realistic, within a Timeframe

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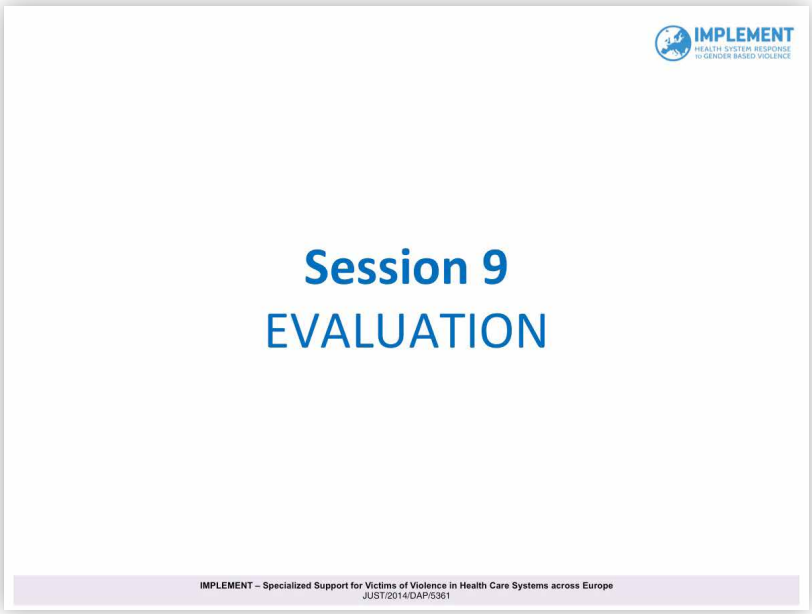

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NOTES

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