RESPONSE Training Manual for Reporting of Gender-Based Violence in Women's Health Services

Training Manual for health care teams

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GBV | RESPONSE
MULTI-AGENCY RESPONSE TO GENDER BASED VIOLENCE

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CONTENTS

PROJECT RESPONSE

1. GENDER-BASED VIOLENCE CORE CONCEPTS

1.1 Forms of Gender-based Violence (GBV) Against Women
1.2 Prevalence of GBV
1.3 Why is GBV a Health Problem?
1.4 The Roles of Health Care Teams in Addressing GBV

2. IDENTIFYING GENDER-BASED VIOLENCE IN THE WOMEN'S HEALTH SERVICES

2.1 Signs and Symptoms of GBV
2.2 Challenges in Addressing GBV
2.3 Recording and Documenting in Women's Health Services

3. COMMUNICATION SKILLS FOR HEALTH CARE TEAMS USING CONCEPTS OF MOTIVATIONAL INTERVIEWING

3.1 Principles for Developing Communication Skills
3.2 Principles of Communication for Health Care Providers: RULE
3.3 Ask. Listen. Inform

4. SAFETY PLANNING FOR PATIENTS DISCLOSING GBV CONDUCTED BY SOCIAL WORKERS

4.1 Understanding Risk
4.2 Carrying out a Risk Assessment
4.3 Safety of the Women and their Children
4.4 Supporting the Patient to Develop a Safety Plan

5. PATHWAYS FOR REFERRAL AND REPORTING

5.1 Referral Pathway Core Concepts and Benefits

6. RECOMMENDATIONS FOR ACTION. MULTI-SECTORIAL RESPONSE TO VIOLENCE

6.1 Policy Level sensitization and advocacy
6.2 Victim Protection Groups
6.3 RESPONSE Project Framework

TRAINING APPENDIX

The appendices contain a range of exercises and case studies, including role plays to support health care professionals to practice communication with and assessment of patients with experience of GBV. They include opportunities to practice asking the question around GBV, validating the response, carrying out a high-level risk and safety check and then offering referral to a specialist.

APPENDIX 1. EXERCISES AND CASE STUDIES

1. Continuum Exercise
2. Medical Power and Control Wheels Exercise
3. Case Study exercises
4 Motivational Interviewing exercises
5. Hand-out: risk indicators & safety planning
5.1 Hand-out: Safety Planning Form Example
6. Social Worker Exercise: What to do when...

APPENDIX 2. FUNDAMENTAL REFERENCE TOOL FOR HEALTH CARE PROFESSIONALS

APPENDIX 3. ADVANCED MOTIVATIONAL INTERVIEWING INFORMATION

APPENDIX 4. CAPACITY BUILDING SEMINARS. POWERPOINT PRESENTATIONS

PROJECT **RESPONSE**

Project RESPONSE is an EU-funded project taking place five European countries (Austria, Germany, France, Romania (project coordinator) and Spain) in order to increase disclosure within women's health services following training of health care teams, which will in turn lead to increased referrals to specialist gender-based violence (GBV) services and more safety planning. Capacity building activities are being implemented in the five countries with the support of GBV trainers, researchers and policy experts at the University of Bristol, and IRISi Interventions, UK, for the project evaluation, and training developments, respectively. More information about the Project and available tools can be accessed on the project RESPONSE website: **www.gbv-response.eu**. A main deliverable of the project is this RESPONSE Manual which aims to support the training of health care teams working in women's health services (health care professionals: medical doctors, nurses, midwives) side-by-side with social workers (GBV advocates, support workers, psychologists) to address GBV in the health setting. The Manual is available in five languages (English, French, German, Romanian and Spanish).

WHY DOES THE PROJECT TARGET HEALTH CARE STAFF WHO WORK IN WOMEN'S HEALTH SERVICES?

The response to GBV is not the responsibility of single groups of professionals. It requires partnership work across a range of professions and sectors. For the purpose of this project and manual, **women's health services** refers to obstetrics, gynaecology and sexual health clinics, the health care professionals working in these settings and medical facilities where female patients can be seen, assessed and supported for issues related to their health. These include maternity and obstetric services, gynaecology departments and sexual health services and clinics. Victims of GBV frequently report that they believe health care providers will ask about and identify the abuse they are experiencing and be able to offer validation, support and onward referral to specialist services. As such, health care professionals, including doctors, nurses and midwives, are in a unique position to support this vulnerable patient population, offer care around their physical and emotional health as well as provide a link to specialist GBV support services existing in their community. We know that patients with experience of GBV suffer the associated physical and mental health consequences long after the abuse has ended and that their quality of life can be diminished if they do not receive appropriate specialist support. Commonly, health care professionals do not receive training around GBV. They often miss the signs of abuse, do not ask women about the experience, and thus, fail to gather a complete history before treating the presenting problem. It is essential that health care professionals receive training to better understand GBV, to better communicate with and ask their patients if they are experiencing GBV, understand how to respond appropriately and know what their local, onward referral route is for specialist GBV support. We propose a multi-agency approach as no single service alone can respond to and support victims when they experience GBV event.

WHO IS THE RESPONSE TRAINING MANUAL FOR?

Women who experience GBV and go to health care services require a supportive and positive response, including a potential screening and onward referral to a GBV specialist. The manual aims to support the training of health care teams: health care professionals side-by-side with social workers, working in women's health services. The manual includes guiding information to improve the skills of health care teams to provide a comprehensive, patient-centred response. By health care professionals we refer to doctors, nurses, midwives, health visitors; particularly those working in gynaecology, obstetrics and sexual health at specialist or hospital level. Primary care professionals with roles in prenatal and postnatal care might also represent a group of health care professionals that could benefit from the training (country specific). Along with health care professionals, the health care team includes social workers (support workers, psychologists) who have the role of gender-based violence prevention advocates.

AS GBV ADVOCATES, SOCIAL WORKERS ARE:

- Specialists working in the field of GBV
- Have experience and training in supporting survivors
- Can carry out detailed risk assessments
- Can support survivors to create a safety plan and talk through options around their care and onward decisions
- Are well connected with local support services and can make onward referrals into other services in agreement with the survivor they are supporting
- Have confidence and competence to work within the health setting and with health care professionals
- Are receiving good supervision from within the GBV sector to prevent repeat trauma

1. 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**[1], is a ground-breaking 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.

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.[1,2] 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.[3]

1.1. FORMS OF GENDER-BASED VIOLENCE

GBV encompasses a wide range of acts, including physical, sexual, psychological and economic violence as well as coercive control. It is important for health professionals to understand and recognize the full range of acts that may constitute GBV (*see Table 1*).[4]

TABLE 1: FORMS OF GENDER-BASED VIOLENCE[5]

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.[6] Acts of sexual violence can include:

[1] Council of Europe, "Convention for the Prevention of Violence Against Women and Domestic Violence", the Istanbul Convention, (2011), and ratified in 2014, http://www.coe.int/en/web/istanbul-convention
[2] Convention on the Elimination of all Forms of Discrimination Against Women. (1992).
[3] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia". (2014), p. 18.
[4] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia". (2014), p. 20.
[5] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia". (2014), p. 20.
[6] World Health Organization (WHO), "World Report on Violence and Health" (2002). p. 149.

	• 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
COERCIVE CONTROL	Coercive behaviour is: • An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim Controlling behaviour 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 independence, resistance and escape and regulating their everyday behaviour

[7] Council of Europe, "Convention for the Prevention of Violence Against Women and Domestic Violence", the Istanbul Convention, (2011), and ratified in 2014, http://www.coe.int/en/web/istanbul-convention

1.2. PREVALENCE OF GBV

The 2013 World Health Organisation (WHO)[8] report on violence against women and the health effects of intimate partner violence and non-partner sexual violence details that overall, 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. While there are many other forms of violence that women may be exposed to, this already represents a large proportion of the world's women. Most of the violence is intimate partner violence. Worldwide, almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. In some regions, 38% of women have experienced intimate partner violence. Globally, as many as 38% of all murders of women are committed by intimate partners. In the UK, the percentage rises to 56%.

1.3. WHY IS THIS A HEALTH PROBLEM?

GBV is an abuse of human rights, a major public health problem with devastating health consequences and enormous costs and challenges to health care services internationally. This is because GBV is linked to a host of different health outcomes and is a risk factor for a wide range of both immediate and long-term conditions. The health impacts may show as physical symptoms, injuries, chronic pain, neurological symptoms, gastrointestinal disorders, gynaecological problems and increased cardiovascular risk. GBV may lead to unintended pregnancies, gynaecological problems, induced abortions and sexually transmitted infections, including HIV[9]. Miscarriage, stillbirth, pre-term delivery and low birth weight are other possible effects of GBV during pregnancy[10]. The patient may be depressed, self-harm, have post-traumatic stress disorder (PTSD), anxiety, insomnia, increased substance use and have thoughts about suicide. Cessation of abuse does not necessarily mean that mental health problems cease as well. The influence of abuse can persist long after the abuse itself has stopped and the more severe the abuse, the greater its impact on physical and mental health. Less well recognised are dental problems and dental neglect (due to dental phobia). GBV can also start or escalate in pregnancy with the most serious outcome being the death of the mother or the foetus. Less recognised are the impacts of unintended pregnancy and the risks for pre-school children.Health care services spend more time dealing with the impact of violence against women and children than almost any other agency and they are often the first point of contact for women who have experienced GBV. The health service can play an essential role in responding to and helping prevent further GBV by intervening early, providing treatment and information and referring patients to specialist services. Thus, health care professionals are in a unique position to help those who experience GBV to get the support they need.

1.4. THE IMPACT OF GBV ON CHILDREN

GBV is a major indicator of risk to children and young people. In the UK, Department of Health figures indicate that nearly three quarters of children who are subject to a child protection plan live in households where domestic violence occurs[11]. In addition, 75% of incidents are witnessed by children[12].

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[8] WHO. "Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence", (2013) p. 2. http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/

[9] Haddad L, Shotar A, Younger J, Alzyoud S, Bouhaidar CM. "Screening for domestic violence in Jordan: validation of an Arabic version of a domestic violence against women questionnaire." International Journal of Women's Health. (2011), p. 79-86.

[10] Halpern CT, Spriggs AL, Martin SL, Kupper LL. "Patterns of Intimate Partner Violence Victimization from Adolescence to Young Adulthood in a Nationally Representative Sample". Journal of Adolescent Health. (2009), p. 508-516.

[11] Department of Health. Women's mental health: into the mainstream. London, Department of Health, (2002) http://webarchive.nationalarchives.gov.uk/20111010181537/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4075487.pdf, p16

[12] Royal College of Psychiatrists. Mental health and growing up, 3rd edition: Domestic violence: Its effect on children. Royal College of Psychiatrists, (2004).

Children's responses to the trauma of witnessing GBV may vary according to a multitude of factors including but not limited to age, race, sex and stage of development. If children do not feel safe in their own home this can have many negative physical, emotional and behavioural effects. These include physical health complaints, developmental delays, anxiety, depression, aggression or anger towards adults and peers, eating disorders, poor school performance, low self-esteem, difficult behaviours and nightmares. GBV may also directly or indirectly cause child mortality. Children can be abused directly, indirectly and may also witness the health consequences that their parents experience. With support, children can make sense of what is happening and do not have to be scarred permanently by their experiences.

1.5. THE ROLES OF HEALTH CARE TEAMS IN ADDRESSING GBV

The number of women spontaneously disclosing their experience of violence is low as their safety is often at stake and health care professionals are not trained in how to ask about violence. Active asking about GBV by health care professionals, through clinical enquiry/screening, is needed to help survivors of GBV to disclose[13]. In turn, once the health care professional has asked about GBV and received a disclosure, a safety plan for referring the survivor into specialist support needs to be in place. Thus, women's health care systems in Europe remain a key but under-utilised entry point through which survivors of gender-based violence can be identified and reported to specialist services. Furthermore, it is often the health care professionals who have the most contact with survivors6. Routine perinatal care visits offer crucial opportunities for healthcare professionals to screen, report and refer abused women to specialist services. However, health care professionals lack the skills needed in identifying and referring pregnant women experiencing abuse. **RESPONSE aims to support these and to equip the health care teams with the necessary tools to ask patients about GBV, respond, refer on if appropriate and record the disclosure in the patient's medical record.** It is the responsibility of health care professionals to ensure that their staff are trained and equipped to provide first line support around GBV. RESPONSE introduces the partnership model of working; whereby there is shared responsibility for the support and best care of patients with experience of GBV. Health care professionals need to recognise when they ask about GBV and how to provide an initial response and safety check. A smooth referral pathway to specialist workers is needed. These workers can offer a full assessment and either offer support to the patient themselves or offer a referral to other specialised women services.

In RESPONSE, the social worker can take up the role of specialised support. Each country and health care setting will have its own social worker who may be known by a different title, e.g. advocate, support worker, outreach worker, social worker. The function of such staff needs to include:

- A private space to meet and speak
- An interpreter if required who is not from the victim's family
- A survivor-centred approach
- Validation of the patient's experience
- Identification of GBV
- Risk assessment and safety planning
- Follow-up care both for health and GBV related issues
- Clear contact details for next steps

[13] García-Moreno C, Hegarty K, Flavia A, d'Oliveira L, Koziol-MacLain J, Colombini M, Feder G, "The health-systems response to violence against women". Lancet. (2015), p. 1567-1579.

2. IDENTIFYING GENDER-BASED VIOLENCE IN WOMEN'S HEALTH SERVICES

Facilitating **disclosure** of GBV is an important starting point for any health care based intervention. Asking about GBV, when done in a professional and supportive manner, counters feelings of isolation, guilt, and shame that survivors of violence may experience, and also helps to convey the message that help is available and that the patient may use it if she feels ready.[14]

The health care professional, in whatever health care setting, needs to know how to:

- Ask about GBV
- Give a validating and understanding response
- Carry out a safety check
- Offer a referral to a local specialist for support
- Record the discussion in the patient's medical record

In health care settings two approaches are used to facilitate the disclosure of GBV: universal screening and case finding.[15]

Universal Screening: also known as routine enquiry, is routinely asking all 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.[16] **Case-finding is based on selective and careful clinical consideration, particularly when health staff are specially trained in how to best respond and refer**.

The RESPONSE project is following the 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"[17] , thus, using the case-finding approach.

Screening is considered to be good practice in obstetric services. The training of all staff in effectively asking about GBV needs to be ensured.

In settings where the screening model is promoted, attention is needed to ensure that health care professionals working in these settings are asking sensitively and actively rather than mechanically and simply "going through the motions". Open questions should be asked and follow up questions are encouraged to ensure clarity. Women should never be asked about GBV when accompanied or in the presence of family members or children over 2 years old. A way to speak with the woman alone must be found and issues of confidentiality and when that confidentiality can be broken, e.g. in case of disclosure of child abuse or harm to another, must be explained clearly.

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

Women need to feel that if they disclose, their disclosure will be taken seriously, managed sensitively and positively while support will also be offered to them. There is understandable fear around reporting and asking for help when women are pregnant and if they already have children, as they may fear that their parenting capabilities are called into question. Fears of removal of their children, involvement of social care and escalation of abuse if their abuser finds out that they have disclosed are present. Women need to be supported to share information and seek the help they need. Each country will have its own thresholds for involvement of statutory services in cases of GBV where children, babies and unborn children are involved.

2.1. SIGNS AND SYMPTOMS OF GBV

GBV can impact all aspects of women's 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[18].

The 2013 World Health Organisation (WHO) report[19] on violence against women and the health effects of intimate partner violence and non-partner sexual violence recognises the consequences of the violence on women's emotional, physical and reproductive health. Women who have been physically or sexually abused by their partners report higher rates of a number of important health problems. They are:

- 16% more likely to have a low-birth-weight baby
- More than twice as likely to have an abortion
- Almost twice as likely to experience depression
- In some regions, 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence

The diagram on the next page highlights the impact on health of intimate partner violence as evidenced in the WHO report.[20]

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[18] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014), p. 39.
[19] WHO, "Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence". (2013), p. 2.
[20] WHO, "Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence". (2013), p. 8.

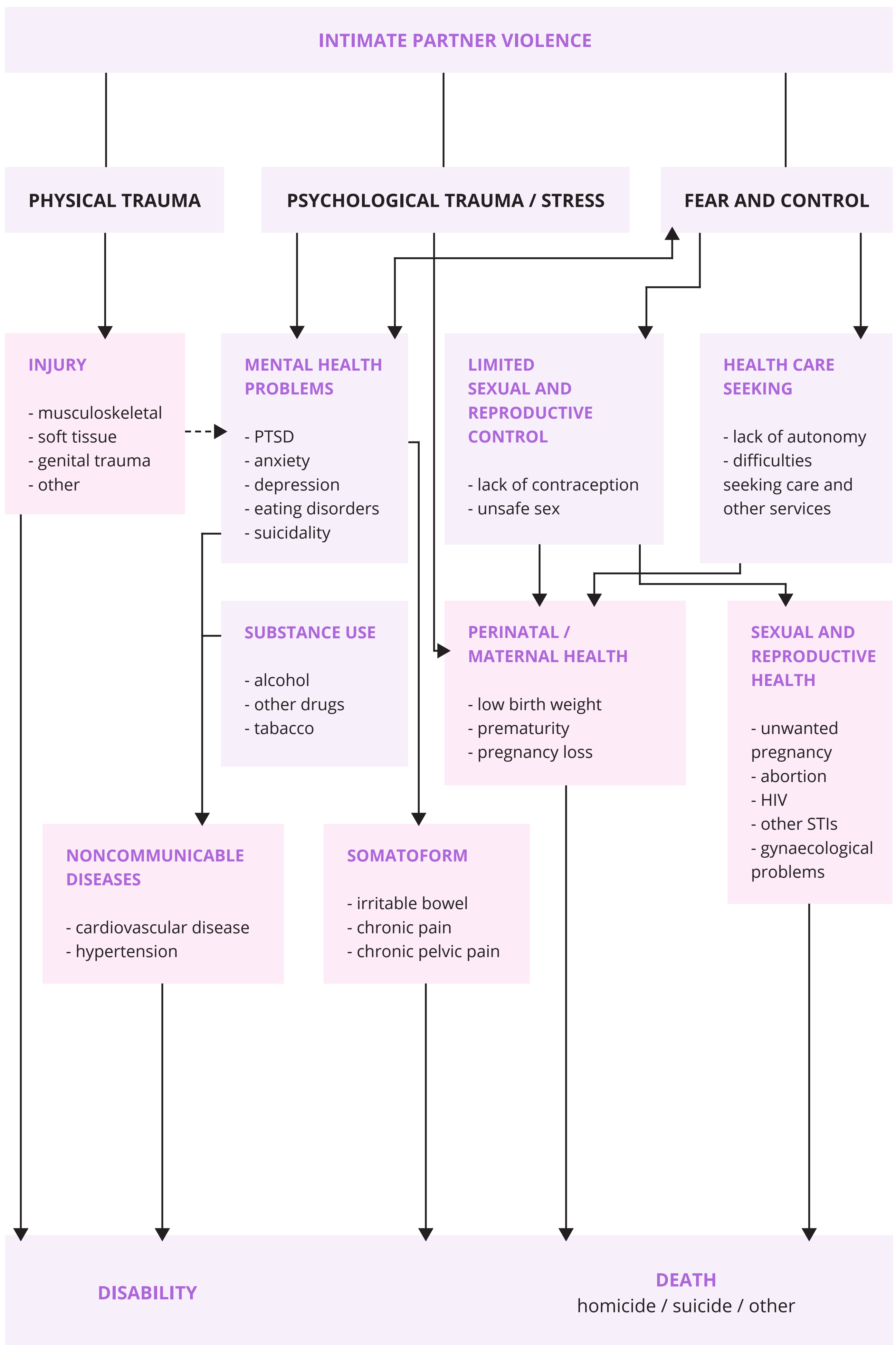

Figure 1. Pathways and health effects on intimate partner violence

Valpied and Hegarty[21] summarise the health impacts in the table below which highlights how pervasive the impact of GBV is across all aspects of health. The situational section of the table recognizes the wider impact of GBV on the life of the victim, her family, the local health care service.

TABLE 2: POSSIBLE HEALTH INDICATORS OF INTIMATE PARTNER ABUSE

Physical	Gynecological / Reproductive Psychosocial	Psychosocial	Situational
• Chronic gastrointestinal symptom • Chronic diarrhea • Chronic abdominal pain • Chronic headaches • Other chronic pain, especially where unexplained • Unexplained hearing loss • Injuries, especially to head/neck or multiple regions • Bruises in various stages of healing • Lethargy	• Chronic pelvic pain • Sexual dysfunction • Vaginal bleeding (especially repeated cases) • Frequent bladder or kidney infections • Sexually transmitted infections • Multiple unintended pregnancies/ terminations • Miscarriages • Delayed prenatal care • Low infant birth weight	• Anxiety • Depression • Eating disorders • Panic disorders • Post-traumatic stress disorder • Sleep disorders • Somatoform disorters • Alcohol or other substance misuse • Suicide ideation or attempts • Self-harm	• Frequent healthcare service use and/or hospital admissions • Frequent/high-level medication use • Abuse of a child in the family • Delays in seeking treatment • Not following through with treatment and/or appointments • Inconsistent, implausible or vague explanation of injuries • Partner who is intrusive or overattentive in consultations • Social isolation • Recent separation or divorce from (ex) partner

[21] Valpied J, Hegarty K, "Intimate partner abuse: identifying, caring for and helping women in healthcare settings". Women's Health. (2015), 11(1), p. 51-63.

SIGNS AND SYMPTOMS SPECIFIC TO OBSTETRICS

GBV is a major cause of maternal and foetal death. A number of factors should raise concerns about experience of GBV in pregnant women[22]:

- Patient books late or does not attend clinics
- Patient repeatedly attends with minor problems or has repeat admissions
- Patient does not complete treatment or self-discharges
- Patient is depressed, anxious or self-harms (high levels of symptoms of perinatal depression, anxiety, and PTSD are significantly associated with having experienced domestic violence[23]
- Patient presents with injuries, in particular to abdomen, breasts, inner thighs, head and neck. She may try to persuade the health care professional that these are not very serious.
- Patient experiences frequent vaginal discharge, post-coital bleeding, urine infections or pelvic pain
- Patient experiences recurrent miscarriages, unexplained stillbirths or pre-term labour
- There is intrauterine growth restriction or low birth weight
- The pregnancy is unplanned or unwanted
- Patient makes a termination request or has undergone multiple terminations
- Patient may have problematic substance use or be unable to stop smoking

In addition, women who experience GBV are more likely to have obstetric complications including[24]:

- Premature labour
- Stillbirth
- Low birth weight baby
- Antepartum haemorrhage
- Chorioamniotis

Violence occurring during pregnancy poses a danger to both the woman and her unborn child. Among the respondents to the European Agency for Fundamental Rights (FRA) 2014, Violence Against Women study, who were pregnant during the relationship with their partner and who experienced violence in the relationship, 20% of the victims of current partner violence and 42% of victims of previous partner violence say that physical or sexual violence also took place during pregnancy.[25]

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[22] Lewis et al., "Why Mothers Die 2000-2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom". (2004), available at: http://www.hqip.org.uk/assets/NCAPOP-Library/CMACE-Reports/33,2004-Why-Mothers-Die-2000-2002-The-Sixth- Report-of-the-Con dential-Enquiries-into-Maternal-Deaths-in-the-UK.pdf.

[23] Howard L M, Oram S, Galley H, Trevillion K, Feder G, "Domestic violence and perinatal mental disorders: a systematic review and meta-analysis". PLoS Med. (2013), 10: e1001452.

[24] Bewley S, Welch, J, eds. "ABC of domestic and sexual violence". John Wiley & Sons. (2014), p. 69-72.

[25] FRA, "Violence against Women: An EU-wide survey". Brussels, FRA. (2014), p. 46.

TABLE 3: WOMEN WHO WERE PREGNANT DURING THE RELATIONSHIP WITH A VIOLENT PARTNER, AND WHETHER OR NOT THE PARTNER WAS VIOLENT AGAINST THEM DURING PREGNANCY (%)

Pregnancy and violence

Violence occurring during pregnancy poses a danger to both the woman and her unborn child. Among the respondents who were pregnant during the relationship with their partner and who experienced violence in the relationship, 20% of the victims of current partner violence and 42% of victims of previous partner violence say that physical or sexual violence also took place during pregnancy.

Violence against women: an EU-wide survey - Main results

	Partner violent during the pregnancy (%)	Partner not violent during the pregnancy (%)	No answer (%)	Total (%)	*n*
Current partner	20	77	2	100	1,762
Previous partner	42	56	1	100	3,120

Note: Taken individually, the sum of categories "Partner violent during pregnancy", "Partner not violent during the pregnancy" and "No answer" can differ from the total indicated in the table by +/- one percentage point. The difference is due to rounding.

Source: FRA gender-based violence against women survey dataset, report in 2014

The FRA 2014 report states that, *"Healthcare professionals need to be aware of the vulnerability of pregnant women to violence so that they are in a position to effectively address this."*[26] Measures could be taken to encourage antenatal care providers to routinely check if a woman is at risk of violence, when they present at check-ups at the women's health services. Existing good practices could be identified at the Member State and EU levels. **RESPONSE supports these measures and recommends to be included in the health care settings where the project is being implemented**.

SIGNS AND SYMPTOMS SPECIFIC TO GYNAECOLOGY

The most consistent, longest lasting and largest physical health issues in women who experience GBV are gynaecological problems. Those who experience GBV have a three times increased risk of gynaecological problems and the worse the combination of physical and sexual abuse is, the worse are the health problems are confronting with27.

Women experiencing GBV may repeatedly fail to attend for cervical smear tests and are at increased risk of conditions including[28]:

- Menstrual disorders
- Pelvic pain
- Pain during intercourse
- Vaginal discharge
- Pelvic inflammatory disease
- Post-coital bleeding

Women who experience GBV have a three times increased risk of gynaecological problems.

[26] FRA, "Violence against Women: An EU-wide survey". Brussels, FRA, (2014).
[27] Campbell J et al., "Intimate Partner Violence and Physical Health Consequences". Arch Intern Med. (2002, 162(10), p. 1157-1163.
[28] Bewley S, Welch J, eds., "ABC of domestic and sexual violence". John Wiley & Sons. (2014), p. 69-72.

SIGNS AND SYMPTOMS SPECIFIC TO SEXUAL HEALTH[29]

Young women who are experiencing GBV may be more likely to attend sexual health clinics than other health settings. Street sex workers in abusive relationships are at continuing risk of sexually transmitted infection (STIs), violence and abuse.

Women experiencing GBV may present to sexual health services or women's health services for a variety of reasons:

- Vaginal discharge
- Following rape
- After being forced to have sex with others for the financial gain of her partner
- With a sexually transmitted infection caught from her partner
- Concern about HIV status

Also, women affected by GBV are often not allowed to manage their own fertility. Reproductive coercion involves behaviours that a partner uses to maintain power and control in the relationship and that are related to reproductive health.

Perpetrators may try to control contraception use either by forcing it to be taken or more usually preventing it from being taken or destroying it. Women living in violent and abusive relationships may be very fearful of becoming pregnant and are more likely to have an unintended pregnancy than women who are not experiencing GBV. A patient who attends repeatedly requesting contraception or emergency contraception should be asked about her relationship and asked directly whether she is experiencing GBV. Long acting reversible contraception should be discussed.

2.2. CHALLENGES IN ADDRESSING GBV

Health care professionals face barriers in asking and supporting women effectively around the issue GBV. Some of these barriers, considered for both patients and professionals, are summarised below:

BARRIERS FACED BY HEALTH CARE PROFESSIONALS IN PROVIDING EFFECTIVE SERVICES TO SURVIVORS OF GBV[30]:

- Insufficient knowledge about causes, consequences and dynamics of GBV
- Own attitudes and misconceptions
- Own experiences of GBV
- Lack of clinical skills in responding to GBV and so reluctance to ask as unsure of what to do next
- Lack of information about existing support services
- Lack of time for medical care for presenting problem let alone dealing with subsequent GBV disclosure
- Lack of internal protocols around GBV including asking, responding and documenting
- Uncertainties about rules around confidentiality and statutory reporting duty.
- Absence of standard procedures, policies and protocols to ensure that health professionals' response to all survivors of GBV follow standards of good clinical care
- Concern over what happens once a disclosure has been made and not knowing who the health care professional might speak with or who else might become involved, e.g. police

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[29] *genitourinary medicine*.

[30] UNFPA-WAVE, "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia". (2014), p. 183.

BARRIERS FACED BY WOMEN SURVIVORS IN ACCESSING WOMEN'S HEALTH SERVICES AND DISCLOSING VIOLENCE[31]:

- Shame, guilt, and the feeling to be solely or partly responsible for the violence
- Fear of reprisals from the perpetrator
- Fear of stigma and social exclusion by their families and communities
- Fear of social isolation and the feeling of having to deal with the experienced violence all by themselves
- Low self confidence and self-esteem
- 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)
- Lack of privacy during appointments and so unable to speak with heath professional alone
- Concern over not being believed because of negative response of professionals in the past

ADDITIONAL BARRIERS FACED BY WOMEN BECAUSE OF ISSUES OF DIVERSITY INCLUDE:

- Lack of physical access to any health care services for women living in remote areas
- Language and cultural barriers faced by migrant women and women belonging to ethnic minorities
- Fear of drawing attention to irregular immigration status or of losing status following separation from a violent spouse
- Concern over ongoing support if the perpetrator is the person who looks after the woman if she has a disability
- Stigma or disbelief if a woman is in a same sex relationship
- Incorrect assessment by health care professionals that some cultures and communities accept GBV

IN ORDER TO DECREASE SOME OF THESE BARRIERS, HEALTH CARE PROFESSIONALS SHOULD CONSIDER THE FOLLOWING:

- Let a woman know that she is not to blame or responsible for what is happening and that no one deserves to be treated that way. Tell her that she does not have to deal with the problem alone and that there are local organisations that have years of expertise in supporting women experiencing violence in relationships. Provide her the details when you discuss with her and provide her the local helpline number. The specialist organisations provide practical and emotional support and may have refuge space if a woman wishes to leave and has nowhere to stay. They can advise on legal matters and housing needs. The woman does not have to leave her home to be referred onto these organizations. Sometimes making contact or visiting the organisations gives women the support they want – or the familiarity to make leaving possible the next time violence occurs.

- Provide ongoing support and keep the lines of communication open. Ask her how things are going at subsequent appointments and whether there is anything she is concerned about that she wishes to discuss. If possible, make arrangements so that you see her for the remainder of her care. This will facilitate ongoing support and communication. You will also be able to keep track of any changes occurring, e.g. if the violence gets worse.

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

The woman must lead the process of change at her own pace and with support to outline her options and choices (Chapter 3, presents more information). All women's health staff have a responsibility to act in the woman's interest, but not to decide in her place. She is the only person who knows what is best for her. She is the only person who has all the information about her situation. If a woman decides to stay with her violent partner, you have not failed. By remembering that our intervention is only part of the process, we hopefully reduce the pressure on staff and prevent anyone feeling that they must try and immediately solve the situation.

IF SHE DISCLOSES AND HER PARTNER IS WAITING OUTSIDE ROOM:

- Do not discuss the violence in depth. The partner may become suspicious and walk in mid conversation.
- It is safer to limit the conversation, without making the woman feel as though you are not interested. Offer the woman referral information and arrange another appointment to discuss it fully, when it is safer. Try to arrange the next appointment at a time when her partner cannot make it.
- Find out how to reach her safely to discuss things further at another time. Perhaps there is a trusted friend or family member that could take a message for her. You could arrange to meet her at their home if she feels it is safer.[32]
- Make sure the woman feels OK before inviting her partner into the room. Women who experience domestic violence often say that they fear that their partner will find out they have told someone, provoking further violence.
- Help her to prepare an answer in case her partner questions her about what was discussed during the confidential time. It is fine to make up a story with her - perhaps reference to a previous health concern. The important point is that the woman feels safe and prepared to carry on with the appointment.

IF SHE DISCLOSES DO NOT:

- Give her direct advice, or tell her to leave him.
- Tell her to defend herself or hit him back.
- Take action without her consent - or discuss what she has said with other colleagues without her permission (except if child protection issues mean you need to contact a social worker; and then you can still inform her).
- Ask her why she puts up with it or what she has done to make him hit her.
- Trivialise the abuse or minimise the danger (by not taking her seriously or telling her she should not put up with it).
- Expect immediate results.
- Try to solve the woman's problem for her.
- Let the abuser know that your patient has disclosed abuse.

Leaving a violent relationship requires planning and preparation in order for the woman to be safe. You may place the woman at risk of further violence if you coerce or pressure her to leave her partner before she is ready.

[32] Taking into consideration the specificity of your setting, resources and/or existing services.

2.3. RECORDING AND DOCUMENTING IN WOMEN'S HEALTH SERVICES

Documentation is an essential part of best clinical practice and good patient care. Notes and records must be clear and accurate in order to provide any health care professional involved in a woman's care with a snapshot understanding of what happened in each consultation in terms of:

- History
- Who was present
- Who said what
- Health findings both negative and positive
- The medical care plans
- How concerns were addressed

EXAMPLES OF QUESTIONS TO ELICIT INFORMATION:

- That looks painful. How did that happen?
- Has someone hurt you? Please tell me some more about that.
- Has anyone threatened you?

When recording these answers, remember that the best possible notes will help if a statement is required in the future or if evidence needs to be given in court.

TABLE 4: SKILLS HEALTH CARE PROFESSIONALS NEED WHEN DOCUMENTING A CONSULTATION WITH A VICTIM OF ABUSE[33]

DO	DON'T
Write notes at the time or immediately after the consultation	Leave writing notes until the end of a shift
Write clearly and legibly	Take a detailed history. Stick to the facts.
Stick to the facts and be objective	Ask leading questions
Explain confidentiality to your patient and the limits of confidentiality, e.g. if a safeguarding risk is disclosed; that everything you are told, could be disclosed in court	Be selective about what you write down. Document all detail you are told in response to your questions.
Concentrate on what was done, where, when and by whom	Use non-approved abbreviations or write illegibly. You or another person will struggle to understand the notes if they are required for future statements or court.
Record information from third parties, e.g. "The patient's mother told me that..."	Be judgmental or paternalistic
Record relevant information verbatim, "He punched me in the face and my nose began to bleed.)	
Document who was present at the time of the consultation	
Sign all notes	
Date all notes	
Document a clear management and care plan	
Treat your patient with care and sensitivity	

[33] Bewley S, Welch, J, eds., "ABC of domestic and sexual violence". John Wiley & Sons. (2014), p. 74-82; p. 87-90.

According to the local facilities available, a patient who is assumed to be sexually abused or assaulted may be referred to a special centre for forensic examination. A forensic examination aims to be performed as a detailed history and physical examination but also aims to collect carefully information and elements referring to the perpetrator. This examination is different from other types of examinations that occur elsewhere in medicine. According to the local regulations special forms and recording procedures should be followed to record the sexual assault. Care providers need to be familiarized with local provisions and centres.

There is an agreed language when assessing a patient for physical injuries in terms of words, descriptions and documentation. Any notes made must be clear for all other health care professionals to understand in the future. The key elements of best practice are outline below[34]:

- Document everything you see. Some things may not be related to the assault and it is not for you to decide this.
- Always use accepted medical descriptions, e.g. abrasion.
- Always use standard anatomical nomenclature, e.g. left iliac fossa.
- Use anatomical body sketches or diagrams to record injuries.
- Measure the injury, mark it on the diagram and describe it, e.g. round yellow bruise 2.8x2.8cm, 5cm
- above the olecranon on the posterior aspect of the right arm.
- There are often no physical injuries following sexual assault, document the absence of injuries.
- Take your time.

Do not under-estimate the shock the patient may be in. She may need emotional support as well a care around physical injuries. Do not under-estimate the effect that this sort of consultation may have on the health professional involved in the case.

[34] Bewley S, Welch, J, eds., "ABC of domestic and sexual violence." John Wiley & Sons. (2014), p. 87-90.

3. COMMUNICATION SKILLS FOR HEALTH CARE TEAMS USING CONCEPTS OF MOTIVATIONAL INTERVIEWING

Health care providers can support survivors of GBV, to disclose experiences of GBV. The communication style practitioners use during practitioner-patient interaction is vital in supporting GBV survivors and in facilitating change. Health care providers can play an active role in GBV behavioural and social change. This chapter presents Motivational Interviewing (MI), a counselling approach which has been used in psychotherapeutic practice and in numerous clinical trials for various health problems in which motivation and behavioural change was needed. The chapter presents what are the MI principles and what are the MI skills and techniques health practitioners can use during practitioner-patient interaction, in order to establish and increase patients' trust and to have open discussion with their patients in a non-intrusive way.

MI is rather new to the field of GBV. Using some elements of MI when working with GBV survivors might be a challenge as most health care providers are not trained in this communication strategy. However, health care providers are more familiar with the Stages of Change Model – a model on which MI was built - and this is a good basis from which to begin learning about the MI approach. Health care providers must always check in with patients where they are in their experience of and journey through GBV, before beginning working with them.

Disclosing violence is difficult. We suggest that training health care teams to improve consultations styles should be added to any training of health care providers to improve disclosure and empower changes in dealing with GBV by survivors. If possible experience counsellors in MI should be involved.

3.1. PRINCIPLES AND EVIDENCE FOR DEVELOPING COMMUNICATION SKILLS

Definition. MI is defined as a "collaborative, person-centred form of guiding, to elicit and strengthen motivation for change"[35]. This goal-oriented communication method is used for behavioural change and works by eliciting people's own motivation for change and strengthening their commitment to change[36]. MI was developed by psychologists for counselling purposes, and partly to be used for training in general practice. Health care providers can use elements of motivational interviewing in their own daily practice to help patients find their motivation to change behaviours in the interest of their own health[37]. Certain principles of MI may be useful to apply during consultations between the patient and GBV advocates such as a social worker and between the health care providers and GBV advocate during Victim Protection Group meetings (concept of Victims Protection Group is detailed in chapter 6.2).

Exposure to GBV can lead to difficulties in establishing trust with health care providers. By using appropriate communication methods presented in MI, health care providers can increase referral of GBV in women's health settings.

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[35] Miller WR, Rollnick S, "Ten things that motivational interviewing is not. Behavioural and cognitive psychotherapy". (2009), 37(02), p. 129-140.
[36] Rollnick S, Miller WR, Butler CC, Aloia MS, "Motivational interviewing in health care: helping patients change behaviour". (2008), p. 12.
[37] Rollnick S, Miller WR, Butler CC, Aloia, MS, "Motivational interviewing in health care: helping patients change behaviour". (2008), p. 13.

Motivational interviewing can be used to support GBV survivors in the following ways[38]:

- Managing their health outcomes
- Seeking help and accessing support services
- Starting safety planning
- Seeking social support
- Reducing any addictions used as coping mechanisms
- Getting and keeping a job
- Improving their self-efficacy
- Ameliorating associated mental health problems

> **Health care providers in women's health services can use concepts of motivational interviewing to increase referrals to specialist services. No matter if they have 10 minutes – 30 minutes – 1 hour time for consultation, communication skills can be applied.**

Motivational interviewing techniques do not require extensive time to be spent with the patient. The length and format of consultations are not relevant in delivering the concepts. Moreover, practitioners can use motivational interviewing as a communication tool that relaxes the atmosphere and makes GBV survivors feel comfortable during consultations, regardless of the practitioners' intention to increase GBV reporting.

Motivational interviewing framework. Health care providers can use MI by establishing a *collaborative partnership* with the patients, evoking patients' reasons for change, emphasizing their *autonomy*, and expressing *compassion*[39]. Motivational interviewing is done *for* patients and not *to* them. Collaborating with patients facilitates trust and helps to engage them in the conversation.

TABLE 5: MOTIVATIONAL INTERVIEWING BASED PRINCIPLES FOR IMPROVING COMMUNICATION.

COLLABORATION	COMPASSION
• Collaborate with the patients • Consider patients as experts • Put first what patients know about themselves • Explore interests rather than persuade • Avoid being the expert • Avoid considering patients as passive recipients • Avoid confronting patients • Avoid imposing your ideas	• Promote patients' welfare • Prioritize patients' needs • Accept patients' choices • Respect emotional difficulties patients encounter • Seek to understand patients' experiences, values and motivations • Avoid explicit and implicit judgment
EVOCATION	**AUTONOMY SUPPORT**
• Draw out patients' reason for change • Avoid imposing your reasons for change • Avoid convincing patients of the need to change • Avoid telling patients what to do and why	• Empower patients in making the change • Make patients responsible for their actions • Encourage patients to develop strategies for change

[38] Workgroup, I. P. V., "Programs and practice". (2010), p. 92-102.
[39] Miller, W. R., & Rollnick, S, "Motivational interviewing: Helping people change". Guilford press, (2013), p. 25-36.

3.2. PRINCIPLES OF COMMUNICATION FOR HEALTH CARE PROVIDERS: RULE

The motivational practice is guided by four principles existing under the acronym **RULE**[40]:

- **R**esist the righting reflex,
- **U**nderstand your patient's motivations,
- **L**isten to your patient,
- **E**mpower your patient.

R RESIST THE RIGHTING REFLEX

Health care providers need to resist the reflex of fixing or protecting a patient, before the patient asks for help. Persuading GBV survivors to report or leave their abusive partners, may have the opposite effect, with survivors tending to protect their partners and to avoid help seeking. Moreover, when health providers try to persuade the GBV survivors saying **"I think you need to do something about this. The situation looks bad and you're in danger!"**, the natural response of GBV survivors is to bring a counter-argument such as **"I'm fine, it's not that bad"**.

U UNDERSTAND YOUR PATIENT'S MOTIVATIONS

When we want to change our behaviours, our reasons for change are triggering behaviour change. In MI, motivation for change comes from patients not from health practitioners. Thus, health practitioners need to evoke and explore GBV survivors' motivations for change instead of presenting their own thoughts on why patients should change.

L LISTEN TO YOUR PATIENT

In listening to patients' change talk it is important to ask open questions to elicit their personal views on change, accept periods of silence and show empathy.

E EMPOWER YOUR PATIENT

Exploring GBV survivors' ideas on how they can change favours their empowerment to action. Consider patients as their own experts for change.

[40] Rollnick S, Miller WR, Butler CC, Aloia, MS, "Motivational interviewing in health care: helping patients change behaviour". (2008), p. 7-10.

3.3. ASK. LISTEN. INFORM

Ask the right questions

Ask open-ended questions	How are you feeling today? What would you like to talk about today? How are things going with your partner? What things worry you about your relationship? What would be the things you would like to change in your relationship?

Listen. According to MI techniques, health care providers should spend 80% of the time listening and 20% of the time talking. When listening, care providers need to identify what MI calls ***"change talk"***. ***"Change talk"*** represents the vocabulary that patients use when expressing desire, ability, reason and need for change. At the same time patients can talk about commitment to change, activation for change and taking steps. **DARN-CAT** is an acronym to remember what health care providers need to listen to during their consultations.

Listening to "change talk"*		
Preparatory change talk	**Desire**	"I want to..." "I would like to..." "I wish..."
	Ability	"I could . . . " "I can . . . " "I might be able to . . . "
	Reasons	"I want to do this because..." "It would probably be better if..."
	Need	"I ought to . . . " "I have to . . . " "I really should . . . "
Implementing change talk	**Commitment**	"I am going to . . . " "I will . . . " "I intend to . . . "
	Activation	"I am ready to..." "I am prepared to...." "I am willing to..."
	Taking steps	"I did..." "I started to..."

*Adapted from Rollnick S, Miller WR, Butler CC, Aloia, MS, "Motivational interviewing in health care: helping patients change behaviour". (2008), p.33.

Although listening might sound simple, Thomas Gordon[41] expressed 12 roadblocks to listening that people use in conversations most of the time. It is highly important that health care providers avoid these roadblocks when talking with their patients. These roadblocks, will block the conversation and will reinforce patients' sustained talk, i.e. talk opposing change.

ROADBLOCKS IN HEALTH CARE PROVIDER - PATIENT COMMUNICATION

1. Ordering, directing, or commanding
2. Warning or threatening
3. Giving advice, making suggestions, or providing solutions
4. Persuading with logic, arguing, or lecturing
5. Moralising, preaching, or telling clients what they "should" do
6. Disagreeing, judging, criticising, or blaming
7. Agreeing, approving, or praising
8. Shaming, ridiculing, or labelling
9. nterpreting or analysing
10. Reassuring, sympathizing, or consoling
11. Questioning or probing
12. Withdrawing, distracting, humouring, or changing the subject

Inform. In daily practice, health practitioners are used to provide information to patients. When applying MI, informing patients becomes different, as practitioners are not providing information but exchanging information with the patients. Before providing information, health care professionals are encouraged to ask for permission. After exchanging information, health care providers are encouraged to ask for patients' feedback on what they just shared with them. More information about this topic is included in Appendix 3, Table 1.

Communication skills and techniques (applied also outside MI). OARS is a useful acronym in remembering the four core behaviours practitioners need to use in order to elicit change talk. Through open-ended questions, affirmations, reflections and summarising, practitioners guide patients in moving from ambivalence about change to actually planning the change and ultimately to changing behaviours. These four skills have to be used in every MI conversation practitioners intend to have with their patients, even if the conversation lasts only for a couple of minutes (Appendix 3, Table 2). For more communication techniques that can be used while speaking with patients (Appendix 3, the IQ-LEDGE-C Table).

[41] Miller WR, Rollnick S, "Motivational interviewing: Helping people change". Guilford press. (2013), p. 65.

4. SAFETY PLANNING FOR PATIENTS DISCLOSING GBV CONDUCTED BY SOCIAL WORKERS

The safety of patients who have experienced GBV must be at the centre of any health sector intervention to GBV. Immediately after separation, the risk of physical violence increases. In addition, the majority of murders, attempted murders and acts of serious violence are committed when a female survivor attempts to leave a violent perpetrator[42].

Health professionals have an important role to play in offering referral to a social worker with access to specialist GBV support services who will support a victim in risk assessment and safety planning. If time permits a social worker should work in close cooperation with special GBV support services to develop a risk assessment and plan for safety.

REMEMBER: RISK IS DYNAMIC

> **What a patient told you yesterday, this morning or an hour ago about her risk may have changed several times already. She may be at less or greater risk each time you see her so ask about risk and safety during every meeting or consultation.**

4.1. UNDERSTANDING RISK

Risk factors to consider (adapted from UNFPA-WAVE Manual[43]):

- Previous acts of violence against the woman, the children or other family members, as well as former partners
- Previous acts of violence outside the family
- Is there to be or has there been a recent separation or divorce
- Acts of violence committed by other family members used to control the survivor.
- Possession and/or use of weapons
- Abuse of alcohol or drugs may disinhibit a perpetrator already using violence
- Threats should always be taken seriously. In many cases of women being killed by intimate partners, they had been repeatedly threatened with murder before being killed.
- Extreme jealousy and possessiveness
- Extremely patriarchal concepts and attitudes
- Persecution and psychological terror (stalking), including via email, text, social media
- Danger for children, including threats to remove, harm, kill them
- Non-compliance with restraining orders by courts or police

Additional 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.

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

4.2. CARRYING OUT A RISK ASSESSMENT

HEALTH CARE PROFESSIONALS (DOCTORS, NURSES, MIDWIVES)

Risk assessments support health care professional to understand the immediate risks faced by their patients. Health care professional are not expected to carry out a full and detailed risk assessment. Risk assessment should be based on the evaluation of the evolution or escalation of violence, patients' view on safety, some systematically asked questions on perpetrator behaviour and context, and finally the collaboration to care, proposed by the social worker in partnership with women's specialized services.

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 or risks to the children, new born baby, foetus?

Depending on the response to the questions, the health care professional will know whether to follow the emergency care and referral pathway or refer in to the social worker.

SOCIAL WORKERS

A more detailed risk assessment should be carried out by an experienced social worker (GBV advocates, support workers, psychologists) specialised in GBV support. Each organisation/locality/country will have a standard risk assessment form that they use.

In the UK, the ***SafeLives Risk Indicator Checklist*** (RIC)[44] is most commonly used to risk assess a woman with experience of GBV. This is a series of questions asked by a professional trained in using the tool. In addition to considering the "score" a patient reaches when asked these questions, professional judgement is taken into consideration. It is essential that the person asking the questions has had appropriate training and understands the dynamics of GBV. See Footnote for accessing the form.

4.3. SUPPORTING THE PATIENT TO DEVELOP A SAFETY PLAN

This helps the patient plan in advance for the possibility of future violence and abuse. The risk from GBV changes constantly but a safety plan provides room to think through various events or scenarios at all levels of risk.

- A safety plan can be a useful resource
- A patient-led activity that the patient can complete outside of consultation time. The patient can take the safety plan away if it is safe for them to do so
- The plan includes what to do in an emergency, helplines and sources of advice

[44] SafeLives Risk Indicator Checklist (RIC) available here:
http://www.safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL.pdf

CHECKLIST FOR SOCIAL WORKERS IN DEVELOPING A SAFETY PLAN WITH A SURVIVOR OF GBV:

A safety plan can cover various stages and the social worker will have time to explore these different elements with patients:

Safety in the relationship . Think about:

- 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 the police 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 calling the police.
- 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. Think about:

- 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.

Safety when a relationship is over. Think about:

- Contact details for professionals who can advise or give vital support.
- Changing landline and mobile phone numbers.
- Social media and emails - consider security settings on social media and take care if posting anything on Facebook or Instagram. Change email address.
- 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 children about the importance of staying safe.
- Asking an employer for help with safety while at work.

[45] Department of Health. "Responding to domestic abuse: A handbook for health professional". UK, (2005).

5. PATHWAYS FOR REFERRAL AND REPORTING

Health care 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 support 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 counselling. In turn, health care professionals may also receive referrals for women survivors, for instance from police, women's shelters or other health care professionals.[46]

Routine health visits during pregnancy offer a crucial opportunity for identification, safety planning, referral and reporting of GBV in pregnant women who are at high risk during this vulnerable period.

The **RESPONSE project aims to increase referral/reporting to specialist services for survivors of gender-based violence in women's health settings using a rights-based approach, which is gender and survivor focused.** The women's health services provider (doctor, midwife and/or nurse) receives training on identification of GBV and closely collaborates with a social worker, who acts as GBV advocate. This person may be based in a specialised women's services already in place in the given country, and so can ensure an appropriate referral pathway for the survivor. If there are no specialised women's services in place in the country in question, it is the role of the health care professionals along with the social worker or advocate to encourage the establishment of regulations to support women victims of GBV within their health facility.

5.1. REFERRAL PATHWAY CORE CONCEPTS AND BENEFITS

Women's health care settings provide favourable conditions in which to develop GBV interventions, care and referral pathways. RESPONSE is such an intervention and provides training and awareness raising, proactive identification of women affected by GBV and referral to social workers trained to support women.[47]

Supporting survivors of GBV needs to be carried out in partnerships. RESPONSE aims to establish good partnerships between health and social care.

TRAINING

For all health care professionals, ongoing training on GBV should be mandatory. Some key elements are detailed below.

Training should:

- Take place in health care settings and involve all staff including front desk and ancillary teams
- Be delivered regularly to ensure all new and rotating staff are included
- Be department-wide and have buy-in from heads of department and team leaders
- Be developed in partnership with specialist GBV organisations
- Use case studies and role play
- Take into account practitioners' environment, roles and responsibilities
- Consider pre-training questionnaire in order to best match message with audience

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

[47] Bewley S, Welch, J, eds., "ABC of domestic and sexual violence". John Wiley & Sons. (2014), p. 103-106.

- Use adult-centred learning
- Assess feedback from post training questionnaires in order to tailor and modify content to best suit needs of learners
- Link to continuing professional development as an incentive to attend

In the long term, effectiveness of training and reduction in GBV using early intervention and prevention needs to be demonstrated. Benefits to the health service would include:

- A reduction in repeat incidents and so a reduction in repeat attendance
- Fewer consultations
- Less prescribing
- Long term health benefits for patients
- Better quality of life
- Long term cost saving for health improved quality of care

CREATING CARE PATHWAYS

- Look at what services locally exist
- What pathways currently exists – can these enhance and support well survivors?
- Are health care professionals already in touch with local specialist services or do these links need to be created and supported?
- Give examples of successful projects, *e.g. MeMoSa in the Netherlands, MOZAIC in UK*[48]

Survivor input – listen to survivors and use their views and experiences of services and health care to inform practice. Victim support groups and patient involvement groups that meet regularly are valuable contributors to and assessors of care and referral pathways.

When introducing new ways of working, it is useful to consider the challenges and opportunities that they bring[49].

TABLE 6: CHALLENGES AND OPPORTUNITIES OF CREATING CARE PATHWAYS.

CHALLENGES	OPPORTUNITIES
Convincing health care practitioners that GBV is a health issue	Establish links with local specialists in GBV in both voluntary and statutory sectors. Refer to national policy, guidance and legislation Discuss cases of GBV in clinical meetings Conduct an anonymous survey on GBV in the health care setting
Initiating change in clinical practice	Initiate the role of clinical champion with an interest in GBV Link with local adult and child safeguarding leads across the health sector locally Ensure that the internal human resources team has a policy for staff experiencing GBV Display GBV posters and have leaflets available in public areas

[48] Mozaic Women's Well Being Project. Available at: http://www.together-uk.org/southwark-wellbeing-hub/the-directory/16111/mozaic- womens-well-project/
[49] Bewley S, Welch, J, eds., "ABC of domestic and sexual violence". John Wiley & Sons. (2014), p. 103-106.

Developed tailored GBV training	Work in conjunction with local specialist organisations and tailor training to each specific health context Co-facilitate training with health practitioners
Motivating health care practitioners to attend training	Make GBV training mandatory, link to continuing professional development and include in adult and child safeguarding training Offer training at times to suit the health care teams
Evaluating and monitoring changes in practice	Develop clinical guidelines to include guidance on how to ask about GBV safely Give clear details on how to record and document GBV Include a GBV coding scheme in the patient record system and conduct regular audits Have clear care pathways on referral routes for women with experience of GBV Explore funding for health service research with local academics
Sustaining the intervention	Ensure health champions and staff at senior and strategic levels are involved in all stages Keep GBV on the agenda at clinical meetings Ensure a rolling programme of GBV training Share and sustain good practice by sharing case studies and audits of patient records Support bids to commission GBV advocacy services

6. RECOMMENDATIONS FOR ACTION. MULTI-SECTORIAL RESPONSE TO VIOLENCE

The problem of GBV needs to be recognized throughout health care and social services, including primary health care, specialised health care, as well as various organizations and institutions. These entities need to empower women's organizations that specialize in support services for GBV victims. Each of these entities may need to develop its own model of how best to implement and respond; but having a multi-sectorial response to violence will increase the likelihood of survivors getting the help they need.

An example of this is the MARAC Model in the UK[50], which is a multi-agency risk assessment conference. A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A GBV specialist, police, children's social services, health and other relevant agencies work collaboratively to assist the victim. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential. Together, the meeting writes an action plan for each victim. They work best when everyone involved understands their roles and the right processes to follow. See Footnote for accessing the model.

STANDARDS FOR GBV SUPPORT SERVICES ACCORDING TO THE ISTANBUL CONVENTION, ARTICLE 18[51]	
Services are based on a gendered understanding of violence against women and focus on the human rights and the safety of the victims.	Services aim at the empowerment and economic independence of women victims of violence
Services are based on an integrated approach, which takes into account the relationship between victims, perpetrators, children and their wider social environment.	Services allow, where appropriate, for a range of protection and support services to be located on the same premises.
Services aim at avoiding secondary victimization	Services should be available and address the specific needs of vulnerable populations, including children victims.

6.1. POLICY LEVEL SENSITIZATION AND ADVOCACY

Previous work on policy level sensitization and advocacy, Project IMPLEMENT – *EU Policy Recommendations and Legal Frameworks*[52] lead to drafting policy recommendations to improve the specialised support for victims of gender-based violence (GBV) in health care systems across Europe, in accordance with existing regulations and recommendations, especially the Council of Europe Convention on preventing and combating violence against women and domestic violence, also known as the Istanbul Convention. The Convention, specifically states in Article 15 – Training of professionals[53]:

[50] Safe Lives, Multi-Agency Risk Assessment Conferences (MARAC) Model, (2013), available here: http://www.safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

[51] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia", (2014), p. 57.

[52] Project IMPLEMENT. "EU Policy Recommendations and Legal Frameworks". (2017), developed as part of WS3, available at: http://gbv-implement-health.eu/

[53] Council of Europe, "Convention for the Prevention of Violence Against Women and Domestic Violence", the Istanbul Convention, (2011) and ratified in 2014 (2014), http://www.coe.int/en/web/istanbul-convention

1. Parties shall provide or strengthen appropriate training for the relevant professionals dealing with victims or perpetrators of all acts of violence covered by the scope of this Convention, on the prevention and detection of such violence, equality between women and men, the needs and rights of victims, as well as on how to prevent secondary victimization.
2. Parties shall encourage that the training referred to in paragraph 1 includes training on coordinated multi-agency co-operation to allow for a comprehensive and appropriate handling of referrals in cases of violence covered by the scope of this Convention.

In order to increase multi-sectorial collaboration, it is necessary to specify in EU, national and/or institutional policies the role of the health personnel in preventing and combating GBV and provide a list of « relevant professionals » (e.g. health professionals, general practitioners, midwives, obstetric teams and emergency room personnel) who require training in how to identify and support victims of gender-based violence.

TABLE 7: STANDARDS FOR HEALTH CARE TRAINING ACCORDING TO THE ISTANBUL CONVENTION, ARTICLE 15[54] AND IMPLEMENT RECOMMENDATIONS[55]

		INCREASE HEALTH CARE PROFESSIONAL TRAINING
National	**Policy level**	Promote dedicated legislative framework to combat GBV, with an article specifying the initial and continuing education for health professionals who come into contact with potential victims. Example: Examples of this in the European Union include: France: the law of August 4 2014 'Law on real gender equality' (LOI n° 2014-873 du 4 août 2014 pour l'égalité réelle entre les femmes et les hommes is a multi-dimensional approach to addressing inequalities between women and men, notably Article 51.[56]
National	**Organization level**	Create, implement and monitor a national action plan on combatting GBV. Such a plan must include an explicit article to empower the health sector and health professionals to include GBV reporting/referral as part of their routine health screening in order to promote primary prevention responses to violence. These activities should be supported by on-going training on identification and support of GBV victims in the health setting. Create an interministerial committee to coordinate national policy activities related to combating GBV throughout the relevant ministries: health, education, research, social, and justice. This is a crucial way to ensure enforcement of measures are taken and that violence prevention is integrated into health, social and educational policies promoting gender and social equality. This Committee, should have a dedicated budget, and would be responsible for implementation of the GBV-National Action Plan at national level. Such a committee has been created in France, "*Mission interministérielle pour la protection des femmes victimes de violences et la lutte contre la traite des êtres humains* (MIPROF)"[57].

[54] UNFPA-WAVE "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia", (2014), p. 57.
[55] Project IMPLEMENT. "EU Policy Recommendations and Legal Frameworks". (2017), developed as part of WS3, available at: http://gbv-implement-health.eu/
[56] French Law on GBV, Domestic Violence and its Consequences on Children, (2010) *Loi 2010-769 du 9 juillet 2010 relative aux violences faites spécifiquement aux femmes, aux violences au sein des couples et aux incidences de ces dernières sur les enfants*
[57] MIPROF, available here: http://www.familles-enfance-droitsdesfemmes.gouv.fr/dossiers/actions-dispositifs-interministeriels/miprof-mission-interministerielle-pour-la-protection-des-femmes-victimes-de-violences

	Education level	Training of health professionals should be integrated in the official frameworks mainly at national levels. Training of the health professionals are dependent on the existing capacity and resources, or development of new ones: 1. Introduction of mandatory training modules in the medical/nursing/ midwives school curriculum and questions related to GBV in the medical exams; 2. Propose specific training modules in the continuous education courses that are mandatory for doctors/nurses/midwives to follow; 3. Propose a training plan for health professionals and pedagogical tools (films, brochures, etc.); 4. Approve continuing education credits for the trainings for health professionals; 5. Offer a national telephone number which provides guidance for health professionals who are in contact with potential victims of GBV; 6. Publish at regular intervals informative articles regarding the role of health professionals in combatting GBV in the health setting in related professional magazines or journals to raise awareness.
Women's Health Services	**Policy Level**	Identification and referral to specialised services for victims of GBV must be mandated and explicitly stated in the health setting's policy and procedures, e.g. Hospital Manual. Mobilise each large health setting (e.g. hospitals, clinics) to establish « Victim Protection Groups» or « Reference Person » to facilitate the provision of specialised services for victims of GBV.
	Organization Level	Example: In Austria a team of trained health professionals (obstetrics, emergency room, midwives, etc.) are called upon for any potential victims of GBV, in order to facilitate the support to victims regarding referral to police services and specialised support services such as intervention centre or women's shelters (**more details in section 6.2 below**) Each health setting must make local tools available to improve identification and referral of women as victims of GBV to specialised support services. Such examples include:
	Education Level	1. Support trainings for doctors/nurses/midwives at department/hospital level and assure 2. Training manual with various modules (see IMPLEMENT training manual, www.gbv-implement-health.eu); 3. Fundamental Reference Tool for doctors, residents and interns to refer to in clinical practice[58]; 4. Implement information sessions for health settings to raise awareness of how health professionals can make a difference in combating GBV in the health setting.

[58] Blank K, Rosslhumer, M, "IMPLEMENT Training Manual on gender-based violence for health professionals". (2015), p. 62.

6.2. VICTIM PROTECTION GROUPS

Ideally at a local level, identification and referral to specialised services for victims of GBV should be mandated and explicitly stated in the health setting's policy and procedures, e.g. Hospital Manual.

If made mandatory, this will mobilise each large health setting (e.g. hospitals, clinics) to establish «Victim Protection Groups». This best practice has been established in hospital settings where a team of trained health professionals (obstetrics, emergency room, midwives, etc.) is called upon for any potential victims of GBV, in order to facilitate support regarding referral to police services and specialised support services such as a specialist intervention centre or women's shelters.

TABLE 8: AUSTRIAN CASE STUDY: VICTIM PROTECTION GROUPS IN THE HEALTH CARE SYSTEMS

Since the beginning of 2011 there is a legal mandate[59] in Austria, to deliver victim protection groups in health care systems. According to law, health care systems need to have in place victim protection groups for children as well as adults. One of the key components is to recognize early signs of domestic violence and any suspicion of violence in order to strengthen sensitization of the staff on the issue of domestic violence.

The group should have as members at least two specialists for the emergency department and gynaecology, as well as further nurses and a lead person responsible for psychological and psychotherapeutic treatment in the hospital.

Role of Victim Protection Groups:

- Victims of gender based violence receive extensive and appropriate support.
- The entire clinical staff team is asked to participate in training and education initiatives around GBV.
- Intensified multi-agency working and cooperation between the medical and the nursing sector, victim protection groups, women's shelters, police and registered doctors.
- Regulated financial and personal resources to increase victim protection, and support disclosure of GBV.

Medical facilities are mandated to convey the Victim Protection Group for all those affected by domestic violence. The groups are responsible for the early screening of domestic violence and in particular, the sensitization of different medical specialists on the impact and effects of domestic violence. This law has been an important improvement for the support of those with experience of GBV and who require support in the health care facilities.

With this legal framework for the health care system, Austria follows the Council of Europe, "Convention for the Prevention of Violence Against Women and Domestic Violence", the Istanbul Convention[60] which says, in summary, in Article 15 that:

- There should be training and education for members of occupational groups who work with victims and perpetrators in order to prevent and detect violence, promote gender equality and the needs and rights of victims to prevent secondary victimization;
- The training should be multi-agency and support partnership working to create simple care pathways from health into specialist GBV support services.

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[59] Austrian Federal Law for the implementation of victims of gender based violence in public health care systems, (2010), Bundesgesetz über Krankenanstalten und Kuranstalten, BGBI. I Nr.61/2010/ KAKuG 2010

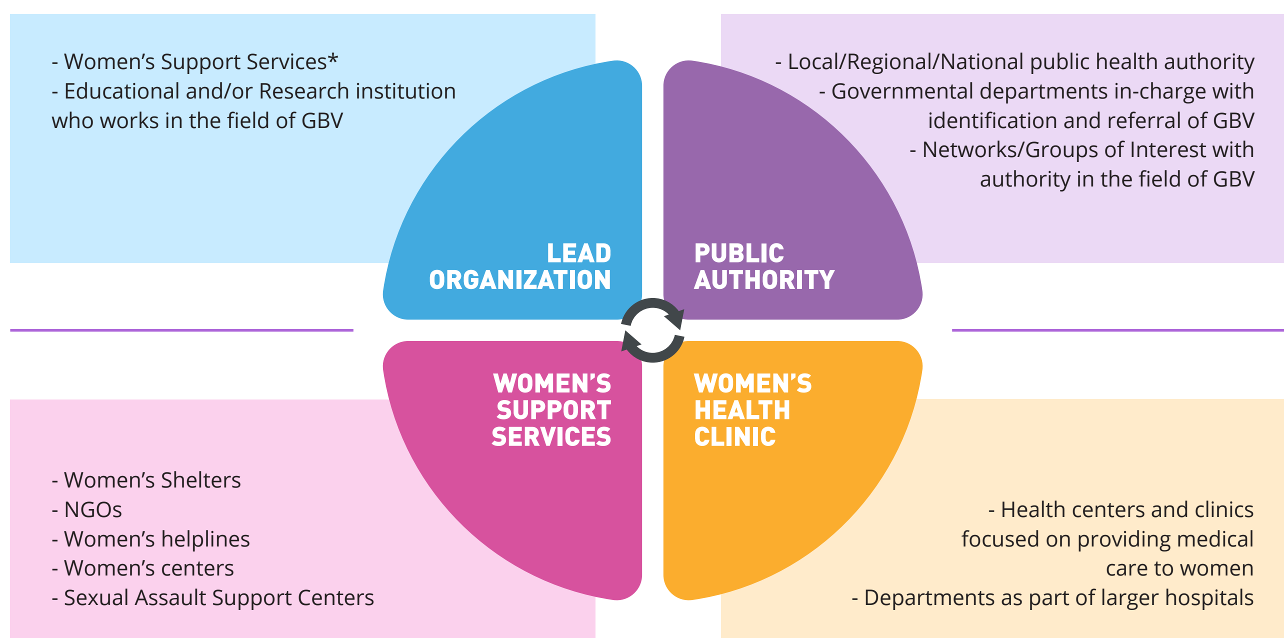
[60] Council of Europe, "Convention for the Prevention of Violence Against Women and Domestic Violence", the Istanbul Convention, (2011) and ratified in 2014, http://www.coe.int/en/web/istanbul-convention, [Austria has ratified the Istanbul Convention in 2013].

6.3. PROJECT RESPONSE FRAMEWORK

The FRA EU-wide survey on violence against women[61] found that among the respondents who were pregnant during the relationship with their partner and who experienced violence in the relationship, 20% of survivors of current partners and 42% of survivors of previous partner violence stated that physical or sexual violence also took place during pregnancy. Furthermore, health care professionals are likely to be the first professional contact for survivors of GBV, and if they disclose, they often tell health providers[62]. In order to increase multi-sectorial and multi-disciplinary cooperation in maternal health services to reduce underreporting of GBV in maternal health settings during routine pregnancy care, the **RESPONSE Project Framework** proposes at least one group of stakeholders formed of: one lead institution, one (maternal) health clinic which offers medical services to women and one public authority as partners. The RESPONSE Project Framework focuses on medical care delivery to patients which may be victims of GBV. The Framework is designed as patient/victim-centred involving different stakeholders and implemented in the Project RESPONSE to show how cooperation across organizations can profoundly change the referral/reporting of women, victims of GBV. The model strives to integrate GBV into existing women's health medical services with support across different organizations. It is also critical to establish guidelines for how to handle situations and issues that involve multiple institutional action, as the model proposed in the section. It is important that partners[63, 64]:

- Understand the phenomenon of violence and the spiral of violence;
- Recognize the manifestations of trauma;
- Screen everyone routinely about violence;
- Conduct follow-up;
- Cooperate with other professionals and experts;
- Share resources and common goals on the topic of GBV;
- Exchange information and activities on the topic if GBV.

** If the lead institution is the Women's Support Services than the proposed model has three important pillars. Moreover, as most setting are low on resources, each setting that wants to apply this model should start by using three main pillar s to construct their multi-sectorial approach.*



[61] FRA, "Violence against Women: An EU-wide survey". Brussels, FRA. (2014), p. 46
[62] FRA, "Violence against Women: An EU-wide survey". Brussels, FRA. (2014), p. 20.
[63] 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.
[64] UNICEF, "Handbook for Coordinating Gender-based Violence Intervention in Humanitarian Settings". (2010), p. 110.

> **“Successful multi-sectorial 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 more cooperation and specialised training between the health 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.[65, 66]

EIGHT STAGES OF DEVELOPING COOPERATION[67]:

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

[65] FRA, “ Violence against Women: An EU-wide survey”. Brussels, FRA. (2014), p. 70.
[66] Blank K, Rosslhumer, M, “IMPLEMENT Training Manual on gender-based violence for health professionals”. (2015), p. 38.
[67] 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.

7. EVALUATION

Crucial to any intervention to assist victims of GBV is an evaluation component to assess the impact of the intervention, in this case a training in the health care setting, and to determine if it has made a difference.

Typically, an evaluation has two parts, the first is the **process** evaluation (what was done and how) and the second is the **outcome** evaluation (what difference did the project make). It is important to gather indicators for each part. **Ideally, you want to compare the work you are doing in a particular health setting (referred to as training health setting), with a similar health setting that is not currently receiving any intervention or training (referred to as control health setting)**.

Process indicators for capacity building seminars and training

1. Training Evaluation Form to assess feedback from the training participants (see following pages).
2. Health Professional Readiness Questionnaire (see following pages) completed pre- and post-training to determine change in the training clinic.

Outcome indicators for capacity building seminars and training: 3 data collection periods
At training clinic: baseline 0 (4 weeks before or at the start of the training), 4 weeks after the training, 6 months after the training:

a. Number of patient contacts total in the clinic in the past 4 weeks
b. Number of patients the health professional discussed gender-based violence with in past 4 weeks
c. Number of patients identified as being victims of gender-based violence in past 4 weeks in the training clinic
d. Risk assessment completed for patients in past 4 weeks in the training clinic
e. Number of patients referred to support services in past 4 weeks in the training clinic

At control clinic: baseline 0 (4 weeks before the training is done at the training clinic), 4 weeks after the training done at the training clinic, 6 months after training done at the training clinic:

a. Number of patient contacts total in the control clinic in the past 4 weeks
b. Number of patients identified as being victims of gender-based violence in past 4 weeks in the control clinic
c. Number of patients referred to support services in past 4 weeks in the control clinic

Step 1. Identify the clinics, both training and control clinics can be a maternity, prenatal care, obstetrics and gynaecology health department, or women's health clinic. The clinics should be similar in number of patients/clients and economic status of clients seen per month, similar in number of health professionals working in the clinic),

Step 2. Collect baseline data, indicators from both clinics (training clinic and control clinic),

Step 3. Implement the training of health professionals in training health setting. After the evaluation is performed comparing the two clinics after 6 months, it is recommended to offer the training to the control clinic as well.

An evaluation checklist, training form and pre- and post questionnaire are provided on the following pages in order to assist in the process of evaluation.

RESPONSE Evaluation Checklist for programme implementers

Evaluation activity	√ = Completed
1. Training clinic identified in obstetrics/gynaecological/prenatal health or women's health setting	
2. Control clinic identified, similar in # of clients seen per day, # of health professionals	
3. Baseline data prior to training, data collected from both clinics: Training clinic: **past 4 weeks**: # patients total in clinic past 4 weeks # of patients health professional discussed violence with ___ # patients identified as victims of violence ______ # of referrals _______ # of risk assessments and safety plannings _________ Control clinic: **past 4 weeks**: # patients total in clinic # patients identified as victims of violence ______ # of referrals _______	
4. Training completed: minimum 1 training, 4 hours with minimum 30 health professionals Date of training(s): _________ Duration of training: ________ (hours) # participants: _________ (30 minimum) # of pre-training questionnaires completed: _______ # of post-training questionnaires completed: _______ (see page 4-6 for the questionnaire) Number of hours of follow-up meetings done: ____ (minimum 3 hours)	

5. Four weeks after training, data collected from both clinics: Training clinic: **past 4 weeks** # patients total in clinic ______ # of patients health professional discussed violence with ___ # patients identified as victims of violence ______ # of risk assessments and safety plannings _________ # of referrals _______ Control clinic: **past 4 weeks** # patients in clinic _____ # patients identified as victims of violence ______ # of referrals _______	
6. Six months after training, data collected from both clinics: Training clinic: **past 6 months** # patients total in clinic _____ # of patients health professional discussed violence with ___ # patients identified as victims of violence ______ # of risk assessments and safety plannings _________ # of referrals _______ Control clinic: **past 6 months** # patients total in clinic _______ # patients identified as victims of violence ______ # of referrals _______	

RESPONSE Training Evaluation Form[68]

1. How do you evaluate the training overall, on a scale of 1 to 10? ______

1 - very satisfied **10 - not at all satisfied**

2. Please assess the following aspects of the training

	Yes, very much	Somewhat yes	No, rather not	Not at all
The training was well structured.	☐	☐	☐	☐
There was appropriate time allocated to each module.	☐	☐	☐	☐
Time for discussion was sufficient.	☐	☐	☐	☐
The handouts and materials were useful.	☐	☐	☐	☐
The training was relevant.	☐	☐	☐	☐
The training will benefit my work.	☐	☐	☐	☐
I would recommend the training to others.	☐	☐	☐	☐

3. 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.	☐	☐	☐	☐
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.	☐	☐	☐	☐

[68] Blank K, Rosslhumer, M. "IMPLEMENT Training Manual on gender-based violence for health professionals", (2015), available online at: www.gbv-implement-health.eu

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

	Excellent	Good	Not so good	Poor
Training facilities	☐	☐	☐	☐
Coffee breaks, lunches	☐	☐	☐	☐
Location of the venue	☐	☐	☐	☐

Any comments or suggestions for improving the training?

____

____

____

____

____

Thank you very much for supporting this evaluation!

RESPONSE Pre and Post-Training Questionnaire[69]

It is important to collect feedback and comments from participants of this training. By telling us what you think, we can make sure that the training we offer is suited to your needs and requirements. The information you give is confidential and you do not have to put your name on the form.

1. What is your job title? Please circle.

- ☐ Doctor
- ☐ Nurse
- ☐ Midwife
- ☐ Social Worker
- ☐ Psychologist
- ☐ Other, please specify ______________________________

2. Have you had previous training on gender-based violence (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)?

☐ No ☐ Don't know ☐ Yes ___ Estimated total number of hours

3. How prepared you feel,

Tick the number which best describes how prepared you feel

1 = Not prepared 2 = Slightly 3 = Moderately 4 = Fairly well 5 = Well perpared

3.1 Ask questions to promote disclosure of gender-based violence with your patients

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3.2 Appropriately respond to disclosures about gender-based violence in your patients

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3.3 Identify signs and symptoms associated with gender-based violence based on patient history and physical examination ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3.4 Perform a risk assessment on a patient ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3.5 Document violence history and physical examination findings in patient's record

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3.6 Make appropriate referral for a patient ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

[69] Adapted from the Physician Readiness to Manage Partner Violence Survey (PREMIS): Short LM, Alpert E, Harris JM, Surprenant ZJ. "A tool for measuring physician readiness to manage intimate partner violence". Am J Prev Med. (2006), 30 (2), p. 173–180.

4. **How many new diagnoses (picked up an acute case, uncovered ongoing abuse, or had a female patient disclose a past history) of gender-based violence would you estimate you have made in the last 6 months?** ______________ Number

5. **Which of the following actions have you taken when you identified gender-based violence in a patient in the last 6 months? (Tick all that apply)**

5.1 Referral to a social worker

☐ always ☐ mostly ☐ sometimes ☐ almost never ☐ never

5.2 Referral to violence prevention services

☐ always ☐ mostly ☐ sometimes ☐ almost never ☐ never

5.3 Referral to a shelter

☐ always ☐ mostly ☐ sometimes ☐ almost never ☐ never

5.4 Referral to the police

☐ always ☐ mostly ☐ sometimes ☐ almost never ☐ never

5.4 Referral to the court

☐ always ☐ mostly ☐ sometimes ☐ almost never ☐ never

6. **Any comments to share:**

____

____

____

____

____

____

____

____

____

____

Thank you for completing this form!

II. TRAINING APPENDIX

Appendix 1. Exercises and Case Studies

1. CONTINUUM EXERCISE[70]

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.

2. MEDICAL POWER AND CONTROL WHEELS EXERCISE[71]

The group is divided in half. The incomplete medical power and control wheel is handed out to one group, and the incomplete advocacy wheel is handed out to the other group. Each group must fill out the wheel according to the best of their knowledge.

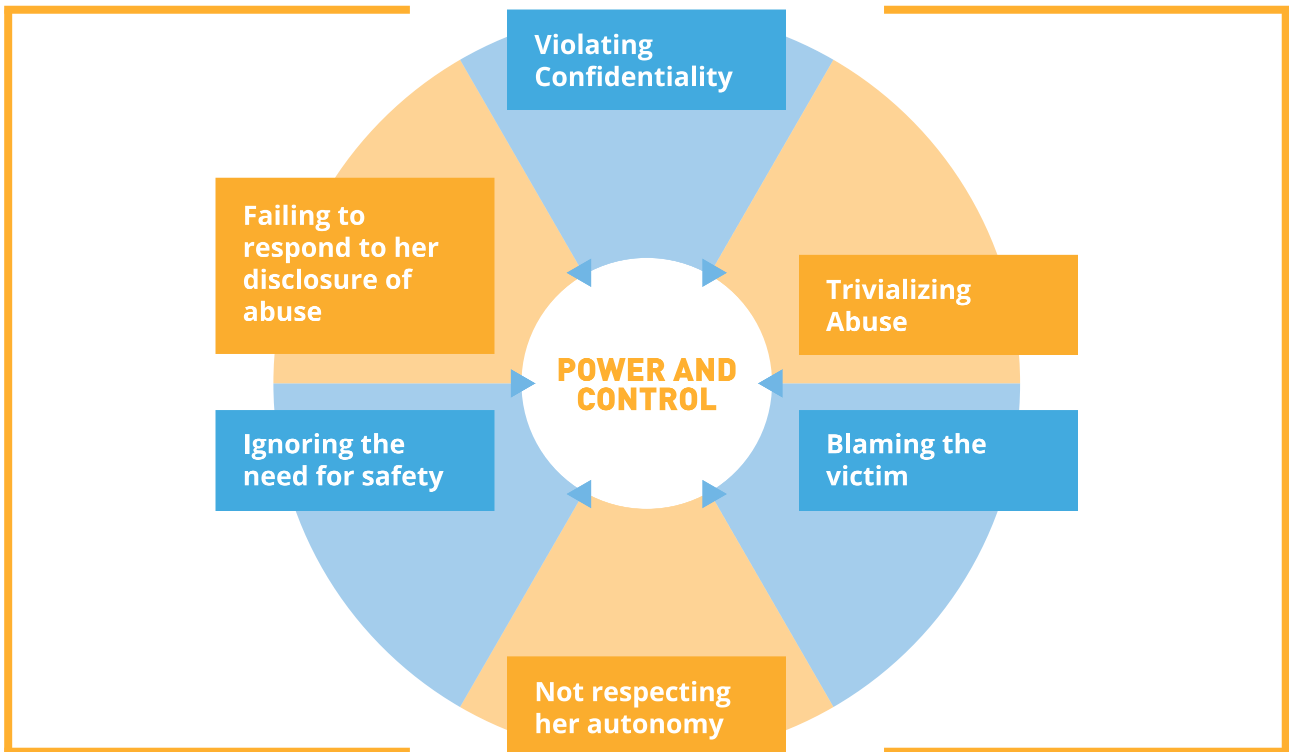
The group with the power and control wheel must consider how the response of the health care professional can collude with the perpetrator, disempower the survivor, prevent the survivor from seek support, etc. The group should give examples to complete a couple of segments of the wheel, for example,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

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

PART OF THE PROBLEM?

Adapted from the IRIS Workbook

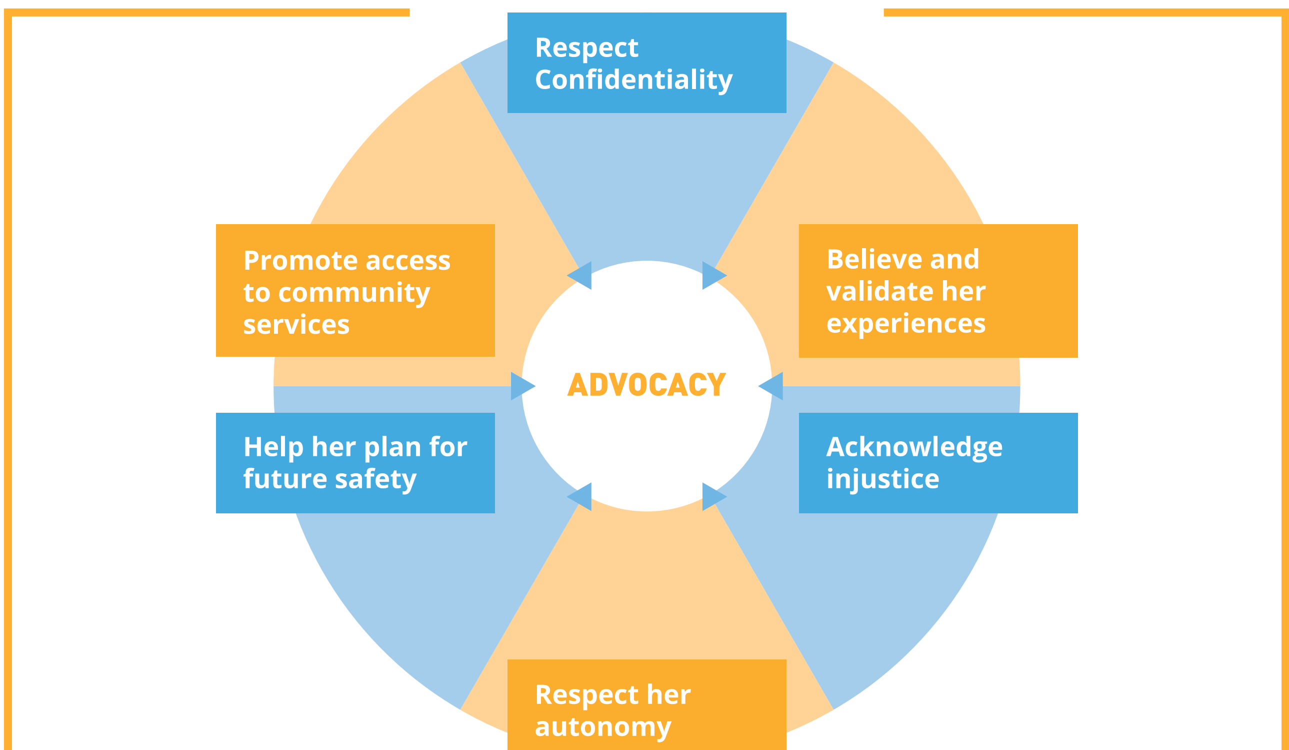
MEDICAL POWER AND CONTROL



OR PART OF THE SOLUTION?

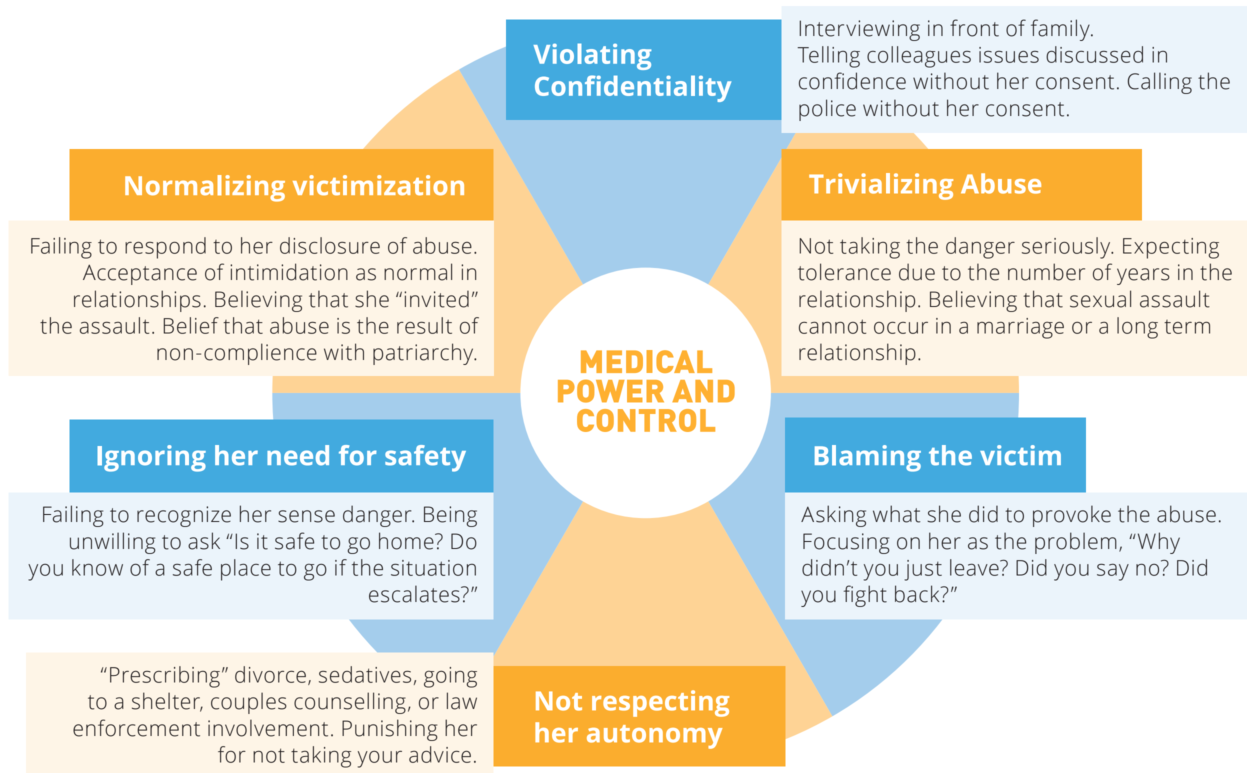
Adapted from the IRIS Workbook

MEDICAL ADVOCACY



The completed wheels are below. One of the things they help to demonstrate is 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. This means that we can all be part of the problem or part of the solution.

ESCALATING DANGER INCREASED ENTRAPMENT



4. CASE STUDY EXERCISES

Case study 1

The Sexual Health Clinic: Divide into groups of 3: one person is the patient, one the clinical lead and the third the observer. Please take the role on the piece of paper you are given and follow the instructions.

Case history of woman affected by GBV, presenting to sexual health clinic

34 year old

- Lives with her partner (of two years) and one year old child
- Attending for contraception advice
- Her partner wants her to have sex without a condom
- He is insistent that if she loves him there is no need to use condoms and he doesn't like condoms
- On two occasions he has slapped her in the face
- She feels it was her fault as she upset him by shouting – it was his way of calming her down
- She's sure that her child was asleep and didn't hear anything
- Wouldn't want to tell police, as feels it would be unnecessary
- Feels scared to say to partner that she prefers to carry on using condoms
- Unclear of options and support
- Reviewed by health adviser - options of support in the community given
- Child protection issues and social services referral discussed

Role-play:

Intro: This exercise is not to generate perfect consultations but is about learning in a safe environment (so "imperfect" consultations are equally valuable). The focus is on you and your patient feeling comfortable - so if you ask a question that makes you or the patient feel uncomfortable then this is an important learning experience.

Please divide into groups of three – and decide who is the health care professional (i.e. doctor/nurse/health adviser), patient and observer.

Each of you will be given a slip of paper telling you your role, the clinical scenario and what task we would like you to focus on in the role-play.

Take a few minutes to read your task, and then let's do the role-play for 5-10minutes, with discussion at the end for 5-10 minutes (1st discussion in small groups, then in one large group).

Each observer will make notes.
Each person does not know what the others' tasks are.

For the observer:

Please make notes on the following questions that we would like you to try to answer:

- How much time does the health care professional spend listening/asking questions? What are the specific questions used to ask about GBV?
- Are they open or closed questions?
- Would you give them a red/amber/green? Red being a question best not used, amber being a question that you could use and green being a really good question to ask about GBV.

For the health care professional:

You are a doctor seeing a woman in a routine sexual health clinic who is attending for contraception advice. You are working through your electronic pro-forma and ask her about condoms. She says that her partner does not allow her to use condoms. You then start thinking about enquiring about domestic violence and abuse.

During this role-play, please think about:

- What do you think worked well?
- What worked less well?
- How would you change it in the future?

For patient:

You are a 34-year-old woman with 1 child (a 1 year old).

You have been with your partner for two years. You love your partner and are attending for contraception advice. You had been using condoms since you had your child but your partner is now insistent that if you love him there is no need to use condoms and he doesn't like them.

There have been two occasions when your partner has got angry – when he slapped you in the face. You feel that this was your fault as both times you had upset him and had been shouting. Both times, after the incident, he was very apologetic. You are sure that your child was asleep and didn't hear anything. You had decided that these things sometimes happen.

You have not spoken to anyone about this. During this role-play, please think about:

- How did you feel?
- What made you feel comfortable?
- What made you feel uncomfortable?

Source: ADViSE training (Assessing for Domestic Violence in Sexual Health Environments), East London, UK, 2015

Case study 2

In small groups read through the following case studies. For each case study and each woman described, consider:

- The impact of the abuse upon her emotional health.
- The impact of the abuse upon her physical health.
- The impact of the abuse upon her sexual health.
- The impact of the abuse on her relationships outside the immediate family.
- In addition, please:
    - Identify any safeguarding concerns.
    - Identify points of contact with healthcare workers and where an offer of a referral to a social worker could have been made.
    - Determine when, in your clinical role, you may have treated this woman as your patient, what you would have asked her to begin a conversation around domestic abuse and what support you would have offered.

Example 1
Alishia is a 35-year-old Asian woman. She has been married to Karim for 12 years. They have three children, aged ten, six, and two. Alisha was a secretary, but has not worked since her first child was born. Karim is a computer programmer. Alisha has experienced abuse from Karim throughout their marriage. He is a domineering man, and likes to be in charge of family matters. As the sole breadwinner, he has always controlled the family finances, restricting the amount of money available to Alisha for household shopping and items for the children. Alisha has always thought she would like to return to work, but she now lacks confidence in her skills. This has been aggravated by Karim's negative attitude towards her, saying that no one would employ her, she is useless, and that it is anyway her job to stay at home and look after the house and the children. Karim can be very moody, and unpredictable in his behaviour towards Alisha. She constantly feels anxious about pleasing him, and feels that she is 'walking on eggshells' all the time. Karim is always criticising Alisha and does not like her to go out. other than to take the children to and from school. Karim is very sexually demanding.

Example 2
Angela is having her first baby. She is 22, and is now eight months pregnant. She has lived with her partner, Neville, for two years. They have extended family in the city where they live, and several friends. Angela describes their relationship as „shaky, with a few arguments, but we always make it up again." Since Angela became pregnant, Neville has started being abusive towards her. This has involved two major incidents of physical violence. Neville kicked Angela in the stomach when she was 22 weeks pregnant, and caused vaginal bleeding. Last night he pushed Angela down the stairs. She feels bruised and dizzy. Angela has missed many appointments for antenatal care, as Neville does not like her attending. Angela is very frightened of what will happen next and is concerned for her unborn baby.

Example 3
Diane is 39, and has been married to Kevin for 20 years. They have three children, aged 20, 18 and 15 years old. Diane has experienced serious violence throughout her marriage; she has been admitted to hospital twice because of physical injuries. On one occasion she said she had been decorating the flat, and fallen off a ladder; she had broken two ribs, dislocated a shoulder, and had extensive bruising. On another occasion, Kevin banged her head against a wall, causing her to lose consciousness. She was admitted to hospital with a head injury. Last year, she took an overdose of anti-depressants, which her GP had prescribed for her depression. She has now been referred to a Community Psychiatric Nurse for counselling.

Example 4

Cathy is 34 and has three children aged 13, 10 and 3. She is pregnant. Her partner, Steve, has told her that they cannot have more children and to have a termination. He says that if she doesn't he will throw her out of the house and keep the children. Cathy will not have an abortion. She is at her first appointment with the midwife and is upset and exhausted. There has never been any physical violence directed at her but Steve has broken a window in the house, is verbally abusive and constantly humiliates Cathy in front of the children, friends and family. Cathy says it is safe to go home as Steve will be out today until late but she wants to leave the house with the children and does not want to see Steve.

EXERCISE 4. MOTIVATIONAL INTERVIEWING EXERCISES*

Case study: Using Motivational Interviewing when communicating with the patients (version 1 with narative)

The case study was adapted from Domestic Abuse Training Manual for Health Practitioners, HEVAN (2007). The original text was modified to integrate the Motivational Interviewing skills detailed in Chapter 4.

In pairs, read the following dialogue of a discussion between a woman and her midwife/gynaecologist/health visitor. Highlight the points of good practice demonstrated by the clinician. Consider the language used, the way the clinician asks questions and how she manages and guides the discussion.

Aimee with Health Visitor / Gynaecologist / Midwife

> Motivational interviewing conversation starts with ENGAGING the woman in the conversation. Health providers are advised NOT to start talking about violence, without establishing a collaborative relationship with the woman. To establish trust and collaboration with the patient, practitioners can ask one or two simple questions:
>
> How are you feeling today?
> How have things been going lately for you?
>
> After asking one or both questions, practitioners should follow patients' answers with a reflection.

Health Visitor: Hello Aimee. Thanks for coming to the consultation. How are you feeling today?
Aimee: Hello! I'm feeling ok.
Health Visitor: That's good to hear. It seems that things are going well for you. (reflection)
Aimee: Yes, thank you!

> Mandatory, before talking about violence is ASKING PERMISSION from the woman to talk about violence. Practitioners are advised NOT to start talking about violence without asking the woman if she agrees with the discussion.

Health Visitor: It is very important that all patients accessing our services, have the opportunity to talk about their experience of domestic violence, because domestic violence is very common and it can get worse during pregnancy. So, would it be ok for you if we focus the conversation a little on domestic violence? (asking for permission) We respect the confidentiality of what you tell us at all times and the only exception to that is if you choose to tell us that a child is being hurt or anyone's life is at risk.

Aimee: Yes, it's ok.

Health Visitor: Would it be ok for you to talk about your feelings of fear or about experiencing violence from anyone close to you? (asking for permission)

Aimee: Well, I think Mark has been under a lot of strain at work recently but it is getting to be a bit much.

Health Visitor: It sounds as though you're feeling under strain too. What has his behaviour been like at home? (Reflecting feelings, drawing out with open question, refocusing on Aimee)

Aimee: Well, I thought we'd sorted it out. After Sam was born Mark started to get aggressive and he hit me a few times. It hasn't happened for nearly a year and I honestly thought he wasn't going to get like that again. But last week, he got furious because I'd been out with a friend all day and I hadn't got the food ready. He punched my stomach. I was terrified.

Health Visitor: You went through such a difficult situation last week. (reflection to express empathy) There was no way you could predict that, as nothing had happened for over a year. He took you by surprise. (affirmation to normalize woman's reaction to avoid self-blame) That is so frightening. (reflection) Would you tell me what happened after that? (asking for permission and open-ended question)

Aimee: He left and I started to wonder if I should go to stay with my mum. I was going over later to pick up Samantha anyway and I was afraid of what he might do next. But I didn't stay and when he got back he was very apologetic. He's been a lot better since then as if he's got something out of his system. Nothing bad seemed to happen so I left it.

Health Visitor: Although you don't approve of his behaviour as you know it's dangerous for you and for Samantha, you decided not to leave him. (double sided reflection – to raise ambivalence about doing something about the situation) The fact that he was so apologetic made you find excuses for him and leave things as they are. (reflection) And what are you feeling about it now? (Open question)

Aimee: I'm just so confused. I kept pretending it wasn't happening but now I'm wondering what I'm doing wrong to provoke him.

Health Visitor: You're wondering if it's your fault but you're really not to blame. Nobody deserves to be hit or to have to live in fear. (reflection + affirmation - Acknowledging her feeling of self-blame but following it with the message that it's not her fault)

Aimee: But I really love him and we used to get on so well before. I wish it would be like that still.

Health Visitor: You're feeling a strong conflict inside. On the one hand you feel frightened and have wanted to leave at times, and on the other, you want to stay and for things to go back to how they were before. (Double sided reflection to empathise with how Aimee is feeling and the conflict she's in - this helps Aimee take her thoughts one step further)

Aimee: I wonder if things can ever be the same as before.

Health Visitor: You would do anything to make things as before, but you know that accepting his behaviour is not an option in the long term. (reflection) What would you like to do about this situation? (Open question)

At this point, the conversation between the health provider and the women should focus on what the woman did so far and what she intends with regards to the situation. The discussion should focus on what the woman desires to do, what are her plans to approach the situation and what are the risk situation that might compromise her plans of solving the situation. The practitioner is only guiding the conversation through reflections and open questions, without advising the woman. In some cases, **giving information** is needed, as some woman find themselves helpless. Giving information is allowed in two situations:

1. If the woman asks for help
2. If the practitioner asks for permission to share information, if observing that the woman is not able to generate any solution

Aimee: (Silence)

Health Visitor: Would you like me to give you some information about what help is available to you?

Aimee: Yes, it might be good to know. I guess so.

Health Visitor: Well, sometimes it can help to talk about how you're feeling and we have a counsellor you can see who can spend more time with you. You can work with the counsellor to solve confusing feelings and the counsellor can support you, whatever you decide to do. Then if your partner gets violent again there are several options. You can always call the police to help you in that situation because you know it's illegal for him to hit you. (Information giving, empowerment, reinforcing that she is in charge)

Aimee: I don't think I could ever do that to him.

Health Visitor: It is a difficult decision to do that and hopefully you will never have to do it (reflection). If you are still interested in other support services, there is also the local specialist domestic abuse service if you want to speak to someone on the phone at any time, or if you ever need to leave in a hurry and you need somewhere to stay. You can contact them even if you aren't thinking of leaving straight away, just to be in touch for them to support you. There are some numbers here on this leaflet. Would it be safe for you to take a leaflet or would you rather write the numbers down? (Information giving, concern for safety)

Aimee: I'll write them down in code as I don't want Mark to know I've spoken about this.

Health Visitor: You feel more comfortable, at this point, to write them down in code (reflection). Sometimes it's good to have things ready too, in case you ever need to leave in a hurry, things like important documents, medicines, toys for Samantha etc. (Information for preparing for a crisis and leaving)

Aimee: Yes, that sounds like a good idea.

Health Visitor: Also Aimee, would it be ok for you if we talk a little about Samantha? (Focusing the conversation on the child and asking for permission)

Aimee: Yes, it's ok.

Health Visitor: Do you think she may be at risk of harm from Mark? Was she ever present when he hit you? (clear and direct question about the child's safety)

Aimee: No luckily she wasn't around and didn't see what happened. I'm pretty sure that he wouldn't harm her. You know, I think I would like to see the counsellor as I can't believe this is happening to me.

Health Visitor: We know that even when a child isn't in the same room as where the violence occurs that they may well be affected so I will ask you about this again when we next meet. Would you like to use the phone to make an appointment? (Aimee nods as yes).

Aimee, would it be ok if I record what you've told me in your case notes?

Aimee: I don't want anyone else to know about it. I feel too ashamed. I don't want you to record it.

Health Visitor: You don't want people to know now but it could be important for you in the future to have a record especially if you ever decide to take legal action or need to apply for housing. And your notes remain confidential within this department. (If the woman requests further explanations, the practitioner should explains the reasons for recording and reassures her about confidentiality)

Aimee: Oh I see, well I suppose if you're sure that no-one will find out and if it could help me, then maybe you should.

Health Visitor is (1) getting a detailed description of what happened last week in Aimee's own words, (2) records previous incidents that Aimee recalls and (3) asks Aimee to check what she has written and then dates and signs it.

Health Visitor: This happens to a lot of women and it's not their fault. (affirmation – normalizing woman's feelings) The important thing is that you get the support you need. Whenever you need, call me or come and see me at any time.

Case study: Using MI when communicating with the patients (version 2 without narative)

In pairs, read the following dialogue of a discussion between a woman and her midwife/gynaecologist/health visitor. Highlight the points of good practice demonstrated by the clinician. Consider the language used, the way the clinician asks questions and how she manages and guides the discussion.

Aimee with Health Visitor / Gynaecologist / Midwife

Health Visitor: Hello Aimee. Thanks for coming to the consultation. How are you feeling today?

Aimee: Hello! I'm feeling ok.

Health Visitor: That's good to hear. It seems that things are going well for you.

Aimee: Yes, thank you!

Health Visitor: It is very important that all patients accessing our services have the opportunity to talk about their experience of domestic violence because domestic violence is very common and it can get worse during pregnancy. So, would it be ok for you if we focus the conversation a little on domestic violence? We respect the confidentiality of what you tell us at all times and the only exception to that is if you choose to tell us that a child is being hurt or anyone's life is at risk.

Aimee: Yes, it's ok.

Health Visitor: Would it be ok for you to talk about your feelings of fear or about experiencing violence from anyone close to you?

Aimee: Well, I think Mark has been under a lot of strain at work recently but it is getting to be a bit much.

Health Visitor: It sounds as though you're feeling under strain too. What has his behaviour been like at home?

Aimee: Well, I thought we'd sorted it out. After Sam was born Mark started to get aggressive and he hit me a few times. It hasn't happened for nearly a year and I honestly thought he wasn't going to get like that again. But last week, he got furious because I'd been out with a friend all day and I hadn't got the food ready. He punched my stomach. I was terrified.

Health Visitor: You went through such a difficult situation last week. There was no way you could predict that, as nothing had happened for over a year. He took you by surprise. That is so frightening. Would you tell me what happened after that?

Aimee: He left and I started to wonder if I should go to stay with my mum. I was going over later to pick up Samantha anyway and I was afraid of what he might do next. But I didn't stay and when he got back he was very apologetic. He's been a lot better since then as if he's got something out of his system. Nothing bad

seemed to happen so I left it.

Health Visitor: Although you don't approve of his behaviour as you know it's dangerous for you and for Samantha, you decided not to leave him. The fact that he was so apologetic made you find excuses for him and leave things as they are. And what are you feeling about it now?

Aimee: I'm just so confused. I kept pretending it wasn't happening but now I'm wondering what I'm doing wrong to provoke him.

Health Visitor: You're wondering if it's your fault but you're really not to blame. Nobody deserves to be hit or to have to live in fear.

Aimee: But I really love him and we used to get on so well before. I wish it would be like that still.

Health Visitor: You're feeling a strong conflict inside. On the one hand you feel frightened and have wanted to leave at times, and on the other, you want to stay and for things to go back to how they were before.

Aimee: I wonder if things can ever be the same as before.

Health Visitor: You would do anything to make things as before, but you know that accepting his behaviour is not an option in the long term. What would you like to do about this situation?

Aimee: (Silence)

Health Visitor: Would you like me to give you some information about what help is available to you?

Aimee: Yes, it might be good to know. I guess so.

Health Visitor: Well, sometimes it can help to talk about how you're feeling and we have a counsellor you can see who can spend more time with you. You can work with the counsellor to solve confusing feelings and the counsellor can support you, whatever you decide to do. Then if your partner gets violent again there are several options. You can always call the police to help you in that situation because you know it's illegal for him to hit you.

Aimee: I don't think I could ever do that to him.

Health Visitor: It is a difficult decision to do that and hopefully you will never have to do it. If you are still interested in other support services, there is also the local specialist domestic abuse service if you want to speak to someone on the phone at any time, or if you ever need to leave in a hurry and you need somewhere to stay. You can contact them even if you aren't thinking of leaving straight away, just to be in touch for them to support you. There are some numbers here on this leaflet. Would it be safe for you to take a leaflet or would you rather write the numbers down?

Aimee: I'll write them down in code as I don't want Mark to know I've spoken about this.

Health Visitor: You feel more comfortable, at this point, to write them down in code. Sometimes it's good to have things ready too, in case you ever need to leave in a hurry, things like important documents, medicines, toys for Samantha etc.

Aimee: Yes, that sounds like a good idea.

Health Visitor: Also Aimee, would it be ok for you if we talk a little about Samantha?

Aimee: Yes, it's ok.

Health Visitor: Do you think she may be at risk of harm from Mark? Was she ever present when he hit you?

Aimee: No luckily she wasn't around and didn't see what happened. I'm pretty sure that he wouldn't harm her. You know, I think I would like to see the counsellor as I can't believe this is happening to me.

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Aimee, would it be ok if I record what you've told me in your case notes?

Aimee: I don't want anyone else to know about it. I feel too ashamed. I don't want you to record it.

Health Visitor: You don't want people to know now but it could be important for you in the future to have a record especially if you ever decide to take legal action or need to apply for housing. And your notes remain confidential within this department.

Aimee: Oh I see, well I suppose if you're sure that no-one will find out and if it could help me, then maybe you should.

Health Visitor: This happens to a lot of women and it's not their fault. The important thing is that you get the support you need. Whenever you need, call me or come and see me at any time.

*The case study was adapted from Domestic Abuse Training Manual for Health Practitioners, HEVAN (2007). The original text was modified to integrate the Motivational Interviewing skills detailed in Chapter 3.

5. HANDOUT: RISK INDICATORS & SAFETY PLANNING[72]

Risk indicators

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

- **Separation** – has the survivor recently left/plans to leave? Any child contact issues with perpetrator
- **Pregnancy** – is the woman pregnant now or has she given birth in the last six weeks?
- **Escalation** – is the abuse getting worse or happening more often?
- **Cultural issues/sensitivity/isolation** – are there any specific issues
- **Stalking** – is she being harassed or threatened by anyone, particularly a former partner? (includes emails/texts)
- **Sexual assault** – has she reported sexual assault as part of the abuse?
- **Other 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 dialling 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).

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

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.

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.

5.1. HANDOUT: SAFETY PLANNING FORM EXAMPLE[73]

Suggestions for increasing safety - in the relationship

- 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.
- I can avoid shops, banks, and ______________ that I used when living with my abusive partner. I can change my route to/from ____________.

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

- 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

6. SOCIAL WORKER EXERCISE - WHAT TO DO WHEN...[74]

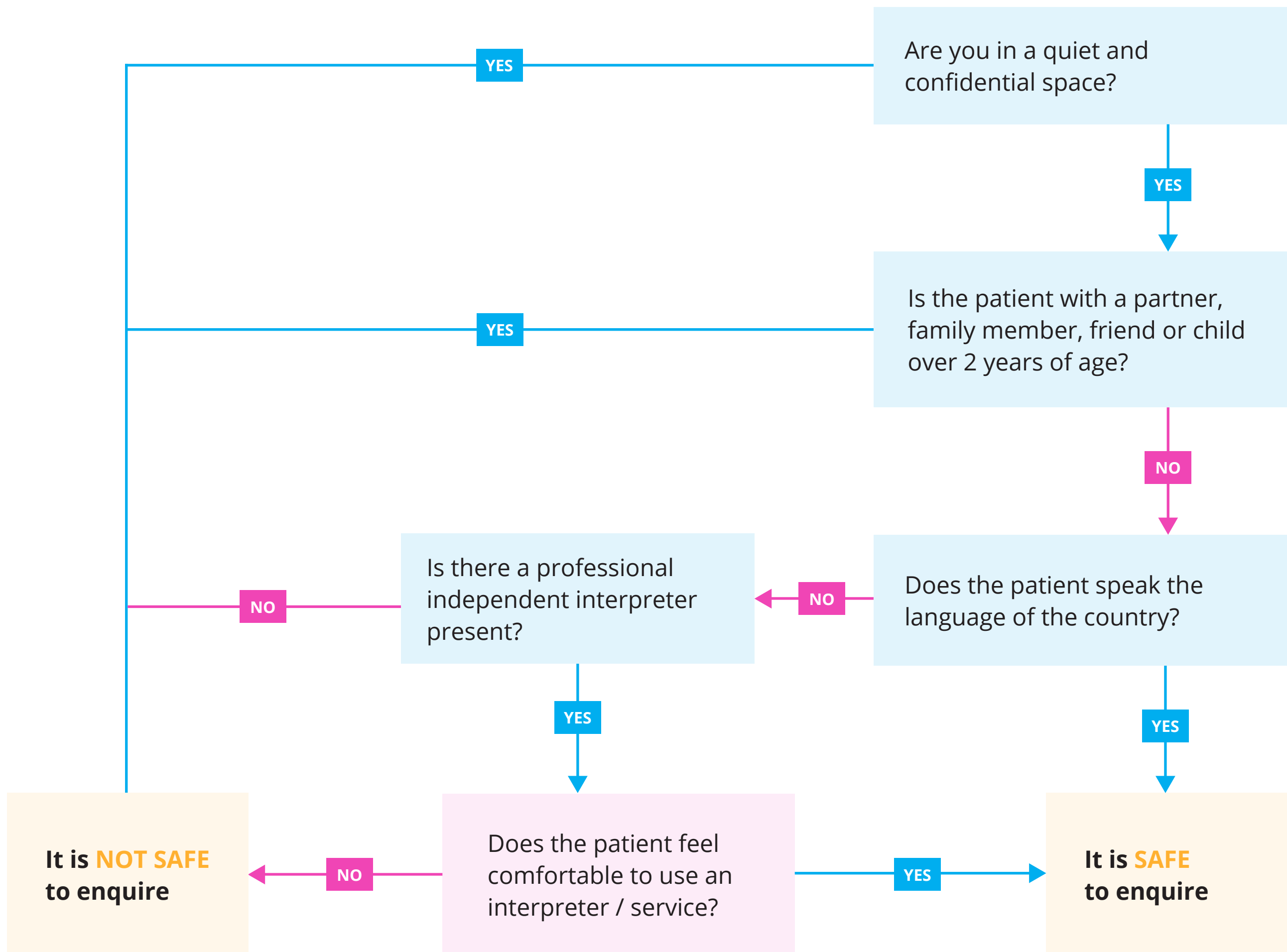
In a group, explain what you would do in the following situations:

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.
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.

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

APPENDIX 2. 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 listening
- 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.

REFFERRAL PATHWAY

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

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

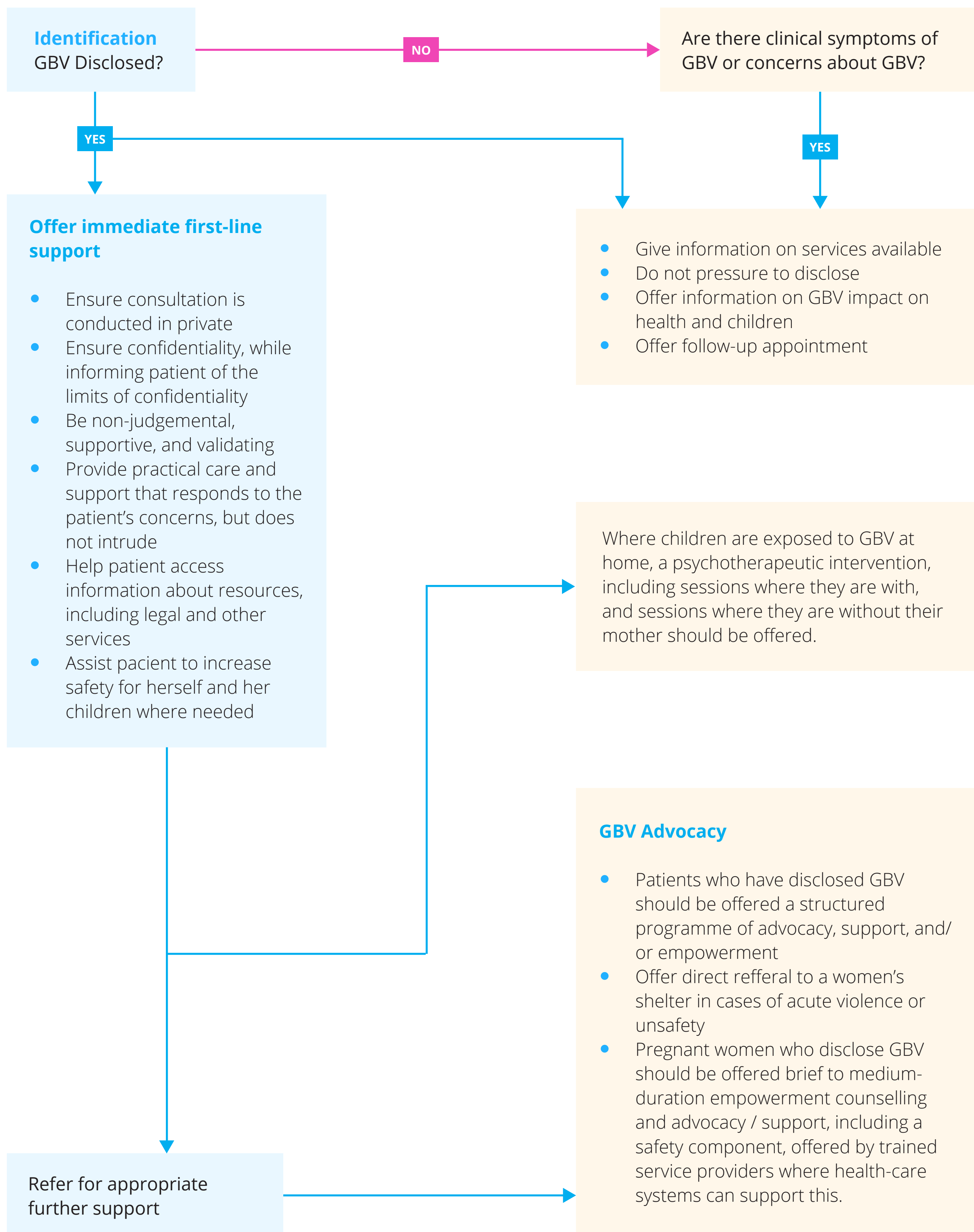
- "I am concerned that your symptoms may have been caused by someone hurting you. Has someone been hurting you?"
- "From our experience we know that patients can get this kind of injury from a physical attack. Has this happened to you?"
- "Has your partner/ex-partner or an adult family member humiliated 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 disorders
- 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 or kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Chronic pain (unexplained)
- Traumatic 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

APPENDIX 3. ADVANCED MOTIVATIONAL INTERVIEWING INFORMATION

TABLE 1: TIPS FOR EXCHANGING INFORMATION

CHUNK–CHECK–CHUNK

When using the Chunk–Check–Chunk strategy, the health practitioner provides a chunk of information, checks patient's understanding, provides another chunk of information, and so on. This strategy is useful when the practitioners must provide a large volume of information and engage the patient at the same time. Checking patient's understanding is not done by using a closed ended question such as "Got it?" but by asking the patient to reflect how the provided chunk of information reflects his/her own situation. Checking if the patient understands the information and if the information is useful for the patient transforms the informing process into a conversation.

ELICIT-PROVIDE-ELICIT

The Elicit-provide-elicit (EPE) strategy is used to draw from patients what they need to know, what they want to know and what the new information represents for them. This strategy involves, besides informing, both asking and listening.
First step in EPE – Elicit - involves asking patients an open-ended question to help them focus the information exchange process. Practitioners can either ask patients what is important for them to know - "What would you most like to know about...?"- or, ask patients what they already know about a topic – "What do you already know about...?".

Second step in EPE – Provide – involves providing information in an appropriate manner. You can ask for permission to exchange information, by simply asking ""Would you like me to tell you about . . . ?"

Third step in EPE – Elicit – involves asking another open-ended question to provide patient's response to the chunk of information you just shared. You can ask patients "What do you make of that?", "What does this mean for you?" or "What more would you like to know?".

TABLE 2: MOTIVATIONAL INTERVIEWING SKILLS AND TECHNIQUES / **MI SKILLS. THE OARS**

OPEN-ENDED QUESTIONS

Patients can't answer open ended questions with a limited response such as "Yes", "No", "Maybe". Open-ended questions are door-openers helping practitioners explore patients' needs, concerns and motivation.

> "What are you most worried about?"
> "How can I help you today?"
> "What worked in the past in this type of situation?"
> "What motivates you most to change?"

AFFIRMATIONS

A health practitioner uses affirmations by making statements of appreciation for the patient and for his/her strengths. Affirmations are positive statements, focus on the presence of an attribute and not its absence and take the form of clear words of understanding and appreciation. Affirmations are not compliments, as compliments involve evaluative judgments. Patients can react negatively if judged.

Use the following strategies when making affirmations:
(1) focus on specific behaviours rather than on attitudes, decisions, and goals,
(2) don't use the personal pronoun "I",
(3) use descriptions not evaluations,
(4) refer to non-problem areas rather than problem areas,
(5) attribute interesting qualities to clients.

For example, for a woman avoiding to report GBV due to the fear of being separated from her children, a practitioner might affirm "You deeply love your children and you are willing to go through difficult situations just to be with them."

For a woman considering reporting and abuse, a health practitioner might affirm "You have a great determination to make your life better."

REFLECTIONS

Reflecting back what the patients said is the most challenging skill. These skills requires practitioners to listen carefully the patients and reflecting what they said by using other words. By using reflection practitioner show that they listen and try to understand patients' situations and offer them the possibility of hearing back their thoughts, feelings and behaviours.

Simple reflection (repeat what the client said – avoid using identical words)

Patient: "I don't know what to do."
Practitioner: You feel you can't do anything in this situation."

Double-sided reflection (use patient's words and express patient's ambivalence about the situation)

Patient: "I don't know what to do but I can't go on with this."
Practitioner: "On one side you feel like you're trapped and you can't see a solution for your situation but on the other side you know it's time to do something, as this is not the life you want to live."

Amplified reflection (rephrase patient's words in an exaggerated manner)

Patient: "I don't know what to do."
Practitioner: "You're terrified by the thought that you will never find a way to get out of this."

SUMMARIES

Summaries are a special application of reflective listening. Through summaries, the practitioner is doing more than just handing back to patients what they just narrated. When summarizing, the practitioner needs to select from the conversation those elements that help patients move forward in their motivation for change while, at the same time, expose these ideas in a succinct but comprehensive manner. In the end, the summary needs to send to the patient the message "I paid attention to what you said and I understand and appreciate you." and at the same time elicit from the patient the change talk.

Collective summary: "So let's go over what we have talked about so far."
Linking summary: "A minute ago you said you wanted to talk about ......Maybe now we can talk about....."
Transitional summary: "So you will make an appointment today before you leave and we'll talk again soon."

TABLE 3: THE IQ-LEDGE-C

I IMPORTANCE-CONFIDENCE RULER

The important-confidence ruler assesses patient's importance and confidence to make a change. A set of three questions (one main question and two follow up questions) must be asked in a specific order for both the importance and confidence.

Importance
Q1. "How important is for you right now to....? On a scale from 0 to 10 where 0 means not at all and 10 means highly important, what number would you choose?"

Follow-up questions
Q2. Ask why they chose the given number and not a lower number:
"How come you chose a 5 and not a smaller number?"
Q3. Ask what might happen to increase the number by a point or two:
"What would mean to get from a 5 to a 7?"

Confidence
Q1. "How confident are you that you could make this change, if you decided to? On a scale from 0 to 10 where 0 means not at all and 10 means highly confident, how confident are you that you can make this change?"
Q2. Ask why they chose the given number and not a lower number:
"How come you chose a 5 and not a smaller number?"
Q3. Ask what might happen to increase the number by a point or two:
"What would mean to get from a 5 to a 7?"

Q QUERY EXTREMES

Ask about the best - and worst - case scenarios, to elicit additional information.

Worst-case scenario: "What's the worst thing that might happen if you don't change this behaviour/continue to...?"
Best-case scenario: "What's the best thing that would happen if you change this behaviour/stop doing...?"

L LOOKING BACK - LOOKING FORWARD

Ask about a time before the current concern emerged and ask how the patient views the future

Looking back
"How have things been better in the past?"
"What past events can you recall when things were different?"

Looking forward
"What might happen if things continue as they are?"
"What might happen if you were succeed in making the changes you want?"
"How do you see yourself in the future/in five years?"

E EVOCATIVE QUESTIONS

Using open-ended questions about the patient desire, ability, reason and need to change.

Desire: "What would you like to happen?"
Ability: "What are your strengths?/What can you do about it?"
Reason: "What motivates you to change?"
Need: "How important is for you to change?"

D DECISIONAL BALANCE

Ask the patient for the good things about changing and the bad things about not changing.

Important! Avoid asking for the bad things of changing and the good things of not changing, as these questions will elicit sustained talk and push the patient towards not changing.

Good things about changing: "What are the advantages if you seek help/report the abuse/change the...?"

Bad things about not changing "What are the disadvantages of not seeking help/ not reporting the abuse/not changing the...?"

G GOALS AND VALUES EXPLORATION

Practitioners explore together with patients the goals that they have and how changing the behaviour (e.g., reporting the abuse, seeking for help, giving up alcohol, seeking social support) fits with the establish goals. Moreover, practitioners can explore how not changing the behaviour would impede patients in reaching the establish goals and values.

Practitioners can ask the following:
"What do you expect from your life?"
"What is the most important thing for your?"
"What do you want to achieve in your life?"
"What values are important for you?"

"How does your current behaviour fit into your value system?"
"How does the current situation conflict with your value system?"
Important! Patients usually select the goals and values from a goals and values list that the practitioner shows or reads.

E ELABORATION

Using open-ended questions to explore patients' motivation and commitment for change. Practitioners can ask for specific examples, for clarifications, for a description of the last time the GBV incident occurred.

"Can you give me a specific example of...?"
"What can you tell me more about...?"
"What else?"
"How do you see this change happening?"

C COMING ALONGSIDE

By using this strategy of "reverse psychology," practitioners are actually presenting to patients the negative side of their ambivalence about change and thus, reflect their sustained talk. This strategy frees up the client to think and feel the other side.

"No matter the costs, it's important for you not to give up."
"Your situation with your partner is not something you want to discuss in our work together."
"We should just give up this subject as you are not at all interested in doing something about it."

Important! This strategy should be used only with very resistant patients and should be the last strategy that the practitioner uses, after the other strategies failed to address patient's ambivalence about change.

APPENDIX 4. CAPACITY BUILDING SEMINARS. POWERPOINT PRESENTATIONS

RESPONSE

Multi-agency response for reporting of GBV in women's health services

Capacity building session for health care teams

Recommended time: 4 hours (or 2 x 2 hours)

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Welcome and introductions

- Name
- Role
- Previous training on GBV
- Experience of working with survivors of GBV
- Expectations of the session

Information for trainers:

- Be sure to know your audience before the training in order to adapt the content to the participants and local setting. Try to find out their experience and about previous training they have attended on GBV two weeks in advance or more.

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Group agreement

- Phones off or on silent
- Be in the room, be present
- Treat each other with respect
- One person to speak at a time
- Challenge the view/opinion/statement not the person
- Manage confidentiality
- No question is a stupid question
- Please participate! Active learning is encouraged!
- Take care of ourselves

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Outline of RESPONSE training

The project runs across five European countries: Austria, France, Germany, Romania (lead partner) and Spain

- To provide training and capacity building sessions for health care teams in women's health settings
- To increase the skills of health care teams in GBV identification
- To increase disclosure of GBV in women's health setting following training
- To increase referrals for patients with experience of GBV to specialist services
- To increase safety for patients with experience of GBV

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Outline of RESPONSE Manual

To support delivery of the training and the programme in women's health care services

- Provides detail and supplementary information on:
- GBV core concepts and identification of GBV in the health care setting
- Communication skills – using motivational interviewing (MI)
- Safety planning
- Pathways for referral and reporting
- Recommendations for action locally – multi-sectoral response
- Evaluation of local programmes
- Appendices:
- Exercises and case studies
- Advanced MI information
  - Reference tool for health care
  - Risk indicator checklist

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Outline of the session

- What is GBV?
- Why is a response required from those working in women's health services?
- Impact on women's health
- Challenges and barriers for women and their health care providers
- Communications techniques – introducing motivational interviewing
- Risk assessment and safety planning
- Care pathways and making a referral
- How to record and document (*specific to each setting*)
- Developing cooperation across communities and professions

Information for trainers:

- Add any relevant information you consider important for the local setting where the capacity building session is being held.

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GBV | RESPONSE

Gender-based violence core concepts

Topic 1

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What is GBV?

- Gender-base violence (GBV) is violence committed against women because they are women
- GBV is a violation of women's human rights including:
    - Right to life
    - Right to be free from torture and inhuman or degrading treatment or punishment
    - Right to equal protection under the law
    - Right to equality in the family
    - Right to the highest standards of mental and physical health

(Istanbul Convention, 2011)

- GBV is a public health and health care problem

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What does GBV include?

GBV is the term used to describe violence and abuse against women and girls in its widest sense and encompasses:

- Domestic violence and abuse
- Coercive control
- Violence and abuse from an intimate partner or adult family member
- Female genital mutilation (FGM)
- Sexual violence
- Forced marriage
- Honour based violence

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Forms of GBV

- Physical
- Sexual
- Psychological
- Coercive control
- Economic
- Isolation
- Threats

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Prevalence of GBV

- Worldwide, almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner
- In some regions, 38% of women have experienced intimate partner violence.
- Globally, as many as 38% of all murders of women are committed by intimate partners.

WHO. "Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence", (2013) p. 2

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GBV | RESPONSE

GBV impact on women's health

Topic 2

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Why is GBV an issue for women's health care professionals?

- GBV is linked to a host of health outcomes
- GBV is a risk factor for immediate and long term health conditions
- Health care services spend a lot of time dealing with the impact and effect of GBV on women
- Health care services are often the first point of contact for women with experience of GBV
- Health can play an essential preventative role and offer early intervention
- The impact of GBV is wider than on the person experiencing it directly, e.g. affects children and wider family

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What is the impact of GBV on women's health? (1)

- Death
- Reduced life expectancy
- Physical harm
- Unhealthy coping mechanisms – alcohol and drug use, self harm
- (Psycho) Somatic consequences
- Reproductive health consequences
- Psychological health consequences

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What is the impact of GBV on women's health? (2)

Women experiencing GBV are:

- 16% more likely to have a **low-birth-weight baby**
- more than twice as likely to have **an abortion**
- almost twice as likely to experience depression
- in some regions, 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence

WHO. "**Global and regional estimates** of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence", (2013)

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WHO Study Statistics

	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		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 for site, age group, current marital status, and education

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Pregnancy and violence

Women who were pregnant during the relationship with a violent partner, and whether or not the partner was violent against them during pregnancy

	Partner violent during the pregnancy (%)	Partner not violent during the pregnancy (%)	No answers (%)	Total (%)	*N*
Current partner	20	77	2	100	1,762
Previous partner	42	56	1	100	3,120

European Agency for Fundamental Rights (FRA). **Violence against Women: An EU-wide survey**. Brussels, FRA, (2014)

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GBV | RESPONSE

Role of health care professionals
Focus on: medical doctors, midwives, nurses

Topic 3

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Health care professionals (OBGYN)

- The health care response to GBV is the responsibility of all health care professionals
- A previous project focused on the response in emergency departments (IMPLEMENT)
- Elements of the primary care response to GBV are different from that in acute care and hospital-based services
- We focus (RESPONSE Project) on the response from health care professionals working in:
    - Obstetric services
    - Gynaecology services
    - Sexual health services

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Grant number: JUST/2015/RDAP/AG/MULT/9746

The role of health care professionals in women's health services

- Recognise when GBV might be an issue for their patient
- Ask about GBV in a sensitive way when there is a clinical reason to do so
- Ask routinely when women are attending for perinatal care appointments
- Validate what the patient is telling them
- Know where to refer a patient or who to talk to for more support
- Record disclosures

BUT: Health care professionals often lack the skills to identify women experiencing GBV in women's health services

We aim to support this and to equip you with the tools to ask patients about GBV, respond, refer on if appropriate and record the disclosure in the patient's medical record.

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Obstetrics. Factors to consider (1)

- Patient books late or does not attend clinics
- Patient repeatedly attends with minor problems or has repeat admissions
- Patient does not complete treatment or self-discharges
- Patient is depressed, anxious or self-harms
- High levels of symptoms of perinatal depression, anxiety, and PTSD are significantly associated with having experienced domestic violence*
- Patient presents with injuries, in particular to abdomen, breasts, inner thighs, head and neck. She may try to persuade the health care professional that these are not very serious.

M. Bewley, Susan, and Jan Welch, eds. "**ABC of domestic and sexual violence**." John Wiley & Sons, (2014), p.69-72

*Howard L.M., Oram S., Galley H., Trevillion K., Feder G. "**Domestic violence and perinatal mental disorders: a systematic review and meta-analysis**". PLoS Med. 2013; 10: e1001452.

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Obstetrics. Factors to consider (2)

- Patient experiences frequent vaginal discharge, post-coital bleeding, urine infections or pelvic pain
- Patient experiences recurrent miscarriages, unexplained stillbirths or pre-term labour
- There is intrauterine growth restriction or low birth weight
- The pregnancy is unplanned or unwanted
- Patient makes a termination request or has undergone multiple terminations
- Patient may have problematic substance use or be unable to stop smoking

M. Bewley, Susan, and Jan Welch, eds. "**ABC of domestic and sexual violence**." John Wiley & Sons, (2014), p.69-72

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Obstetric complications

- Premature labour
- Stillbirth
- Low birth weight baby
- Antepartum haemorrhage
- Chorioamniotis

M. Bewley, Susan, and Jan Welch, eds. "**ABC of domestic and sexual violence**." John Wiley & Sons, (2014), p.69-72

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Gynaecology

Women who experience GBV have a three times increased risk of gynaecological problems.

The worse the combination of physical and sexual abuse, the worse the gynaecological problems

Campbell J et al. "**Intimate Partner Violence and Physical Health Consequences**". Arch Intern Med. 2002;162(10):1157-1163. doi:10.1001/archinte.162.10.1157. http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/211435

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Gynaecology continued

Women experiencing GBV may repeatedly fail to attend for cervical smear tests and are at increased risk of conditions including:

- Menstrual disorders
- Pelvic pain
- Pain during intercourse
- Vaginal discharge
- Pelvic inflammatory disease
- Post-coital bleeding

M. Bewley, Susan, and Jan Welch, eds. "**ABC of domestic and sexual violence**". John Wiley & Sons, (2014), p.69-72

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Sexual health

Women experiencing GBV may present to sexual health services or women's health services for a variety of reasons:

- Vaginal discharge
- Following rape
- After being forced to have sex with others for the financial gain of her partner
- With a STI caught from her partner
- Concern about HIV status

Younger women and women involved in street sex work may be more likely to attend sexual health services when they are experiencing GBV

M. Bewley, Susan, and Jan Welch, eds. "**ABC of domestic and sexual violence**". John Wiley & Sons, (2014), p.69-72

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Reproductive coercion

Reproductive coercion involves behaviours that a partner uses to maintain power and control in the relationship and that are related to reproductive health.

Women affected by GBV:

- are often not allowed to manage their own fertility
- may be forced to take contraception
- may be prevented from taking contraception (more usual than being forced to take it)
- are more likely to have an unintended pregnancy than those not experiencing GBV
- may fear becoming pregnant

M. Bewley, Susan, and Jan Welch, eds. "**ABC of domestic and sexual violence**". John Wiley & Sons, (2014), p.69-72

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Reproductive coercion

A patient who attends repeatedly requesting contraception or emergency contraception should be asked about her relationship and asked directly whether she is experiencing GBV.

Long acting reversible contraception should be discussed.

M. Bewley, Susan, and Jan Welch, eds. "**ABC of domestic and sexual violence**". John Wiley & Sons, (2014), p.69-72

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Grant number: JUST/2015/RDAP/AG/MULT/9746

RESPONSE is a partnership model of working

Team of health care professional (HCP) and social care/specialist GBV sector

Promotes a shared responsibility for the support and best care of patients with experience of GBV

Health care professional (HCP)	Social Worker
Initial response	Full risk assessment
Safety check	Safety planning
Referral to social worker/GBV specialist	Support planning including onward referrals

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Best care of patients with experience of GBV

The health care professional and social worker in each setting need to ensure the following for best care of patients with experience of GBV:

- A private space to meet and speak
- An interpreter if required who is not from the victim's family
- A survivor-centered approach
- Validation of the patient's experience
- Identification of GBV
- Risk assessment and safety planning
- Follow up care both for health and GBV related issues
- Clear contact details for next steps

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Requirements for asking about GBV

From IMPLEMENT manual

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

WHEN IS IT SAFE?

- Private and confidential space
- Woman is alone – including no children present

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Role of social workers (support workers, psychologists)

Social workers act as gender-based violence advocates. They are:

- Specialists working in the field of GBV
- Have experience and training in supporting survivors
- Can carry out detailed risk assessments
- Can support survivors to create a safety plan and talk through options around their care and onward decisions
- Are well connected with local support services and can make onward referrals into other services in agreement with the survivor they are supporting
- Have confidence and competence to work within the health setting and with health care professionals
- Are receiving good supervision from within the GBV sector to prevent repeat trauma

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Grant number: JUST/2015/RDAP/AG/MULT/9746

GBV | RESPONSE

Challenges and barriers for women and their health care providers

Topic 4

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Barriers in addressing GBV (1)

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, **Strengthening Health System Responses to Gender-based Violence** in Eastern Europe and Central Asia(2014), p. 175

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Barriers in addressing GBV (2)

Women Patients

Issues of diversity can create additional barriers and include:

- Language and cultural barriers faced by migrant and refugee women and women belonging to ethnic minorities
- Fear of drawing attention to irregular immigration status or of losing status following separation from a violent spouse
- Concern over ongoing support if the perpetrator is the person who looks after the woman if she has a disability
- Stigma or disbelief if a woman is in a same sex relationship
- Incorrect assessment by health care professionals that some cultures and communities accept GBV

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Overcoming the barriers

- Some key messages:
  - You are not to blame or responsible for what is happening
  - No one deserves to be treated that way.
  - You do not have to deal with the problem alone and support is available
- Offer ongoing support and keep the lines of communication open
- Ask her how things are going at subsequent appointments and whether there is anything she is concerned about that she wishes to discuss.
- If possible make arrangements so that you see her for the remainder of her care to facilitate ongoing support and communication. You will also be able to keep track of any changes occurring, e.g. if the GBV gets worse.

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Communication Skills
Focus: Motivational Interviewing

Topic 5

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Motivational Interviewing: Definition

Motivational Interviewing is "a collaborative, person-centred form of guiding, to elicit and strengthen motivation for change"

Miller, W. R., & Rollnick, S. "**Ten things that motivational interviewing is not. Behavioural and cognitive psychotherapy**", (2009), 37(02), p. 129-140

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Motivational Interviewing: Evidence

What problems can we address using MI?
Who can use MI?

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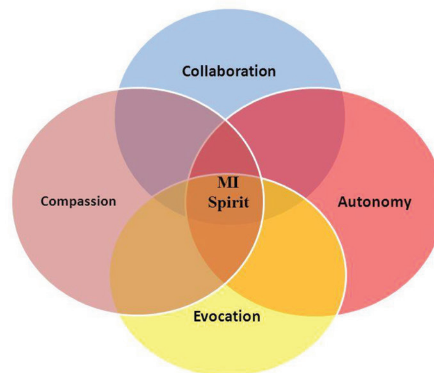
Grant number: JUST/2015/RDAP/AG/MULT/9746



Miller, W. R., & Rollnick, S. "**Motivational interviewing: Helping people change**". Guilford press, (2013), p.25-36

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Motivational Interviewing: Change talk

DARN	CAT
Desire: "I want/would like/wish to"	**C**ommitment: "I am going/intend to/will"
Ability: "I could/can"	**A**ctivation: "I am ready/prepared to"
Reasons: "I want this because"	**T**aking steps: "I did"/"I started to"
Need: "I ought/have/need to"	

Rollnick, S., Miller, W. R., Butler, C. C., & Aloia, M. S. "**Motivational interviewing in health care: helping patients change behaviour**", (2008), p. 33.

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Skills for health care teams

Open-ended questions
Affirmations
Reflections
Summarising

Multi-agency response for reporting of GBV in maternal health services (RESPONSE)
Grant number: JUST/2015/RDAP/AG/MULT/9746

1. Open-ended questions

Open-ended questions

How are you feeling today?

What would you like to talk about today?

How are things going with your partner?

What things worry you about your relationship?

What would be the things you would like to change in your relationship?

What are the things that concern you lately?

Closed questions

Where does it hurt?

Have you talked with someone about this?

Are things getting worse when your partner drinks?

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Grant number: JUST/2015/RDAP/AG/MULT/9746

2. Affirmations

Example 1

Patient: "I don't want to talk about this because I don't know what will happen to my children."

Practitioner: "You deeply love your children and you are willing to go through difficult situations just to be with them."

Example 2

Patient: "I want to speak about this. I can't keep silence any longer."

Practitioner: "You have a great determination to make your life better."

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Grant number: JUST/2015/RDAP/AG/MULT/9746

3. Reflections

Simple reflection (repeat what the client said – avoid using identical words)

Patient: “I don’t know what to do.”

Practitioner: “You feel you can’t do anything in this situation.”

Double-sided reflection (use patient’s words and express patient’s ambivalence about the situation)

Patient: “I don’t know what to do but I can’t go on with this.”

Practitioner: “On one side you feel like you’re trapped and you can’t see a solution for your situation but on the other side you know it’s time to do something, as this is not the life you want to live.”

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Grant number: JUST/2015/RDAP/AG/MULT/9746

3. Reflections (2)

Amplified reflection (rephrase patient’s words in an exaggerated manner)

Patient: “I don’t know what to do.”

Practitioner: “You’re terrified by the thought that you will never find a way to get out of this.”

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Grant number: JUST/2015/RDAP/AG/MULT/9746

4. Summaries

Collective summary: “So let’s go over what we have talked about so far.”

Linking summary: “A minute ago you said you wanted to talk about ……Maybe now we can talk about…..”

Transitional summary: “So you will make an appointment today before you leave and we’ll talk again soon.”

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Motivational Interviewing: RULE principles

Resist the righting reflex

Understand your patient's motivations

Listen to your patient

Empower your patient

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Grant number: JUST/2015/RDAP/AG/MULT/9746

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Safety and risk assessment

Topic 6

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Safety and risk assessment questions (IRIS training)

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)

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Grant number: JUST/2015/RDAP/AG/MULT/9746

SPECCS

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.

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Grant number: JUST/2015/RDAP/AG/MULT/9746

DASH

Domestic Abuse, Stalking and Harassment and Honour-based Violence

Risk indicator checklist (RIC)

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 safety of the victim and children

Ask yourself: „Am I satisfied that I have done all I can?"

SafeLives, **SafeLives Dash risk checklist for the identification of high risk cases of domesti and 'honour'-based violence**

http://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL.pdf

Information for trainers:

- Depending on the setting the risk assessment is carried out by medical staff or social worker; it also depends on the referral system in place locally and local protocols.

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Grant number: JUST/2015/RDAP/AG/MULT/9746

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Creating and using a referral pathway

IMPLEMENT Training. Fundamentals Sheet

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Referral pathways

- Must be simple and clear
- Must take local protocols and resource into account
- Need for a crisis/emergency/high risk referral route and standard risk referral route: one contact for each
- Listen to what survivors tell us they want
- Evaluate and monitor the pathways – demonstrate effectiveness and benefits to patients
- Code the referrals and audit the codes to ensure that patients are being asked about GBV

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Fundamental Reference Tool

- The IMPLEMENT project suggests a fundamental reference tool (Appendix 2, RESPONSE Manual) that covers:
    - Identify GBV
    - Assess risk
    - Treat clinical symptoms
    - Offer immediate first line support
    - Refer on as appropriate
- Develop a local version of the tool and GBV care pathway

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Recording and documenting

Documentation is an essential part of best clinical practice and good patient care

Notes and records must be clear and accurate in order to provide the following:

- History
- Who was present
- Who said what
- Health findings both negative and positive
- The medical care plans
- How concerns were addressed

M. Bewley, Susan, and Jan Welch, eds. "**ABC of domestic and sexual violence**". John Wiley & Sons, (2014), p.69-72

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Grant number: JUST/2015/RDAP/AG/MULT/9746

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Recommendations for action

Topic 7

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Grant number: JUST/2015/RDAP/AG/MULT/9746

A whole community response

- Multi-sectorial and multi-agency response
- At all levels
  - Policy
  - Organization
  - Education
- Good practice examples that can be applied in your health care setting
  - Victim Protection Groups
  - MARAC

Information for trainers:

- If other good practice examples are promoted in your countries, besides the Victims Protection Group example, provide your country examples.

Multi-agency response for reporting of GBV in maternal health services (RESPONSE)
Grant number: JUST/2015/RDAP/AG/MULT/9746

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Capacity building evaluation

Topic 8

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Evaluation: what worked?

- Process evaluation: how the training was performed
  Measure by having each participant complete a training evaluation form at the end of the training (1)
- Outcome evaluation: what was learned and was it useful
  Have each participant complete a pre and post training questionnaire to measure participant change (2)

Must be short and easy to understand for participants

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Example: Training Evaluation Form 1 (RESPONSE Manual)

1. How do you evaluate the training overall, on a scale of 1 to 10? _____		1-very satisfied		10-not at all satisfied
2. Please assess the following aspects of the training	Yes, very much	Somewhat yes	No, rather not	Not at all
2.1. The training was well structured.	❑	❑	❑	❑
2.2. There was appropriate time allocated to each module.	❑	❑	❑	❑
2.3. Time for discussion was sufficient.	❑	❑	❑	❑
2.4. The hand-outs and materials were useful.	❑	❑	❑	❑
2.5. The training was relevant.	❑	❑	❑	❑
2.6 The training will benefit my work.	❑	❑	❑	❑
2.7. I would recommend the training to others.	❑	❑	❑	❑
3. How do you assess the performance of the trainers?				
3.1. I found the trainers to be knowledgeable.	❑	❑	❑	❑
3.2. I found the trainers ensured good interaction and exchange with and among participants.	❑	❑	❑	❑
3.3. I found the trainers had good presentation skills.	❑	❑	❑	❑
3.4. I would recommend the trainers for similar trainings.	❑	❑	❑	❑
4. How do you assess the overall organization/logistics of the training?	Excellent	Good	Not so good	Poor
4.1. Training facilities	❑	❑	❑	❑
4.2. Coffee breaks, lunches	❑	❑	❑	❑
4.3. Location of the venue	❑	❑	❑	❑
Any comments or suggestions for improving the training?				
Thank you very much for supporting this evaluation!				

Multi-agency response for reporting of GBV in maternal health services (RESPONSE)
Grant number: JUST/2015/RDAP/AG/MULT/9746

Example: Pre-Post Test Evaluation Form 2 (RESPONSE Manual)

1. Please indicate how prepared you feel to perform the following tasks (*tick the number which best describes how prepared you feel*):					
	1 = Not prepared	2 = Slightly	3 = Moderately	4 = Fairly well	5 = Well prepared
1.1. Ask questions to promote disclosure of GBV with patients	❑	❑	❑	❑	❑
1.2. Appropriately respond to disclosures about GBV with patients	❑	❑	❑	❑	❑
1.3. Identify signs and symptoms associated with GBV based on patient history and physical examination	❑	❑	❑	❑	❑
1.4. Perform a risk assessment on a patient	❑	❑	❑	❑	❑
1.5. Document violence history and physical examination findings in patient's record	❑	❑	❑	❑	❑
1.6. Make appropriate referral for a patient	❑	❑	❑	❑	❑
2. How many new diagnoses (picked up an acute case, uncovered ongoing abuse, or had a female patient disclose a past history) of GBV would you estimate you have made in the last 6 months? __________Number					
3. Which of the following actions have you taken when you identified gender-based violence in a patient in the last 6 months? (*Tick all that apply*)					
3.1. Referral to a social workerand among participants.			❑		
3.2. Referral to violence prevention services			❑		
3.3. Referral to a shelter.			❑		
3.4. Referral to the police.			❑		
3.5. Notification/referral to the court			❑		
Any comments to share?					
Thank you for completing this form!					

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Grant number: JUST/2015/RDAP/AG/MULT/9746

Partners:

UNIVERSITATEA BABEȘ-BOLYAI

Associate Partners:

Supporting institutions:

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Grant number: JUST/2015/RDAP/AG/MULT/9746

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Grant number: JUST/2015/RDAP/AG/MULT/9746

SELECTED PUBLICATIONS OF RELEVANT INTEREST

Blank K, Rosslhumer, M. IMPLEMENT Training Manual, "Specialized support for victims of violence in health care systems across Europe" (2015), **http://gbv-implement-health.eu/implement_train_EN_201606_hires.pdf**

Bewley S, Welch, J. eds. "**ABC of domestic and sexual violence.**" John Wiley & Sons, (2014)

Fundamental Rights Agency (FRA) "Violence against Women: An EU-Wide Survey" (2014), **www.health-genderviolence.org/**

IRIS, Identification and Referral to Improve Safety, Training Materials, University of Bristol (2017), **http://www.irisdomesticviolence.org.uk/iris/**

MINT. Motivational Interviewing Training New Trainers Manual (2014).
http://www.motivationalinterviewing.org/sites/default/files/tnt_manual_2014_d10_20150205.pdf

www.motivationalinterviewing.org

PRO TRAIN Project "Improving Multi-Professional and Health Care Training in Europe - Building on Good Practice in Violence Prevention" (2007-2009),
www.pro-train.uni-osnabrueck.de/index.php/TrainingProgram/HomePage

Rollnick S, Miller WR, Butler CC, Aloia MS. "**Motivational interviewing in health care: helping patients change behaviour**". (2008)
http://web.vu.lt/mf/r.viliuniene/files/2014/10/Motivational-Interviewing-in-Health-Care.-Helping-Patients-Change-Behavior.pdf

UNFPA-WAVE Training Manual "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia" (2014),
http://eeca.unfpa.org/publications/strengthening-health-system-responses-gender-based-violence-eastern-europe-and-central

UNICEF "Handbook for Coordinating Gender-based Violence Intervention in Humanitarian Settings" (2010),
www.unicef.org/protection/files/GBV_Handbook_Long_Version.pdf

World Health Organization (WHO) "Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines" (2013), **http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf**

World Health Organization (WHO) "Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence" — A Clinical Handbook. Geneva (CH), (2014).
http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/

Women against Violence Europe (WAVE) "WAVE Report 2014" (2014),
http://www.wave-network.org/sites/default/files/01%20WAVEREPORT_2014.pdf

KEY MESSAGES

"The clinician response to women who can be isolated and fearful as a result of their experience is critical to their future well-being...the initial reaction of the person they tell and the follow-up within and beyond the health service can have a profound effect on their life, health and well-being." (Department of Health, UK)

"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." (Quote from health care professional after training)

"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." (Quote from patient following referral from health care professional into specialist GBV advocacy support)