From choice, a world of possibilities

Meeting the Sexual and Reproductive Health Needs and Rights of Survivors of

Gender Based Violence

A Good Practice Training Module for Health Care Professionals

Who we are

IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

We work towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

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International Planned Parenthood Federation
South Asia Regional Office
New Delhi, India
December 2007

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Finally, we wish to acknowledge our IPPF colleagues in the Western Hemisphere Region whose valuable work in the field of women's health and violence against women provided the inspiration and important learning for our work in the South Asia Region.

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IPPF South Asia Regional Office
New Delhi
December 2007

Abbreviations

AIDS:	Acquired Immune Deficiency Syndrome
Beijing PoA:	Beijing Platform of Action
CHRF:	Canadian Human Rights Foundation
CEDPA:	Centre for Population and Development Activities
CBOs:	Community Based Organisations
CEDAW:	Convention on the Elimination of All Forms of Discrimination against Women
DFID, UK:	Department for International Development, United Kingdom
DHYLs:	Discounted Health Years of Life
ECP:	Emergency Contraceptive Pill
EOC:	Emergency Obstetric Care
FPA:	Family Planning Association
FGM:	Female Genital Mutilation
GBV:	Gender Based Violence
HIV:	Human Immunodeficiency Virus
ICPD:	International Conference on Population and Development
INGOs:	International Non-Governmental Organisations
IPPF:	International Planned Parenthood Federation
IRC:	International Rescue Committee
MTCT:	Mother to Child Transmission
MAs:	IPPF Member Associations
NGOs:	Non Governmental Organisations
PPT:	Power Point
RTIs:	Reproductive Tract Infections
SRH/R:	Sexual and Reproductive Health/Rights
STIs:	Sexually Transmitted Infections
SGBV:	Sexual Gender Based Violence
SV:	Sexual Violence
SARO:	IPPF South Asia Regional Office
UN:	United Nations
UNICEF:	United Nations Children's Fund
VAW:	Violence against Women
VCT:	Voluntary Testing and Counselling
WHO:	World Health Organisation
WHR:	IPPF Western Hemisphere Region

A Guide to the Manual

Introduction

The World Health Assembly in 1996 drew attention to the continued lack of acknowledgement by the health sector of the links between gender based violence and women's health by calling on governments and health care organisations to address violence against women as a pervasive public health problem throughout the world. Many health care professionals continue to consider violence against women to be a social rather than a public health problem. Others recognise violence as a health issue, but do not know how to address the issues as health professionals.

A four year initiative, *Working Towards Safe Motherhood in South Asia: combating gender based violence during pregnancy in Bangladesh and Nepal*, implemented in the South Asia Region between 2004 and 2007, aimed to increase the skills and knowledge of sexual and reproductive health (SRH) providers to protect women's SRH and rights by reducing the incidence of gender based violence, especially during pregnancy.

A Good Practice Training Manual for Health Care Professionals: Meeting the Sexual and Reproductive Health Needs and Rights of Survivors of Gender Based Violence is based on an on-going capacity building programme developed as part of project activities to strengthen the capacity of IPPF Member Associations (MAs) to respond to the needs of women who experience gender based violence, especially during pregnancy.

Health care organisations, particularly those working in the field of SRH can improve the quality of women's health care by addressing the needs and safety of women who experience violence. Health care providers who ignore violence against women not only miss the opportunity to address an important public health problem, but can inadvertently put women at additional risk.

IPPF/ SARO hopes that this manual will be used widely by public and private health care professionals working in the health sector to adopt a holistic approach to improving women's health.

Manual objectives

The overall objectives of manual are:

- To increase the understanding and knowledgeof service providers of the social, cultural, economic and political factors that underpin gender based violence.
- To enhance the awareness of service providers of the sexual and reproductive health consequences of violence against women.
- To strengthen the capacity of service providers to meet the practical and strategic needs of women experiencing violence within a human rights framework.

Who is the manual for?

This *Good Practice Manual* was designed to be used by IPPF MAs in the South Asia Region to increase knowledge and skills of medical and non-medical staff, counsellors and outreach staff. We hope that the manual will also be a useful resource to health care managers and frontline clinical staff working in private or non-governmental organisations in developing countries working to improve women's health and well-being.

This manual provides a **basic** introduction to health care professionals working in a sexual and reproductive **health** setting to the issues raised by the intersection of gender based violence as a public health problem and human rights violation. Organisations will need to ensure that there are ongoing capacity building programmes for staff that build on learning acquired from the use of this manual. In turn, providers are also expected to take responsibility for continued professional learning and skills development in this area.

Training methodologies

The training is designed to be highly interactive, employing a variety of training methodologies. Roles plays, case studies, lecture style inputs and presentations are employed to respond to differing learning styles and facilitate maximum learning. Manual sessions are supported by additional handouts and resources, which include:

- Additional content information to support facilitator input;
- Instructions for individual and group exercises;
- Case studies for use in role plays; and
- Pre and post workshop evaluations.

The manual has made full use of existing tried and tested training tools and methodologies to avoid duplication. Wherever information is used from a single source, this is acknowledged in full. In some cases, where several sources have been combined and/or adapted for use, these are also noted at the end of the manual.

Planning, preparation and facilitation

Whilst it is hoped that the manual will be used by providers with a range of training and facilitation skills, the nature of the topics and issues covered in the manual requires that facilitators have BOTH an in-depth knowledge of the session topic as well as strong training and facilitation skills.

In view of the breadth of issues covered in the manual, it is recommended that key professionals with specialist knowledge and expertise are brought in as resource persons to run specific sessions, where necessary.

Facilitators should ensure that sufficient time is allocated to ensure sound planning and preparation. As a rough guide, for experienced trainers, planning and preparation time should be AT LEAST TWICE the length of the session itself. Less experienced trainers will need to allow longer.

Many resources are available on training and facilitation skills, and potential trainers are strongly encouraged to strengthen existing skills by reviewing appropriate available resources.

Manual layout and timing

This manual has been tried and field-tested by the manual development team. However, organisations planning to use the manual will need to review the session content, layout and timing, taking into account specific contexts and learning needs of particular audiences. Additional time will be necessary where translation into another language is required.

When the manual was used as part of project activities, a fourth day was added to provide orientation to all staff on new screening procedures which were being introduced to screen clients accessing clinic services.

Time for morning and afternoon breaks and lunch will need to be allowed for in the programme design.

We wish you success in the training and look forward to receiving feedback from the use of the manual.

Safe Abortion Team
IPPF/South Asia Regional Office
December 2007

Overall Training Objectives

- To increase the understanding and knowledge of service providers of the social, cultural, economic and political factors that underpin gender based violence.
- To enhance the awareness of service providers of the sexual and reproductive health consequences of gender based violence.
- To strengthen the capacity of service providers to meet the practical and strategic needs of women experiencing violence within a human rights framework.

Programme

DAY 1: Introduction to Gender and Violence Against Women

Module objectives

1. Introductions and workshop expectations.
2. Identify and understand key concepts related to gender.
3. Increased awareness of the causes and impact of violence against women including impact on health.

Session	Time	Objectives	Methodology	Materials
1.1 Introductions and expectations	1 hr 30 min	At the end of the session participants will be able to: - get to know other participants - identify workshop expectations, and contributions - agree workshop objectives and group norms - assess existing knowledge on workshop topics	Lecture Participatory exercise Tree exercise Discussion	Pre-workshop questionnaire, Flip chart paper, markers, post-it notes
1.2 Exploring key gender related concepts	1 hr 30 min	At the end of the session participants will be able to: - demonstrate understanding of key gender related concepts - identify ways in which gender stereotypes contribute to and sustain gender inequality	Plenary Group work Group discussion	Defining Sex and Gender, Bangladesh Maps, Key Gender Related Concepts, Flip chart, markers, cards
1.3 Understanding gender based violence	2 hr	At the end of the session participants will be able to: - understand the magnitude of the problem of VAW - define GBV and understand its types, causes and consequences	Plenary Discussion Brainstorm, PPT Group work	Gender Based Violence: A Dissonance Generating Questionnaire, Gender Based Violence: A Dissonance Generating Questionnaire (With Answers),

Session	Time	Objectives	Methodology	Materials
				Gender Based Violence: Key Definitions, Types of Gender Based Violence Around the world, Causes and Contributing Factors of Gender Based Violence, Flip sheet, markers, cards, post-it notes
1.4 Health outcomes of gender based violence	1 hr 30 min	At the end of the session, participants will be able to: - identify GBV in different stages of women's lives - identify the health outcomes of GBV	Plenary Group work, Presentations Plenary	Case studies: Sushila and Sameera, The Life Cycle of VAW and its Health effects, Health Specific Outcomes of Violence Flipchart paper, markers
1.5 Summary and end of day 1	30 min	Discussion		

DAY 2: Working with Survivors of Gender Based Violence

Module objectives:

1. Increase understanding of the key steps involved in managing emergencies arising from GBV and sexual violence.
2. Enhance understanding of the roles and responsibilities of service providers.
3. To become aware of the factors that prevent survivors from accessing support.

Session	Time	Objectives	Methodology	Materials
2.1 Recapturing yesterday	30 min	At the end of the session, participants will be able to: - recapture and relate the previous day's learning with training objectives - clarify key learning	Discussion Plenary	Flipchart paper, white board, markers
2.2. Emergency management of gender based violence	2 hr 30 min	At the end of the session, participants will be able to: - define emergency management - explain emergency clinical management of survivors - explain emergency management of sexual violence	Plenary Brainstorm, PPT, Role play Group activity Presentation Individual work Discussion Plenary	Suggested Role Plays on Emergency Management of GBV, Emergency Management of GBV, WHO Guidelines on Assisting Survivors of Sexual Violence, Asha's Case Study, Emergency Health and Safety Needs after Sexual Violence, Safety Planning, Flip chart paper, board, markers
2.3 Working with survivors	1 hr 45 min	At the end of the session, participants will be able to: - identify obstacles that women face in accessing support services - understand the importance of asking, validating and safeguarding the experiences of survivors	Plenary Group work Discussion Case study Plenary	Barriers that Survivors Face in Accessing Support Services: a role play, Cue cards, marker, a ball of string, cue cards

Session	Time	Objectives	Methodology	Materials
2.4 Roles and responsibilities of service providers	1 hr 30 min	At the end of the session, participants will be able to: - identify the roles and responsibilities of service providers in supporting survivors of GBV - recognize, describe and abide by the three fundamental guiding principles for working with survivors of GBV	Plenary Free listing Lecture Discussion Plenary	Qualities of an Effective Service Provider, Roles and Responsibilities of Service Providers, How to Implement a Routine Screening Policy, Ensuring Privacy, Suggested Steps for Developing a Referral Directory, Flipchart paper, white board, markers
2.5 Communicating with survivors	1 hr 45 min	At the end of the session, participants will be able to: - identify barriers to and key elements of interactive communication - explain the difference between 'advising' and 'informing' - demonstrate effective interactive communication	Plenary Discussion, PPT Role play Discussion PPT Plenary	Effective Communication, Barriers to Good Listening, Introduction to Active Listening, Advising vs Informing, Interaction Technique: 1, Interaction Technique: 2, Interaction Evaluation Check-list, Flip chart paper, markers
2.6 Summary and end of Day 2	30 min		Discussion	

DAY 3: Working with Partners to Provide Holistic Support to Survivors

Module objectives:

1. To enhance understanding of human rights and sexual and reproductive rights in the context of GBV.
2. To acknowledge importance of working collaboratively with other stakeholders in meeting the needs of survivors.
3. To understand the importance of building networks and planning for advocacy.
4. To identify personal action plans.

Session	Time	Objectives	Methodology	Materials
3.1 Recapturing yesterday	30 min	At the end of the session, participants will be able to: - recapture and relate previous day's learning with training objectives - clarify key learning	Plenary Discussion	Flipchart paper, markers
3.2 Human rights and sexual and reproductive health and gender based violence	1 hr 30 min	At the end of the session, participants will be able to: - identify key human rights principles - understand the relationship between human rights, GBV and SRHR	Plenary Discussion PPT Case studies	Underlying Principles of Human Rights, International Laws Protecting Women's Human Rights, Key Components of Reproductive Health, IPPF Charter on Sexual and Reproductive Health, Sexual and Reproductive Health: Case Studies, Flip chart stand, markers, flip chart paper

Session	Time	Objectives	Methodology	Materials
3.3 Upholding the rights of survivors: national laws relating to GBV	1hr 40 min	At the end of the session, participants will be able to: - understand the important role of national laws in protecting and upholding rights of women against GBV - identify their role as service providers in supporting survivors to uphold their legal rights	Plenary Freelist and discussion Group work PPT Discussion	Understanding the Legal Issues, Flipchart paper, stand, marker
3.4 Working with partners to provide holistic support	1 hr 30 min	At the end of the session, participants will be able to: - acknowledge the importance of multi-disciplinary work in providing holistic support to survivors - explore partnership working for engaging in advocacy strategies	Plenary Group work Group work PPT	Providing Holistic Support, Planning for Advocacy, Flipchart stand, paper, markers
3.5 Workshop evaluation and closing	1 hr 15 min	At the end of the session, participants will be able to: - review and evaluate workshop learning - state their commitment to carry forward the learning from the workshop	Plenary Individual work Discussion Questionnaire	Follow up Action Plan, Post Workshop Questionnaire, Workshop Evaluation, Resources Information, Flipchart paper, markers

Day 1 Module

Introduction to Gender and Gender Based Violence

Module Objectives:

1. Introductions and workshop expectations.
2. Identify and understand key concepts related to gender.
3. Increased awareness of the causes and impact of violence against women including impact on health.

Session	Time
1.1 Introductions and expectations	1 hr 30 min
1.2 Exploring key gender related concepts	1 hr 30 min
1.3 Understanding gender based violence	2 hr
1.4 Health outcomes of violence against women	1 hr 30 min
1.5 Summary and end of day 1	30 min

Session: 1.1

Introduction and Expectations

Objectives

At the end of the session participants will be able to:
- get to know each other.
- identify workshop expectations and contributions.
- agree workshop objectives.
- agree group norms for workshop.
- assess existing knowledge on workshop topics.

Time

1 hr 30 min

Material

Flip chart paper, markers and post-it notes

Process overview

Steps	Method	Time
1. Welcome and workshop background	Lecture	10 min
2. Introduction and team building	Participatory exercise	30 min
3. Workshop expectations	Tree exercise	20 min
4. Workshop objectives, programme and establishing group norms	Discussion	20 min
5. Pre-course questionnaire		10 min

1. Welcome and workshop background — Lecture — 10 min

Introduce yourself and any other workshop resource persons. Say a few words on the role of the training team to participants.

Explain briefly the topic of the training including background.

Invite someone from the host organization to briefly highlight the purpose of the workshop.

Provide participants with any necessary logistical information that would be needed for the duration of the training.

Identify two volunteers who will be the 'eyes' and 'ears' for the day. Their task will be to take notes of the day's proceedings and provide a recap at the start of the next day.

2. Introduction and team building — Participatory exercise — 30 min

The following exercise is an example and there are many others that can be used in its place.

Introduce your "other half"

- Using the pre-prepared cards (using contextually appropriate well-known pairs; e.g. Romeo and Juliet, Laila and Majnu, Tom and Jerry, king and queen, car and driver, apples and oranges, etc) mix all the pieces together and hand one half to each participant.
- The task is for each person to find his/her other "half." Once the pairs have been formed, each pair should spend 5 minutes getting to know each other. Information that can be shared includes name, designation, why they are attending this training, whether they have had training before about GBV, what is something they think they are really good at, and one unusual fact about themselves.
- At the end, each participant introduces their partner to the group.

Note to Facilitator: *For a three-day workshop, introductions should take a little longer and involve more interactions between participants. The type of opening and instructor's facilitating style during the introductory sessions will set the tone or climate for the workshop. Participants will feel comfortable and begin to form trust in their instructor(s).*

3. Workshop expectations — Tree exercise — 20 min

Draw the shape of a tree on a flipchart.

Request participants to write on post-it notes: 1 expectation that they have of the workshop and 1 contribution that they are able to make to the workshop.

Ask each participant to stick the 'expectation' notes as the leaves of the tree and 'contribution' notes as the roots of the tree. Wherever possible, group similar expectations together.

Read their expectations one by one and briefly clarify whether or not this workshop could address each of their expectations.

4. Workshop objectives, programme and establishing group norms — Presentation/Discussion — 20 min

Present the overall workshop objectives, making sure that participants understand the workshop objectives, its purposes and expected outcomes.

Facilitate a brief discussion linking the post-its of expectations with workshop objectives to workshop expectations of participants. Inform participants that most of their expectations will be met. If there is anything that cannot be met, place it in the "Parking Lot", explain that if time allows these will be covered at the end of the workshop.

Review the daily programme with participants, making sure to note any overall themes for the given days.

Explain how the workshop sessions will build upon each other to achieve the workshop objectives.

Inform participants that we need to agree on some group norms in order to ensure a successful workshop. Ask participants to suggest and agree on some ground rules.

Some examples are:

- Timeliness – start and end on time
- Active participation
- Active listening
- Accommodating different learning styles
- Language constraints

- Turn off cell phones
- Experience sharing
- Confidentiality!

Once there is agreement, post the list of agreed rules on the walls.

Ask for questions and clarifications.

5. Pre-Learning Questionnaire 10 min

Explain the purpose of the pre-workshop questionnaire: that it will provide baseline information of participants' knowledge and enable measurement of workshop learning outcomes at the end of the workshop.

Conclude the opening session.

Handout 1.1A

Pre-Learning Questionnaire

Please read all the statements listed in column 1 and complete column 2 using the rating scale below.

Rating Scale: 5-Strongly Agree 4-Agree 3-No Opinion 2-Disagree 1-Strongly Disagree

Statement	Rating
1. I can describe ways in which society's expectations of women and men affect the extent to which their needs are met or not met.	1 2 3 4 5
2. I can describe the causes and consequences of gender based violence, including sexual violence.	1 2 3 4 5
3. I can explain the linkages between women's sexual reproductive health and gender based violence.	1 2 3 4 5
4. I can explain the factors which prevent survivors of gender based violence from accessing help and support.	1 2 3 4 5
5. I can explain the links between human rights and sexual reproductive rights in the context of gender based violence.	1 2 3 4 5
6. I am able describe the roles and responsibilities of service providers in supporting survivors of gender based violence.	1 2 3 4 5
7. I can apply the three guiding principles of working with clients i.e. safety, confidentiality and respect.	1 2 3 4 5
8. I can describe the key step necessary in treating and supporting women who need emergency care/support as a result of severe physical and/or sexual violence.	1 2 3 4 5
9. I am able to list the legal measures necessary for upholding the rights of survivors and prevention of violence against women.	1 2 3 4 5
10. I can explain the importance of effective interpersonal communication skills in working with survivors.	1 2 3 4 5
11. I can apply effective inter-personal skills in the counselling process.	1 2 3 4 5
12. I can describe why it is important to work with other stakeholders committed to protecting and upholding the rights of survivors of gender based violence.	1 2 3 4 5

Session: 1.2

Exploring Key Gender Related Concepts

Objectives	At the end of the session participants will be able to: - demonstrate understanding of key gender related concepts. - identify ways in which gender stereotypes contribute to and sustain gender inequality.
Time	1 hr 30 min
Material	Flip chart, markers, cards

Process overview

Steps	Method	Time
1. Session Introduction	Plenary	10 min
2. Defining gender and sex	Plenary and group discussion	30 min
3. Understanding gender roles and gender needs	Group work	45 min
4. Session Summary	Plenary	05 min

Handouts

1.2A: Defining Sex and Gender
1.2B: Bangladesh Maps
1.2C: Key Gender Concepts

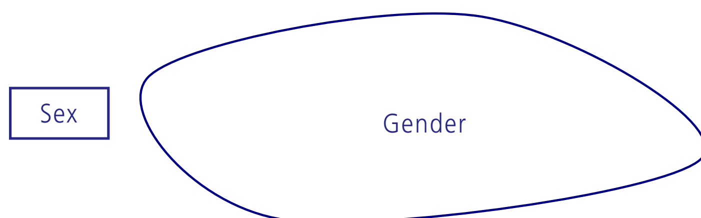
1. Session introduction — Plenary — 10 min

Introduce session objectives.

2. Defining gender and sex — Plenary, group discussion — 30 min

Ask participants to freelist common gender stereotypes. Highlight differences between key concepts of gender, sex, gender roles and gender related needs. Refer to Handout 1.2A, as required.

Explain further the difference between sex and gender using the following illustration:



Inform participants that:

- the idea of "sex" is a small and definite set of differences based on our physical characteristics
- "Gender," however is everything else - a large and amorphous amount of differences between men and women based on what our culture and "values" preaches us what is masculine and feminine. Gender can engross numerous things such as how we should dress, how we should behave in relationships, how we should express ourselves, what our families and communities expect of us as men or women, boys or girls, etc.
- Technology can affect how we view gender. Machines have made it possible for both sexes to do heavy labour; medical technologies have made it possible for sex characteristics to be changed. The content of 'gender' can change for groups of women and men, girls and boys, with time, e.g. individuals can change sexually.

Facilitate a discussion highlighting key points from Handout 1.2A

3. Understanding gender roles and gender needs — Group work — 45 min

Introduce the exercise by explaining that this exercise will enable participants to examine the different roles and needs of women and men. A review of maps drawn up by different groups of people of a village or community will give participants an example of the different perceptions and priorities of different people.

Divide participants into groups of 4 to 6 people, and give each participant a copy of the three Bangladesh maps in Handout 1.2B.

Tell participants that one map was drawn by women, another by men, and another by young men – but do not reveal which was drawn by which people. Ask each group to try to work out which map was drawn by whom, and give their reasons.

Allow 10 minutes for this part of the exercise.

Ask each group to present its conclusions. Then tell them the story of the village, as it was told by the people drawing the maps.

> **Story of the Village:** *The villagers are squatters on the banks of the Jamuna River in Bangladesh. Old men, young men and women respectively were asked to draw a map of their village.*
>
> *The old men, through their map, told the story of their ancestral land, which now lay under the flooded river. They said 'we must stay squatting here, so that we can reclaim the land, once the flood has receded'. The Law states that villages must continue to pay taxes on the land, otherwise it reverts to the government. How could they make sure that they could stay?*
>
> *The women gave the most detail of the immediate settlement, stating that 'we need to earn money here, but we can't move from our settlement because we are women'. What do you suggest? What work could they do?*
>
> *The young men emphasized the road and the railway, which links them to the faraway places where they can seek work as migrants. They get sizeable advance loans, which must then be repaid with interest. They spend about eight months of the year away. How could they find work nearer home?*

Tell the group which map was drawn by which people, and facilitate a short discussion, bringing out the importance of finding out about people's different concerns and

priorities. Draw out specifically the gender role and needs, related to women's mobility, opportunities for income generation, etc. in contrast with men's.

Stress how incomplete a picture would have been obtained if only one map had been used to asses possible interventions to help the villagers. *Emphasise that there is no best map.*

Facilitate a discussion bringing out key learning points from Handout 1.2C

Note to Facilitator: *Map A was drawn by the old men; Map B was drawn by the women, and Map C was drawn by the young men. Let participants work out who drew them and why they think that. They rarely get it all right! You may use your own maps, if you have suitable ones available.*

4. Session summary **Plenary** **05 min**

Sum up key learning points from the session.

Handout 1.2A

Defining Sex and Gender

A quick way to remember the difference between sex and gender is that whilst **sex is biological** i.e. innate physical characteristics that we are born with, **gender is social** i.e. characteristics that are learned gradually and can change over time.

Gender refers to widely shared ideas and expectations (norms) concerning women and men. These include ideas about 'typically' feminine or female and masculine or male characteristics and abilities and commonly shared expectations about how women and men should behave in various situations. These ideas and expectations are learned from family, friends, opinion leaders, religious and cultural institutions, schools, the workplace, advertising and the media. They reflect and influence the different roles, social status, economic and political power of women and men in society.

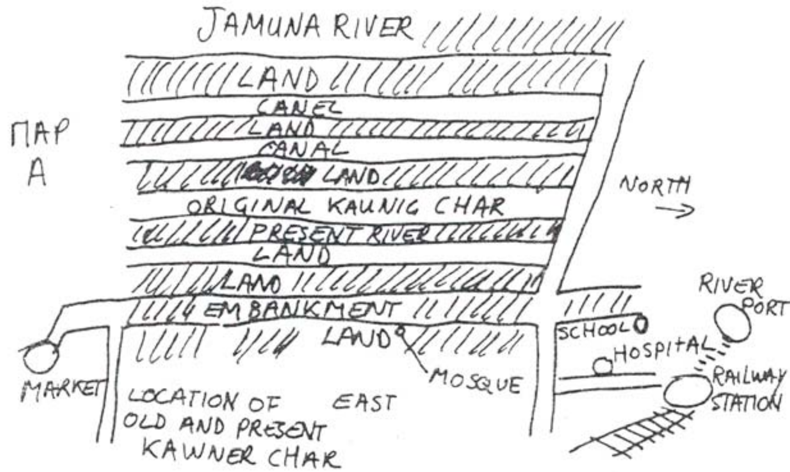
Some other thoughts on sex and gender...

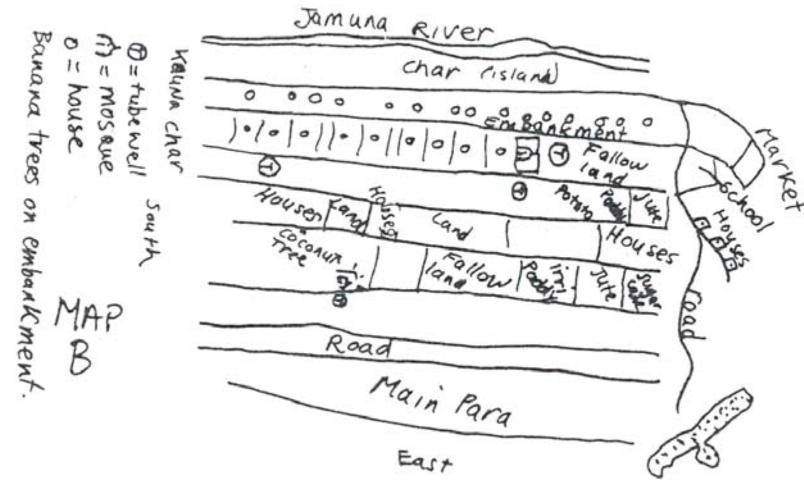
1. Gender is about relationships, not only between men and women but also among women and among men. For example: mothers teach daughters not to contradict men; fathers teach sons 'not to act like women' by crying when they are hurt.
2. Technology can affect how we view gender. Machines have made it possible for both sexes to do heavy labour; medical technologies have made it possible for sex characteristics to be changed. The content of 'gender' can change for groups of women and men, girls and boys, with time, e.g. individuals can change sexually.
3. Gender is an issue for people who are heterosexual as well as bisexual, homosexual or lesbian, and people who choose to abstain from sex.
4. Men and women can manipulate gender-based ideas and behaviour for their own benefit, presumably without harming anyone but at the same time reinforcing stereotypes e.g. women crying or flirting to get what they want.
5. It is difficult to be 100% gender-sensitive: we are almost all influenced by gender in our ideas and actions.
6. Gender sensitivity does not mean that we no longer recognise differences between men and women. Some differences remain because of biology; we may choose to retain others even in equal relationships. For example, men being 'polite' or 'considerate' by opening doors for women.
7. To incorporate a gender-sensitive perspective in our lives, rather than talk about 'gender' itself, we can refer to male and female roles or men's and women's work, for example.

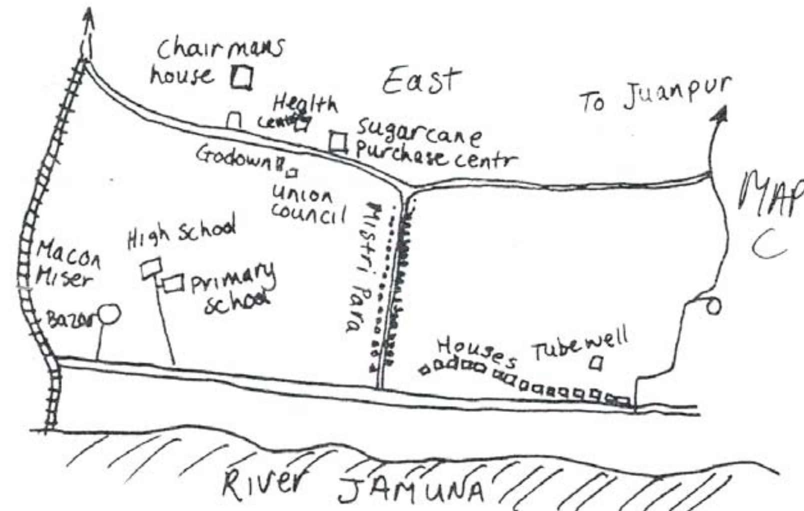
Source: Adapted from multiple sources.

Handout 1.2B

Bangladesh Maps







Source: *The Oxfam Gender Training Manual, Suzanne Williams, Oxfam UK & Ireland, 1994*

Handout 1.2C

Key Gender Related Concepts

Gender Roles: In many societies and cultures, men have more visible and recognized roles than women, largely because men are paid for their productive work and women are not. In these societies, men's roles usually involve jobs, which are assessed and counted in national censuses and accounting systems.

Often, women and men are assigned different activities that reflect social norms that they have been socialized to accept. Some tasks are often called 'women's work' and others 'men's work'. For example, women are usually seen (and portrayed in the media) as nurses, housewives, secretaries, child minders, washers of clothes, while men are often shown as doctors, household heads, managers, wage earners and using the media (reading newspapers). These portrayals of men and women are changing, evidence that the stereotypes are also changing.

Gender Division of Labour: Different roles, responsibilities, and tasks are allocated to women and men based on social ideas of what men and women should do and are capable of doing. Different tasks and responsibilities are assigned to girls and boys, women and men according to their sex-gender roles, and not necessarily according to their individual preferences or capabilities. All work/activities can be divided into three categories - productive, reproductive and community work/activities.

Gender division of labour, therefore, operates not only in reproductive activities within the household, but in the productive and community activities, most of which take place outside the household. The gender division of labour is now considered a key concept to understand how gender inequalities or asymmetries are kept in place and reconstituted. In time this division leads to a gender division of skills. Men and women, boys and girls learn and master only those skills and aptitudes are created in women and men, girls and boys, and are then ascribed solely to one or the other.

Gender division of labour also leads to hierarchies and inequalities because men and women's labour is not valued or rewarded equally. Even now, equal pay for equal work is not the norm in most countries; housework is unpaid; and women are the first to be fired when recession hits the workplace. The allocation of certain tasks to men and women in productive processes (specially in household production) also leads to issues of command and control over land; technology; credit; cash from the sale of products, and so on.

Like gender and gender relations, the gender division of labour is also not the same everywhere. It is specific to culture, location and time. To challenge the gender division of labour in society means challenging what being a "man" or a "woman" in a society entails. Women's productive and reproductive work is generally not assigned much economic value.

Gender Needs: Different roles and responsibilities of women and men will create different needs. It has been found that some reproductive roles are unique, unchangeable and universal, e.g. childbirth. However, other roles related to family, productivity and community management are constructed because of women's subordinate position in the family and society.

Gender needs are distinct from other general needs because they arise from:

- Gender roles and
- Unequal status of women in relation to men and their access to resource/ assets

Generally two types of gender needs are identified:

- **Practical gender needs**
- **Strategic gender needs or interests**

Practical Gender Needs are the needs, which are drawn from the problems of daily lives where women share with men in a specific context. Addressing these immediate needs will help in:

- enabling women to do existing work in a better way
- reducing work burden of women and
- overcoming the hindrances that women face

Practical needs are linked to women's condition, which refers to women's material state—their immediate sphere of experience. If you ask a woman to describe her life, most likely she will describe her condition: the kind of work she does, the needs she sees for herself and her children (clean water, food, education), where she lives, etc. Practical needs refer to the requirements for daily living such as water, commodities, sanitation services, and housing. People do not have to be told of these needs—they usually identify them themselves because they are so urgent and critical. Women may identify practical needs related to food and water, the health and education of their children, and increased income.

A community where women carry water from a long distance river has a practical need for a well. Meeting such needs through development activities can be a relatively short-term process involving inputs such as equipment, (hand pumps, clinics, a credit scheme), technical expertise, and training. Practical needs can usually be met without changing the social position (status) of the affected population. People's living conditions may improve, but little is done to improve their position and status in society. Projects that aim to meet practical needs and improve living conditions generally preserve and reinforce traditional relations between men and women.

Examples of practical or immediate needs in the health sector are:

- related to food, shelter, clothing, employment, education, etc.
- expansion of Emergency Obstetric Care (EOC) Units
- improving antenatal and post-natal care at the union level
- increasing the number of trained family planning staff

Strategic Gender Needs or Interests are those that relate to addressing problems of women's subordination in relation to men. Meeting strategic gender needs are long term that will result in the improvement of gender relation and women's position. Meeting such strategic needs entail some fundamental changes in attitude, beliefs, norms and biases, institutional as well as legal measures. Addressing such gender needs will:

- bring changes in gender roles
- achieve gender equity and equality
- increase women's power, status and choice and
- reduce inequality between men and women

Strategic interests for women arise from their subordinate (disadvantaged) status and position in society. Position refers to women's social and economic standing relative to men. It is measured, for example, by male/female disparities in wages and employment opportunities, participation in legislative bodies, vulnerability to poverty and violence, and so on.

Strategic interests are long-term and related to improving people's position. These include actions to increase people's knowledge and skills, provide legal protection, and bring about equal opportunities among different social groups.

Gender equality is in the strategic interest of women in particular. Empowering women to have more opportunities, greater access to resources, and equal participation with men in decision-making is in the long-term strategic interest of the majority of the world's men and women.

Examples of some of the strategic gender needs are:

- claim for equal wages
- ownership and control of resources and property
- reducing social and legal discrimination
- women's employment in non-traditional jobs; and
- women's representation in decision-making positions

Examples of strategic or long-term needs in the health sector are:

- women's increased participation in health and decision making processes at household as well as institutional levels;
- higher rate of male involvement in family's reproductive role and in child care
- some practical gender needs have potential to address strategic gender interest.

Source: Adapted from de Bruyn, M. & France, N. *Gender or sex: who cares? Skills-building resource pack on gender and reproductive health for adolescents and youth workers.* Chapel Hill: Ipas, 2001; and Kamala Bhasin*, Understanding Gender,* 2002.

Session: 1.3

Understanding Gender Based Violence

Objectives	At the end of the session participants will be able to: - understand the magnitude of the problem - define GBV and understand its types, causes and consequences
Time	2 hr
Material	Flip sheet, markers, cards and post-it notes

Process overview

Steps	Method	Time
1. Session introduction	Plenary	10 min
2. Analyzing the magnitude of GBV	Plenary exercise	30 min
3. Understanding key definitions	Brainstorm, PPT	30 min
4. Exploring types, causes and effects of GBV	Group work	45 min
5. Session summary	Plenary	05 min

Handouts

1.3A: Dissonance Generating Questionnaire
1.3B: Global Statistics about GBV
1.3C: Key Definitions
1.3D: Type of GBV around the World
1.3E: Causes and Contributory Factors of GBV

1. Session introduction **Plenary** **10 min**

Inform participants that this session builds on the previous session and reinforces the idea that GBV is a serious life-threatening global problem. Emphasize that understanding of GBV will help to illustrate to the participants that GBV is a major social, cultural and political problem that we all have a responsibility to address.

Explain that the beginning of this session will focus on:
- the magnitude of GBV
- the definition of GBV
- types and causes of GBV

2. Analyzing the magnitude of GBV **Plenary exercise** **30 min**

Inform participants that GBV is a global problem and numerous researches and studies have been conducted all over the world to document the nature and extent of GBV.

Distribute Dissonance Generating Questionnaire (Handout 1.3A) to participants.

Request participants to read out loud each statement in turn and facilitate discussion points arising from each statement.

Distribute Handout 1.3A.

Note to Facilitator: *The success of this exercise will depend largely on the ability of the facilitator to lead an in-depth discussion on the wide range of issues arising from the questions. It is possible that some participants may not want to believe that the numbers are as high as they are. Assure the group that the numbers are obtained from studies/researches that are sound and reliable. Additionally, some participants may see these high numbers and express hopelessness. If such is the situation, it is very important that the facilitators remind the participants that the important first step in making social change is to understand and believe that the problem exists. Moreover, the facilitator should encourage participants to use such knowledge as valuable tools for breaking down denial in their communities.*

3. Understanding key definitions **Freelist, PPT** **30 min**

Introduce the activity by explaining that we will now look more closely into key definitions related to violence, in general, and violence against women, specifically.

Divide participants into 4 groups and request each group to identify key elements of each of the following types of violence:
- Violence
- Gender based violence
- Violence against women
- Sexual violence

Allow 15 minutes for the group work.

Request each group, in turn, to read out 3 or 4 key elements of each terminology.

Facilitate a discussion, and recap with key definitions of each terminology, using PPT. Refer to Handout 1.3B.

Stress that both GBV and VAW terms are umbrella terms used for any harm that is perpetrated against a woman's will and that has a negative impact on her physical or psychological health, development and identity. Both terms will be used interchangeably in the training.

Distribute Handout 1.3B containing the definition of violence, VAW, GBV and SV.

Note to Facilitator: *Be aware that definitions of GBV have been developed, accepted, and are used by various relevant organizations. Sexual violence (SV), Sexual and Gender Based Violence (SGBV), Gender-Based Violence (GBV) and Violence against Women (VAW) are terms that are commonly used interchangeably. e.g., WHO uses VAW, UNFPA uses GBV and UNHCR uses SGBV. Whatever the acronyms may be, GBV issues remain the same. They involve physical, sexual, psychological and economic abuse.*

4. Exploring types, causes effects of GBV **Group work** **45 min**

Divide participants into two groups and provide post-it notes to both groups.

Draw a shape of a tree on a flipchart.

Ask the first group to identify the types of GBV and the second group to list the causes and/or contributing factors.

When the group work is over:

Post the types of GBV as branches of the tree, causes and/or contributing factors as roots of GBV.

Facilitate a discussion and explain to participants that the branches are the outward manifestations of VAW or types of violence, such as rape, or domestic violence. The roots are the causes, fundamental issues that must exist in a situation for VAW to occur and that, if eliminated, will essentially eliminate acts of GBV. These are societal norms and issues such as: gender discrimination, abuse of power, patriarchy, etc.

The fertilizer of the GBV tree represents the contributing factors. Factors that contribute to type, incidence, and risk of GBV can seem like causes as they directly link between the perpetrator and the act (for example, a man gets drunk, then beats his wife). But contributing factors are not the root cause of violence, they are simply aggravating factors or manifestations of the deeper inequalities or discrimination.

Unpack these responses in terms of what we understand by social, economic, political and religious factors. Refer to Handout 1.3C.

For example, if we take the term 'social' we may get the following responses:

- Position in the family
- Position in the community
- Position in the society
- Self esteem
- Interactive skills
- Realized potential

Recap highlighting key learning points. Refer to Handout 1.3C and 1.3D.

Distribute Handouts 1.3D and 1.3E.

Note to Facilitator: *Encourage all ideas and examples. Make sure that all forms, causes and contributing factors of GBV are covered. It is also important to explain that men and boys can also be the target of sexual abuse, usually committed by other men, but that women and girls are affected disproportionately. It is important that facilitators carefully clarify the differences between violence that is gender-based and violence that is not gender-based while identifying the types of GBV. While discussing the contributing factors, it is important that the facilitator remind participants that contributing factors are not the root cause of violence, they are simply aggravating factors or manifestations of the deeper inequalities or discrimination. If we eliminate all of the contributing factors, that does not mean GBV will stop, and equally, the presence of these factors does not automatically imply the presence of GBV. Not all alcoholics will abuse their partners and not all poverty-stricken individuals will rape. However, there is no doubt that contributing factors do exacerbate the situation and often include such issues as poverty, stress, displacement, alcohol/drug abuse, loss of self-esteem, low self-esteem in men, etc.*

5. Session summary **Plenary** **05 min**

Sum up by key learning points from the session.

Handout 1.3A

Gender Based Violence: A Dissonance Generating Questionnaire

1. In a study carried out by SAATHI (1997) in Nepal, what percentage of women reported GBV as being within the family?
   - 10%
   - 54%
   - 77%
2. How many Nepali women were reported in a UNFPA study (2003) to have been trafficked to India?
   - 10,000
   - 72,000
   - 200,000
3. In a UNICEF study (2001), 58% of Nepali women reported physical abuse:
   - Once a day
   - Once a week
   - Once a month
4. In urban Bangladesh, 48% (WHO, 2005) of women have experienced violence in the last year. These women fall into which age group?
   - 15 – 19 years
   - 25 – 29 years
   - 45 – 49 years
5. In a UNFPA study (2003) how many of the 8000 foetuses aborted in a Mumbai clinic were female?
   - 5999
   - 6999
   - 7999
6. In a WHO study in Brazil (2005), 19% of ever pregnant women who had ever experienced violence reported an abortion as compared to X% of women who had never experienced violence.
   - 4.5%
   - 9%
   - 29%
7. In Japan, 28% of ever pregnant women who had ever experienced violence reported an abortion as compared to X% of women who had never experienced violence. (WHO, 2005):
   - 12.5%
   - 25%
   - 5%
8. In all sites of the WHO study (2005), what % of the women were abused by the biological father of the child they were carrying?
   - 30%
   - 60%
   - 90%
9. 47% of women who had experienced violence in a Brazil city reported suicidal thoughts. What was the figure in Bangladesh? (WHO, 2005)
   - 85%
   - 55%
   - 15%
10. What percentage of women in Bangladesh reported that their partner controlled their access to health care? (WHO, 2005)
    - 27%
    - 57%
    - 97%

Source: Adapted from multiples sources

Handout 1.3A

Gender Based Violence: A Dissonance Generating Questionnaire (With Answers)

1. In a study carried out by SAATHI (1997) in Nepal, what percentage of women reported GBV as being within the family?
   - 10%
   - 54%
   - 77%
2. How many Nepali women were reported in a UNFPA study (2003) to have been trafficked to India?
   - 10,000
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   - 200,000
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   - Once a month
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   - 4.5%
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   - 12.5%
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   - 30%
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   - 90%
9. 47% of women who had experienced violence in a Brazil city reported suicidal thoughts. What was the figure in Bangladesh? (WHO, 2005)
   - 85%
   - 55%
   - 15%
10. What percentage of women in Bangladesh reported that their partner controlled their access to health care? (WHO, 2005)
    - 27%
    - 57%
    - 97%

Source: Adapted from multiples sources

Handout 1.3B

Gender Based Violence: Key Definitions

"[Violence against women]…is a manifestation of historically unequal power relations between women and men which have led to the domination over and the discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial mechanisms by which women are forced into a subordinate position compared with men." *UN Declaration on the Elimination of Violence against Women.23 February 1994*

What is Violence? Defining Violence, VAW, GBV and SV

Violence is a means of control and oppression that can include emotional, social or economic force, coercion or pressure, as well as physical harm. It can be overt, in the form of a physical assault or threatening someone with a weapon; it can also be covert, in the form of intimidation, threats, persecution, deception or other forms of psychological or social pressure. The person targeted by this kind of violence is compelled to behave as expected or to act against her/his will out of fear. An incident of violence is an act or a series of harmful acts by a perpetrator or a group of perpetrators against a person or a group of individuals. It may involve multiple types and repeated acts of violence over a period of time, with variable durations. It can take minutes, hours, days or a lifetime.

Definitions

a) Violence: The World Health Organization (WHO) defines violence as "The intentional use of physical force or power, threatened or actual against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (World Health Organization, Geneva 2002).

b) Violence against Women: The Beijing Platform for Action (PFA) defines violence against women as "any gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."

c) Gender-Based Violence: In 1993, the United Nations adopted the first international definition of violence against women. By referring to violence against women as 'gender-based', the United Nations highlighted the need to understand violence against women within the context of women's and girl's subordinate status in society. While both women and men experience violence, evidence suggest that
the risk factors, patterns and consequences of violence against women are different that violence against men. It is argued that many cultures and beliefs, norms and social institutions that legitimize and therefore perpetuate violence against women. Violence against women, therefore, cannot be understood in isolation from the norms, social structures and gender roles that influence women's vulnerability to violence.

d) 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". (WHO, 2002)

Forms and contexts of sexual violence

A wide range of sexually violent acts can take place in different circumstances and settings. These include, for example:

- rape within marriage or dating relationships;
- rape by strangers;

- rape during armed conflict;
- unwanted sexual advances or sexual harassment, including demanding sex in return for favours;
- sexual abuse of mentally or physically disabled people;
- sexual abuse of children;
- forced marriage or cohabitation, including the marriage of children;
- denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases including HIV
- forced abortion;

Gender-based violence is a pervasive public health and human rights problem throughout the world, but the patterns and prevalence of violence vary from place to place.

"Violence against women" (VAW), "Sexual Violence" (SV), "Sexual and Gender-Based Violence" (SGBV) or "Gender-Based Violence" (GBV) means any act of GBV that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.

GBV, VAW, SV or SGBV is understood to encompass, but not be limited to, the following: physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation. Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; physical, sexual and psychological violence perpetrated or condoned by the State wherever it occurs.

While gender-based violence has a devastating impact on the lives of women and girls who are the majority of victims/survivors, it is also hinders the development of men and boys. Eliminating gender-based violence and gender inequalities helps to strengthen entire communities.

Source: Adapted from multiple sources including *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Professionals in Developing Countries,* IPPF/Western Hemisphere Region, New York, 2004

Handout 1.3C

Types of Gender Based Violence Around the world

Physical Violence

Type of act	Description/Examples	Can be perpetrated by
Physical assault	Beating, punching, kicking, biting, etc., with or without weapons; often used in combination with other forms of sexual and gender-based violence	Spouse, partner, family member, friend, acquaintance, stranger, anyone in position of power
Trafficking, slavery	Selling and/or trading in human beings for forced sexual activities	Any person in a position of power or control; often accompanied by promises of money and a "good job"

Emotional, Psychological and Socio-economic Abuse

Type of act	Description/Examples	Can be perpetrated by
Abuse / Humiliation	Non-sexual verbal abuse that is insulting, degrading, demeaning; compelling her to engage in humiliating acts, often in public; denying basic expenses	Anyone in a position of power and control; often perpetrated by spouses, partners or family members in a position of authority for family survival
Discrimination and/or denial of opportunities, services, economic participation	Exclusion, denial of access to education, health assistance or remunerated employment; denial of property rights, making person ask for an allowance, demanding earnings, spending family finances independently without taking consent	Family members, society, institutions and organizations, government actors
Confinement	Isolating a person from friends/family, restricting movements	Anyone in a position of power and control; often perpetrated by spouses, partners or family members in a position of authority
Obstructive legislative practice	Denial of access to exercise and enjoy civil and political rights, mainly to women.	Family, community, institutions and State

Sexual Assault and Abuse

Type of act	Description/Examples	Can be perpetrated by
Rape and marital rape	Forced/coerced intercourse	Any person, including husband, partner or care-giver
Sodomy	Forced/coerced anal intercourse, usually male-to-male or male-to-female	Any person in a position of power
Attempted rape or attempted sodomy	Attempted forced/coerced intercourse; no penetration	Any person in a position of power
Sexual abuse/ Exploitation	Sexual interactions against her will (e.g., perform in sexual manner, forced undressing and/or nakedness, coerced marriage, forced childbearing, engaging in pornography or forced sex work/labour)	Anyone in a position of power, influence, control, including humanitarian aid workers
Child sexual abuse, defilement, incest	Sexual relations with a child (any person under 18 years of age)	Often perpetrated by someone the child trusts, including parent, sibling, extended family member, friend or stranger, teacher, elder; anyone in a position of power over a child
Forced sex work/labour (also referred to as sexual exploitation)	Forced/coerced sex-trade in exchange of material resources, services, and assistance, usually targeting highly vulnerable women or girls unable to meet basic human needs for themselves and/or their children	Any person in a privileged position, in possession of money or control of material resources and services, perceived as in power, including humanitarian aid workers
Sexual harassment	Any unwelcome sexual advance, request for sexual favours, or other verbal or physical conduct of a sexual nature	Soldiers/officials at checkpoints, teachers, employers, supervisors or colleagues; any person in a position of power, authority, or control.

Harmful Traditional Practices

Type of act	Description/Examples	Can be perpetrated by
Female genital mutilation (FGM)	Cutting of genital organs for non-medical reasons, usually done at a young age; ranges from moderate to extreme cutting, removal of genitals, stitching	Traditional practitioners, supported/condoned/assisted by families, religious groups, communities
Early marriage	Arranged marriage for girls under the age of legal consent (sexual intercourse in such relationships constitutes statutory rape, as the girls are not legally competent to agree to such unions)	Parents, community and State
Forced marriage	Arranged marriage for girls under the age of legal consent or women against their wishes; often a dowry is paid to the family; if she refuses, there are violent and/or abusive consequences. (Legally, such unions would not be considered marriage because of age and/or force)	Parent, family members
Honour killing and maiming	Maiming or murdering a woman/girl as punishment for acts considered inappropriate for her gender believed to bring shame on the family or community	Parent, husband, other family members, or members of the community
Infanticide and/or neglect	Killing, withholding food, and/or neglecting female children because they are considered to be of lesser value in a society	Parent, other family members
Denial of education for girls or women	Removing girls from school so they can perform expected gender roles in families	Parent, other family members

Source: *Guidelines for the Prevention and Response of Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Person,* UNHCR, Geneva, 2002.

Handout 1.3D

Causes and Contributing Factors of Gender Based Violence

1. Cultural

- Gender-specific socialization and cultural definitions of appropriate sex roles
- Expectations of roles within relationships
- Belief in the inherent superiority of males
- Values that give men proprietary rights over women and girls
- Notion of the family as the private sphere and under male control
- Customs of marriage (bride price/dowry)
- Acceptability of violence as a means to resolve conflict

2. Economic

- Women's economic dependence on men
- Limited access to cash and credit
- Discriminatory laws e.g. inheritance, property rights, use of communal lands
- Limited access to employment in formal and informal sector
- Limited access to education and training for women

3. Legal

- Lesser legal status of women either by written law and/or by practice
- Laws regarding divorce, child custody, maintenance and inheritance
- Legal definitions of rape and domestic abuse
- Low levels of legal literacy among women
- Insensitive treatment of women and girls by police and judiciary

4. Political

- Under-representation of women in politics/media/legal & medical professions
- Domestic violence not taken seriously
- Notions of family being private and beyond control of the state
- Risk of challenge to status quo/religious laws
- Limited organization of women as a political force
- Limited participation of women in organized political system

Source: *Heise, L.et al., 'Violence Against Women: A Neglected Public Health Issue in Less Developed Countries,'* Social Science Medicine, 1994, cited in Local Action, Global Change, Learning about the Human Rights of Women and Girls, UNIFEM and The Centre for Women's Global Leadership, 1999.

Session: 1.4

Health Outcomes of Gender Based Violence

Objectives	At the end of the session, participants will be able to: - identify GBV in different stages of women's lives - identify the fatal and non-fatal health outcomes of GBV
Time	1 hr 30 min
Material	Flipchart paper, markers

Process overview

Steps	Method	Time
1. Session introduction	Plenary	10 min
2. GBV in the life cycle of women	Group work, PPT	75 min
3. Session summary	Plenary	05 min

Handouts

1.4A: Case studies: Sushila and Sameera
1.4B: The Life Cycle of VAW and its Health effects
1.4C: Health Specific Outcomes of ViolenceE

1. Session introduction — Plenary — 10 min

Refer back to the previous sessions and discuss with participants about how people experience violence in their own surroundings, from neighbours, family and from their own society. Remind them that many occurrences of violence are not reported, or not even known or regarded as violence. People define GBV differently; society accepts the occurrences and largely does little about the perpetrators. Also mention that women undergo numerous types of violence throughout their lives from womb to tomb; in fact from pre-birth until they die.

Explain to participants that this part of the session will focus on the types of VAW during the different stages of women's lives and the impact of violence on their physical and mental health.

2. GBV in the life cycle of women — Group work, PPT — 75 min

Brainstorm with participants the different stages in the life of a woman, making sure that the following stages are brought out:

- Pre birth
- Infancy
- Girlhood
- Adolescent
- Adult/Reproductive age
- Elderly

Divide participants into 4 groups and distribute the case studies (2 groups will have the same case study). Allow sufficient time for all participants to read their case study and ask any clarifying questions.

Request each group to use the case study to identify:

- the state of physical and psychological/mental health.
- the possible fatal outcomes that may occur.

Distribute flip chart paper and markers and ask each group to identify a rapporteur to report back to the large group at the end of the group work. Allow 30 minutes for the group work.

Facilitate a brief discussion with each group report back, addressing the following questions:

- When did violence begin in the woman/girl's lifecycle?
- What are the factors that made her vulnerable to ill health?
- What role did her husband/father/mother or other family members play?
- How did socio-cultural and political factors affect her health
- What are some of the fatal and non-fatal health outcomes of the violence?

Ensure that the discussion highlights the following issues:

- poor nutrition in early years;
- lack of access to education because of gender discrimination;
- prescribed roles of girls and women;
- tradition of early marriage;
- illiteracy;
- role of husband as decision-maker;
- preference for sons;
- poor health education and support from the health centre;
- lack of involvement & responsibility of spouse for reproductive health of his wife.

Facilitate a brief discussion by presenting the diagram of the Life Cycle of Violence against Women and its Effects on Health. Refer participants to the list of near-fatal and fatal health consequence of GBV. Refer to Handouts 1.4B and 1.4C.

Distribute Handout 1.4B and 1.4C.

3. Session summary — Plenary — 05 min

Sum up key learning points from the session.

Handout 1.4A

Case Study 1: Sushila

Sushila was the fourth child and the youngest girl, with two brothers and two sisters. Her father was a small farmer, and her family survived by farming and selling a small amount of cash crops. Often there was not enough food to feed everybody in the family adequately.

As in most families in her community, her father and brothers ate first, then she and her sister were fed, and her mother ate last. Sushila started school at 6 but, but after two years, as a result of a big famine in their area, she stopped as her parents could not afford to send all the children to school. Her two older brothers continued, while Sushila and her older sister stayed home to help their mother with household chores.

By the time Sushila was 12 and her family's economic situation had improved, she urged her family to let her return to school. However, her father refused because the school was far away and also because it was a mixed school of girls and boys. Her father explained that, in any case, she would be married soon, just like her sister Rima, who at 17, was already married with one child.

When Sushila was 15 she was married to Balram and went to live with his family. Within four months she was pregnant. By the time she was 18, she had given birth to three daughters. She was always tired, her health was poor, and she often felt isolated and depressed. Though she couldn't read, she had heard about family planning and suggested to Balram that they consider it so she could have a rest. Balram became furious and beat her. He pointed out that she had not yet provided him with a son and that family planning was unnatural, anyway. Sushila, feeling that she had been appropriately reprimanded for her bold and presumptuous behaviour did not bring up the subject again. Sushila's health continued to deteriorate. Sex was often painful for Sushila, she was treated several times at the health clinic for itchiness and discharge in her genital area. Each time, the nurses at the clinic told her that she must use condoms to prevent this sickness. They would become quite annoyed that she had not used them. But Sushila knew that condoms were only used by prostitutes, and that Balram would refuse them. Sushila's fourth child was a son, and Balram was very pleased. He looked forward to his second and third son. Meanwhile, Sushila became more and more sad and tired.

Case Study 2: Sameera

Semeera comes from a poor family. Her father, a day labourer, left the family a long time ago, and lives in Dhaka with his second wife. Her father keeps in touch with Sameera and never divorced her mother. Sameera is an only child. She lives in a very impoverished village. There are almost no educated adults in the village although there is a school in the next village.

Sameera got married in 2002. She has been married to her cousin (maternal aunt's son) and lives with her husband in her natal home. The story goes that her mother was looking to get her married, while the groom's family was also looking. As they live in adjacent neighbourhoods and were related, a neighbour suggested, why not get the two married. Although Sameera says the groom's family did not ask for any dowry at the time of marriage, neighbours report that his family had asked for Tk. 20,000 as dowry, and her father negotiated it down to Taka. 10,000.

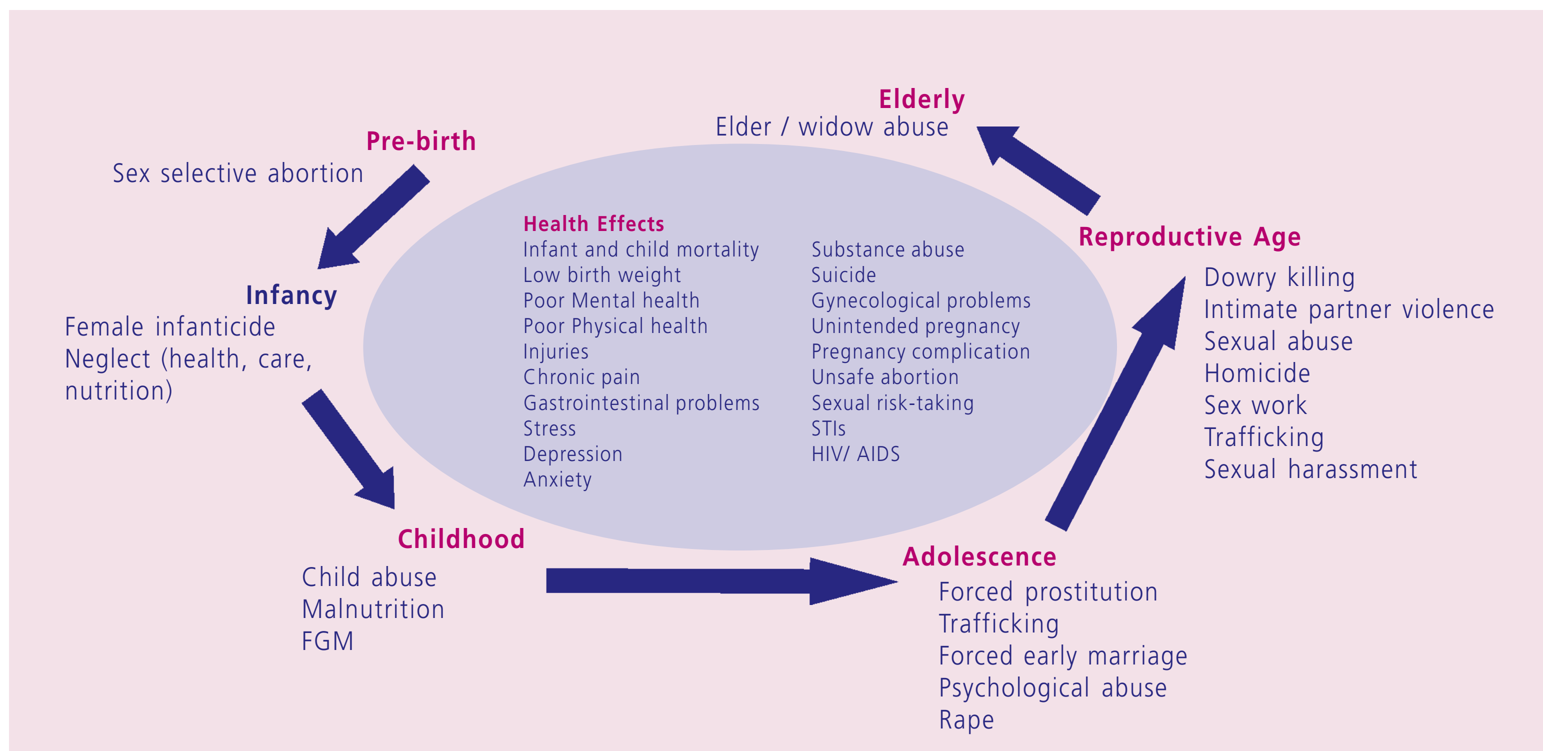
Neighbours also informed us that the reason they were able to bring the price down was because as an only child Sameera would inherit whatever property and money her parents have. Her husband, a rickshaw puller, gambles with the money she earns and beats Sameera. When her mother was asked whether they had tried to find out what the boy and his family were like before getting married, she said they hadn't heard anything that would suggest that he would beat his wife. They chose him because he is very good looking and the dowry demanded was relatively low. The most recent beating was for not cooking rice which, Sameera said she did not do because there was nothing to eat with the rice.

At one point during the marriage Sameera had gone to seek a divorce. Her aunt and mother had also pushed for it once they found out that the boy had a "bad character." Last time we visited, the family was absolutely decided on a divorce from the boy. But when we went this time and saw them still living together, we asked what had happened and what changed their mind, Sameera told us that when they went to the marriage office to get a divorce her husband found out, came to the Quazi's office and persuaded her mother and aunt to give him another chance. He was so persistent that her family gave in and decided to give him another chance provided he lives in her house, and earns money and provides for Sameera.

Source: Adapted from *Gender, Reproductive Health and Advocacy: A trainers manual, CEDPA, 2000*

Handout 1.4B

The Life Cycle of Violence Against Women and its Effects on Health



Source: *Outlook Violence against Women: Effects on Reproductive Health Volume 20, Number 1, Path and UNFPA, Dhaka, 2002*

Handout 1.4C

Health Specific Outcomes of Violence

There are grave and potentially life threatening health outcomes with all types of GBV. The exact consequences vary, depending on the type of GBV. Some examples are:

1. Nonfatal Outcomes:

Reproductive Health Consequences

- Unwanted pregnancy, STIs/ HIV
- Gynaecological disorders, unsafe abortion
- Pregnancy complications, miscarriage, low birth weight
- Pelvic inflammatory disease, sexual disorders

Social Consequences

Most societies tend to blame the survivor for the incident, especially in cases of rape. This social rejection results in further emotional damage, including shame, self-hate and depression. Due to their fear of social stigma and rejection, most survivors never report the incident and never receive proper health care and emotional support. Most incidents of GBV are never reported to anyone due to:

- Blaming the victim
- Loss of ability to function in community (e.g., earn income, care for children)
- Social stigma
- Social rejection and isolation
- Rejection by husband and family

Economic Consequences

GBV contributes to prolonging poverty and increasing material deficiency.

Psychological Consequences

Most psychological and emotional after-effects should be viewed as normal human responses to a horrific, terrifying, extreme event. In some cases, however, the survivor experiences mental illness that requires medical intervention:

- Post traumatic stress
- Depression
- Anxiety
- Phobias/ Panic disorders
- Eating disorders
- Sexual dysfunction
- Low self-esteem
- Substance abuse

2. Fatal Outcomes:

- Homicide
- Suicide
- Maternal mortality
- Infant mortality
- AIDS related mortality

Source: Beth Vann *Training Manual Facilitators guide (2004) Interagency & Multi-sectoral Prevention and Response to Gender-based Violence in Populations affected by Armed conflict*, Global GBV Technical Support Institute, RHRC Consortium, JSI, Arlington, Virginia, 2004

Day 2 Module

Working with Survivors of Gender Based Violence

Module objectives:

1. Increase understanding of the key steps involved in managing emergencies arising from GBV and sexual violence.
2. Enhance understanding of the roles and responsibilities of service providers.
3. To become aware of the factors that prevents survivors from accessing support.

Session	Time
2.1 Recapturing yesterday	30 min
2.2 Emergency management of GBV and sexual violence	2 hr 30 min
2.3 Working with survivors	1 hr 45 min
2.4 Roles and responsibilities of service providers	1 hr 30 min
2.5 Communicating with survivors	2 hr
2.6 Summary and end of Day 2	30 min

Session: 2.1

Recapturing Yesterday

Objectives	At the end of the session, participants will be able to: - recapture and relate the previous day's learning with training objectives - clarify key learning
Time	30 min
Material	Flipchart paper, white board, markers

Process Overview

Steps	Method	Time
1. Discussion on previous day's learning	Discussion	20 min
2. Session summary	Plenary	10 min

1. Review of previous day's learning **Discussion** **20 min**

Welcome participants to the second day. Allow five minutes to think about the previous day's learning and ask participants to note down a key learning from yesterday.

Ask the 'eyes' and 'ears' to give a brief presentation of yesterday's proceedings.

Before moving on, ask participants if there is anything from yesterday's learning that needs further clarification. If not, move on to the programme of the second day.

Identify 2 volunteers to be the eyes and the ears for Day 2.

2. Session summary **Plenary** **10 min**

Acknowledge active involvement of participants, their enthusiasm and commitment to learning.

Session: 2.2

Emergency Management of Gender Based Violence

Objectives

At the end of the session, participants will be able to-
- define emergency management
- explain emergency clinical management of survivors
- explain emergency management of sexual violence

Time

2 hrs 30 min

Material

Flip chart paper and board and markers.

Process overview

Steps	Method	Time
1. Session introduction	Plenary	15 min
2. Emergency clinical management of GBV survivors	Brainstorm, PPT, role play and discussion	45 min
3. Emergency health and safety needs following sexual violence	Group activity, lecture/discussion	45 min
4. Developing safety and security plans	Discussion, individual work	30 min
5. Session summary	Plenary	15 min

Handouts

2.2A: Suggested Role Plays on Emergency Management of GBV + Observer sheet
2.2B: Emergency Management of GBV
2.2C: WHO Guidelines on Assisting Survivors of Sexual Violence
2.2D: Asha's Case Study
2.2E: Emergency Health and Safety Needs after Sexual Violence
2.2F: Safety Planning

1. Session introduction | **Plenary** | **15 min**

Introduce the session by explaining that proper management of survivors of GBV is as important as understanding and responding to GBV. Proper care and well-timed management of clients could make huge differences in the lives of survivors, sometime a difference between life and death.

Inform participants that this session covers the clinical presentation and emergency management of GBV and sexual violence. This session will also consider the importance of such services as collecting forensic evidence, information on emergency contraception, and developing security and safety plans.

2. Emergency clinical management of GBV survivors | **Brainstorm, PPT, role play and discussion** | **45 min**

Ask participants:

- What is meant by emergency management of GBV?
- What are the clinical presentations of GBV?
- Why is it important to pay special and emergency attention to manage GBV, especially sexual violence?

Facilitate a discussion in a large group on emergency management and clinical presentations of GBV.

Divide participants into two groups. Ask each group to select a volunteer to act in the role-play. Distribute one case study to each group (Handout 2.2A). Give each group 10 minutes to discuss and prepare for the role-play.

Request the volunteers to act out the role-play and ask them to include other participants according to the needs of the situation.

Ask observers to observe the following issues (Handout 2.2A).

- Did the case demand the emergency response and management?
- How did the clinic team manage the case?
- How could the management be improved?

Facilitate a discussion beginning with feedback from the observers.

De-role actors by asking them how they felt about the role-play and what issues it raised for them personally or professionally.

Note to Facilitator: *Instead of using the suggested case studies, participants could be asked to suggest a real life situation that they may have encountered in their work.*

Deliver a PPT on the clinical management procedure of GBV referring to Handout 2.2B and 2.2C.

3. Emergency health and safety needs following sexual violence | **Group activity, lecture/ discussion** | **45 min**

Divide participants into four small groups.

Distribute Asha's case study (Handout 2.2D) to everyone and inform them that they have 30 minutes for the group activity.

Ask each group to list their responses on flip chart paper and appoint a rapporteur to provide feedback to the large group.

Instruct participants to imagine that they are Asha. Ask each group to answer the following questions:

- What will be her main concerns?
- What will be her health concerns?
- What will be her safety concerns?
- Who can she turn to for help?

Allow 15 minutes for this stage of the activity.

Ask the group to then imagine that Asha comes to them for help. Ask each group to answer the following questions:

- How could they help her?
- How should they help advocate for her needs?
- Why is it important for her to get medical attention?
- What type of medical attention should be provided?

Allow 15 minutes for the second part of the activity.

Bring all groups back together and facilitate the feedback from each group.

Facilitate a discussion addressing key discussion points. Refer Handout 2.2D.

Explain to participants that the collection of forensic evidence can help the survivor to pursue legal options.

Inform participants that although the collection of forensic evidence is normally conducted by specially trained medical personnel often under strict legal and medical guidelines, service providers can play an important role in supporting and guiding clients to appropriate sources of help and support.

Evidence that would be collected during a forensic exam would include:
- Injury evidence: physical/genital trauma
- Clothing
- Foreign material: soil, leaves, grass, etc.
- Hair: foreign hairs found on the survivor's clothes or body
- Sperm and seminal fluid from vagina, anus, mouth, body, etc.
- Swab samples from bite marks, fingernail scraping

Inform participants that if a rape survivor has expressed a wish to go through a forensic examination, it is best not to bathe before the test is completed, because bathing will wash away important evidence. Many survivors feel 'dirty' or violated after rape and want to bathe right away. If the survivor has bathed already, do not discourage her and tell her that the forensic examination can still be conducted.

Additionally, remind participants that evidence should only be released to the authorities if the survivor decides to proceed with a case.

Inform participants that ECP and HIV prophylaxis treatments work best when they are given as soon as possible after the event.

Present a PPT and facilitate a discussion ensuring that key learning points from Handout 2.2E are addressed in the discussion.

4. Developing safety and security plans — Discussion, individual work — 30 min

Introduce session and ask participants to free list the importance of safety plans for survivors of GBV.

Facilitate a discussion bringing in following key points:
- Service providers can play a very important role in minimising potential risk of violence to women;
- Service providers must educate and inform themselves about the types of danger that survivors of GBV may face as well as the types of danger assessment tools that have been used in different settings, whilst recognising that tools which are successful in one setting may not really work in other due to socio-cultural associated reasons.
- Service providers may need to work with their colleagues and seek help of local resources to identify strategies for safety planning to suit the local setting;
- Service providers need to have a realistic understanding of reality that women in their community face, bowing to the better judgment of the survivor as to the best course of action to maximize her safety.

Ask participants to work individually to list key aspects of developing a safety plan for clients deemed to be in imminent danger of violence

Facilitate a discussion and conclude with a presentation on key points of safety planning details using PPT. Refer to Handout 2.2 F.

5. Session summary — Plenary — 15 min

Sum up key learning points from the session

Handout 2.2A

Suggested Role Plays on Emergency Management of GBV

The following role plays may be used or others developed according to the needs of the target audience.

Role play 1: A pregnant woman came to a clinic with complaints of excessive bleeding. She was waiting in a queue for registration. While passing through the patients' waiting room, the clinic manager noticed that she was shivering due to pain.

Role play 2: An adolescent girl (about 15 years old) came to a clinic. During registration she says that she has a severe headache. While talking to the nurse, she explains that she is pregnant and wants to have an abortion. She is afraid that her parents will find out and throw her out of the house.

Handout 2.2A

Emergency Management of GBV: Observer Sheet

In your role as observers, please note your observations on the following issues:

1. Did the case demand emergency response and management?

2. How did the clinic team manage the case?

3. How could the management be improved?

Handout 2.2B

Emergency Management of GBV

Emergency management involves responding to the needs of survivors by providing immediate attention, treatment and support.

Emergency presentations of violence against women are:
- Burn
- Sexual assault/ rape/ suspected rape
- Violence in pregnancy
- Internal haemorrhage
- Fractures
- Head injury, major and minor
- Poisoning
- Others, including beating and the use of weapons

It is important to conduct a through physical examination, which include examination of the women's entire body for hidden injuries or old injuries. If necessary, health care providers can include any indicated x-rays or laboratory procedures.

Physical Damage:

Physical trauma or damage can occur in many ways:
- using chemicals (acid throwing)
- sharp cutting objects
- blunt objects
- using body parts - kicking, punching, slapping
- gunshot
- strangulation by throttling
- hanging
- burning
- electric shocks

Physical assault or abuse may result in:
- Bruises
- Fractures
- Excess Bleeding
- Burns
- Loss of organs
- Injuries to vital organs including the brain; and
- Death

The physical beating of a woman by a man or woman can take place in many ways. The usual pattern is that the beating increases in frequency and severity as time passes. Any woman who is being abused may believe that they are in some ways responsible for the abuse. Often they are ashamed to reveal that their life is less than perfect. Therefore, health care providers need to be alert to the signs that distinguish an inflicted/intentional injury from an accidental injury. Intentional injuries are those that are deliberately inflicted and include both those inflicted by themselves and by others.

The following signs may suggest that the trauma has been intentionally produced:
- The injury is proximal rather than distal. In an accidental injury, the fingers and hand tend to be injured, whereas in intentional injuries, the upper arm is more often injured.
- The injury is to parts of the body that are hidden e.g. breasts, abdomen, back, etc.
- The presentation for treatment is delayed. The injury was done some days before or there are old scars or bruises visible.

- There may be patterned injuries. These injuries are of such a distinctive pattern that the doctor with reasonable understanding can determine with certainty as to how an injury is caused (e.g. bite marks).
- There may be patterns of injury. Bruises may be found in various stages of healing or there may be fractures in different stages. This implies repeated episodes of trauma.
- The partner/family accompanying the client appears "over protective."
- The injury occurs in pregnancy. Violence in pregnancy affects more women than hypertension, gestational diabetes, or any other ante-partum complication.

In addition to the signs already mentioned, there are signs in a pregnant woman which should alert the clinician of the possibility of violence being involved.

From the history:
- Repeated spontaneous abortions
- STIs and RTIs
- HIV
- Multiple unwanted pregnancies
- Poor contraceptive history
- Baby with a low birth weight
- Previous abuse

On physical examination:
- Genital trauma
- Abdominal trauma
- Trauma in groin and upper inner thigh
- Trauma on the buttock and back of the upper pelvis
- Vaginitis
- Cigarette/beedi burns

Pregnancy related conditions which may be a result of violence:
- Abruptio placenta
- Spontaneous abortion
- Vaginal bleeding due to trauma
- Premature labour

Effects on the foetus:
- Low birth weight
- Pre-maturity
- Fractures
- Cranial bleeding

Clinical Management:

The treatment will be directed at the relief of pain and repair of tissue damage. In the case of a pregnant woman, special attention must also be paid to the foetus. The health care providers should also counsel the members of the in-laws' household and her own household. The health provider should:
- take a detailed history from the patient and try to understand where and how the incident occurred
- try to understand the severity of physical damage and trauma
- encourage patients to tell everything but without coercion or any pressure
- ensure confidentiality and privacy
- respect her views and perceptions
- do not be judgmental
- treat and manage the patients in an empathetic way
- start treatment as soon as possible
- treat according to severity of damage
- assist to make a plan for the protection and safety of the injured parties

Source: *Training Module on the Management of Violence against Women*, Government of Bangladesh, and UNICEF, 2000

Handout 2.2C

WHO Guidelines on Assisting Survivors of Sexual Violence

Victims of sexual assault require comprehensive, gender-sensitive health services in order to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event.

The types of services that are needed include
- pregnancy testing, pregnancy prevention i.e. emergency contraception)
- abortion services (where legal)
- STI testing and/or prophylaxis
- treatment of injuries and psychosocial counselling.

In addition to providing immediate health care, the health sector can act as an important **referral point** for other services that the victim may later need, for example, social welfare and legal aid.

Health workers are also well placed to collect and document the evidence necessary for corroborating the circumstances of the assault, and for identifying the perpetrator and the health consequences of the event. Such evidence is often crucial to the prosecution of cases of sexual violence.

In practice, victims of sexual violence present at any point or sector of the health care system. Therefore**, all health care facilities** should be in a position to recognize sexual abuse and provide services to victims of sexual violence (or at least refer patients to appropriate services and care), irrespective of whether a forensic examination is required. If not already in place, health care facilities need to develop specific policies and procedures for dealing with victims of sexual violence.

Given appropriate knowledge and training **any health worker in a health or medical facility should be able to provide first level health care to victims of sexual violence**. Expertise in the field will develop with further training, professional support and given adequate resources. Ideally, all health workers (i.e. nurses, physicians, social workers, mental health professionals) who come into contact with victims of sexual violence should receive appropriate training; this applies particularly to nurses and physicians who conduct physical examinations of victims of sexual violence and to those who provide services to children and to the courts.

In most countries, **local protocols, rules or laws govern the provision of medico legal services to victims of sexual violence**. These might include certification of the health worker, use of official documentation, an obligation to report any allegations to the appropriate authorities, procedures for the collection and handling of specimens and access to a range of therapeutic interventions (e.g. emergency contraception). Failure to comply with local regulations may compromise future investigations or court hearings. For this reason, it is **imperative** that health workers have a good understanding of the local protocols, rules and laws that govern the field of sexual violence

Source: *Guidelines for medico-legal care for victims of sexual violence*, WHO, Geneva, 2003

Handout 2.2D

Case Study: Asha

Asha is 21 years old and lives in a small village. She is married and has one son. Her husband has left the village temporarily to look for work.

One day, Asha is walking home from a nearby market with a very heavy bag. Since she is also carrying her son. A man who lives in her village, but whom she does not know very well, offers to help her carry her bag. He makes her a little uncomfortable by the way that he looks at her, but the bag and the child together are very heavy, so she accepts.

When they reach home, Asha notices that he does not want to leave. She becomes nervous. As soon as she puts her child down, he grabs her and shows her a knife he had hidden in his clothing. He tells her to be quiet or he will kill her. He pushes her to the ground and rapes her while holding the knife by her throat. When he is finished, he spits on her before he leaves.

Source: Adapted from American Refugee Committee Thailand GBV Program, 2004.

Handout 2.2E

Emergency Health and Safety Needs following Sexual Violence: Helping Asha

Victim-blaming
It is possible that some participants may say Asha is partly responsible for the rape, because she accepted the man's offer to carry her bag and for related reasons. Help participants challenge these beliefs. Tell them that the act of rape was a choice on the part of the perpetrator/rapist and was in no way the responsibility of the survivor. If we continue to blame people for being victimized, then people will continue to remain silent on abuse and violence. We need to create a culture of understanding on abuse, and part of that means placing responsibility where it belongs. Even if a person did something that the community considers dangerous, such as going out at night, it is not a crime that deserves punishment on the charges of rape or violence. It is the perpetrator who deserves punishment, not the survivor.

Facilitate a discussion exploring agreements and disagreements.

Possible concerns of the survivor:
- Fear that community will blame her for assault
- Fear that her husband will blame her
- Fear that her husband will leave her
- Fear that no one will believe her
- Self-blame and shame about the assault

Possible health concerns:
- Pregnancy
- STIs and HIV
- Physical injury

Possible safety or security concerns:
- Fear that the rapist will return to hurt her again
- Fear that her husband will want to take revenge against rapist
- Fear that her husband will be violent toward her as punishment
- Fear that her husband will not believe her that what happened was rape and not consensual
- Feelings of vulnerability and lack of safety

Where the survivor can go to for help:
- Family, friends, someone she trusts
- Religious leaders
- Health staff
- Community leaders
- NGOs and CBOs

How to assist her:
- Ask how you can help her.
- Ask what her concerns are.
- Give her emotional support and be empathetic towards her.
- Follow the guiding principles for working with survivors of GBV/SV
- Follow her lead. Offer her choices and allow her to make decisions.
- Ask her if she feels safe or she needs help with security and would like to report the incident to security personnel.
- Ask if she wants to report the crime to the authorities, explain that she can have forensic evidence collected at a local hospital within 72 hours of the incident.

To overcome her health concerns:
- Offer STI treatment
- Offer emergency contraception pill (ECP)
- Offer HIV prophylaxis
- Offer treatment for other medical problems e.g. hepatitis B, tetanus.

Source: *Training Module on the Management of Violence against Women*, Government of Bangladesh, and UNICEF, 2000

Handout 2.2F

Safety Planning

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

Providers may need to work with staff and seek the help of local resources to identify strategies for safety planning that are adapted to the local setting. To do this adequately, managers need to be aware of the basic issues involved in safety planning, some of which are summarised below:

- Identify possible escape routes and a place where the woman could go in case of emergency (e.g. the home of a family member or friend) if she needs to leave her home at some point in the future.
- Know/memorize phone number(s) for organizations that provide help, if any exist in the area.
- Know where to get emergency contraception in the case of sexual violence.
- Notify one or more trusted neighbours to watch for signs of violence and to call the police or their community members if they notice anything unusual.
- Talk to children about what to do and where to go for help in the case of a violent incident and rehearse an escape plan with them.
- Decide what a woman needs to have ready if she needs to leave her home in a hurry (e.g. clothes, money, documents, keys).
- Pack a bag with these items and store it somewhere in her home or with a friend or relative.
- Come up with strategies for reducing risk once a conflict begins. For example, if an argument cannot be avoided, try to have it in a room with an easy exit. Stay away from rooms where weapons are available.

Source: *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Professionals in Developing Countries,* IPPF/Western Hemisphere Region, New York, 2004

Session: 2.3

Working with Survivors

Objectives	At the end of the session, participants will be able to: - identify obstacles that women face in accessing support services - understand the importance of asking, validating and safeguarding the experiences of survivors
Time	1 hr 45 min
Material	Marker, a ball of string and cue cards each with one of the following written on it: Women's Leader, Legal Advisor, Nurse, Police Officer, Doctor, Social Worker, Protection Officer, NGO worker, Traditional Healer, etc.

Process overview

Steps	Method	Time
1. Session introduction	Plenary	10 min
2. Barriers that survivors face in accessing support services	Role play, discussion	45 min
3. Barriers to working on GBV	Group activity, discussion	45 min
4. Session summary	Plenary	05 min

Handout

2.3A: Barriers that survivors face in accessing support services: a role play. **(Note: this role plays requires preparation)**

1. Session introduction — Plenary — 10 min

Introduce the session by explaining that this session will focus on the barriers that survivors face in accessing support services and the importance of validating their experiences.

Inform participants that, as service providers, knowing our own values and reasons for engaging in working with survivors of GBV is critical to being able to provide quality services. This will help ensure that the service provider can work from a more neutral position and help the survivor to identify their own needs and make their own decisions.

Explain to participants that service providers need to be sensitive to the fact that most women will not spontaneously disclose that they are survivors of violence. However, often this is because they are never asked about it. In reality, many of these women have been waiting a long time to be asked about the violence in their lives. This part of the session will highlight these issues and explore ways to contribute to a reduction of GBV.

2. Barriers that survivors face in accessing support services — Role play, discussion — 45 min

Explain role-play by referring to Handout 2.3A. Allow time for all actors to fully understand their roles and what they will be required to do.

Note: This activity requires some preparation.

Facilitate a brief discussion on the following key questions:
- What did the group see?
- How many times did the client and mother have to tell the story?
- How many examinations were undertaken?
- How much time and energy, and possibly resources, did the survivor and mother have to use?

Ask for suggestions as to how this could have been avoided. Additionally, emphasize the importance of coordination and having good systems of support and referral in place to meet the range of needs that survivors may have.

Ask participants to brainstorm why survivors may not seek help.

Facilitate a discussion ensuring that all the following points are covered:

For all kinds of survivors:
- Shame
- Inaccessibility of services
- Poor response or inappropriateness of services
- Fear of reprisals and legal repercussions

Especially for domestic violence survivor:
- Family/cultural expectations
- Safer to stay in relationship
- Economic dependency
- Potential loss of custody of children
- Optimistic about ending of violence
- Partner's threats
- Loyalty to perpetrator
- Self blame i.e. it is her fault

3. Barriers to working on GBV — Group activity, discussion — 45 min

Ask participants to stand or sit in a circle.

Distribute cards to participants and ask them to write at least 2 barriers or myths that service providers may have that restrict or prevent them to ask clients about GBV.

Ask them to read their responses in turn while standing/sitting round in the same circle.

Review the following barriers/myths if they are not identified by participants.
- This only happens in other places in the world, to other kinds of people.
- This type of thing does not happen to our clients.
- This happened to me and I do not want to admit it.
- It's a private matter.
- It's not my job.
- No time to do this.
- If I ask, it could cause me legal problems.
- Victims don't really want to talk about it.
- Clients will get upset if asked about GBV.
- She must have done something to provoke it.
- I don't want to acknowledge this when I see it.

- There is nothing I can do anyway.
- This happened in the past and could not be affecting her now.
- She doesn't have a lot of marks, so this couldn't have been too bad.
- This has never happened to me, so it could not be happening to a woman like me now.
- I could see why her partner would beat her.
- A woman who is being hit should leave.
- We only deal with medical problems, we are not trained to deal with these sorts of problems.

Inform participants that this activity is important so that service providers can become aware of their own values, motivation and priorities. Whilst every individual's values, motivation and priorities may be different, we as service providers need to be sensitive to the fact that our values, motivation and priorities may further endanger the lives of survivors.

Facilitate a brief discussion stressing that service providers must:
- Demonstrate understanding by being sensitive and non-judgmental.
- Validate the survivor's story – say that you believe her and that no one deserves to be abused, and that help is available.
- Provide support and information.

4. Session summary **Plenary** **05 min**

Sum up key learning points from the session.

Handout 2.3A

Barriers that Survivors Face in Accessing Support Services: a role play

Step 1

Select two persons from a group and request one to be a rape survivor and the other to be her mother.

Ask the rest of the group to volunteer for other roles: women's leader, traditional healer, legal advisor, nurse, police officer, doctor, social worker, protection worker and NGO worker. Distribute prepared cue cards to each person with their role written on one side and the advice they give to the client on the reverse.

Step 2

Request the group to stand in a circle holding their respective titles and bring mother and daughter into the centre of the circle. These two will follow the trajectory given in the scenario below, and recount their story to each new person they encounter. Give the mother the ball of string and tell her to give one end of string to the first person she encounters. Each subsequent person should hold on to a section of the string. (The idea is that as the mother and daughter go from person to person, the string will create a 'web' and illustrate their trajectory.)

Step 3

Explain that the survivor is a nine-year-old girl who has been raped by a neighbour. Explain that the mother doesn't know what to do, so she takes her daughter to the **women's leader** for advice. Here the mother and daughter should walk together to the women's leader, and one of them should share what happened to the daughter. The women's leader should then give the advice written on the back of her cue card and send the pair to the traditional healer. This procedure should be repeated for each person, and each person should hold onto a section of string.

When they reach the **traditional healer** the mother hands the string to that person to hold, but keeps the ball. The traditional healer listens to the story, examines the daughter, says she thinks the girls has been abused, gives some medicine and advises the mother to go to the legal advisor.

The **legal advisor** listens and advises the mother to take her daughter to the clinic for an examination.

The mother and daughter go to the **nurse**. The nurse does an examination and tells them to go to the police officer.

The mother tells the story to the **police officer** who interviews the daughter and says he will investigate, but explains he needs a medical certificate from a doctor.

The mother tells the **doctor** the story and this person performs another physical evaluation and gives the mother a medical certificate to give to the police.

The mother goes back to the **police**.

A few days pass and the neighbour has come over and threatened the mother because he's heard she's been talking about him in public. The mother and daughter walk over to the **social worker**. The mother tells this person the story and expresses that she is scared. This person advises the mother to go to the police.

The **police officer** says he/she hasn't been able to investigate because there is no transport. The mother and daughter proceed to the protection officer.

The mother tells the story to the **protection officer** who says he will help with safety, but advises the mother to go to the NGO worker who can also help.

The mother tells the story to the **NGO worker** who takes down the information, informs the mother of what services are available and the procedures to go through to get help and also tells the mother this has happened to many other girls and it would be good to tell other persons in the community so that they may be able to take action to prevent further incidents.

Step 4
By this time the client and mother are in the middle of a tangle of string with all the different actors holding a piece of the tangle.

Step 5
De-brief and de role actors.

Source: Adapted from *Gender-based Violence: Emerging Issues in Programs Serving Displace Populations,* Beth Vann, RHRC Consortium 2002.

Session: 2.4

Roles and Responsibilities of Service Providers

Objectives

At the end of the session, participants will be able to:
- identify the role and responsibilities of service providers in supporting survivors of GBV
- recognize, describe and abide by the three fundamental guiding principles for working with survivors of GBV

Time

1 hr 30 min

Material

Flipchart paper, white board and markers

Process overview

Steps	Method	Time
1. Session introduction	Plenary	10 min
2. Roles and responsibilities of service providers	Free listing, group work and discussion	1 hr 15 min
3. Session summary	Plenary	05 min

Handouts

2.4A: Qualities of an Effective Service Provider
2.4B: Roles and Responsibilities of Service Providers
2.4C How to Implement a Routine Screening Policy
2.4D: Ensuring Privacy
2.4E: Suggested Steps for Developing a Referral Directory

1. Session introduction | Plenary | 10 min

Explain that while providing services to GBV clients, service providers need to take steps that encourage survivors to feel comfortable in talking about a sensitive, and, possibly painful, subject. This part of the session is focused on discovering the qualities of an effective service provider in providing services to clients of GBV including their role and goal concerning screening, case management and counselling.

2. Roles and responsibilities of service providers | Free listing, group work, discussion | 1 hr 15 min

Request participants to identify the type of work (e.g., screening, interviewing, counselling, etc) they do or could/should do with survivors and the skills needed for engaging with the survivor. Record their responses on the flip chart paper.

Highlight the following key roles and goals of service providers:
- Active screening
- Case management
- Counselling
- Documentation and record keeping

Divide participants in 4 groups and allocate 1 principle to each group and ask them to explore each key principle and activities involved in each category. Provide flip chart paper and ask each group to appoint a rapporteur to report back to the larger group.

Facilitate a discussion on the topic that each group reports on, making sure that the four key roles and responsibilities are fully covered. Refer to all Handouts.

Reinforce the need for organisations to ensure strict privacy and confidentiality within their services. Privacy and confidentiality give women the confidence to reveal a history of violence and abuse to their health care provider. They also give the opportunity to service providers to take action to protect women from future violence. Refer to Handout 2.4D, in particular.

3. Session summary | Plenary | 05 min

Sum up key learning points from the session.

Handout 2.4A

Qualities of an Effective Service Provider

I. Service provider presentation:

- Appropriate dress/appearance
- Professionalism
- Comfortable setting

II. Interpersonal style:

- Emotional
- Consistency
- Compassion
- Warmth
- Respect
- Empathy
- Sincerity
- Concreteness
- Listening abilities
- Sensitivity to socio-cultural factors and condition
- Personal identities

III. Work ethic:

- Dependability
- Punctuality
- Knowledge
- Confidentiality

Source: *Communication Skills in Working with the Survivors of GBV*, 2004.

Handout 2.4B

Roles and Responsibilities of Service Providers

The most important roles and goals of service providers are described below.

1. Active Screening

All providers should actively screen the clients who make visits to the clinic. While screening clients, providers are required to screen the signs and symptoms that are both visible and invisible. They should actively look for indirect indicators of violence such as nervousness, fear and depression. Active screening is mainly used by health care providers to assess and treat clients for histories of GBV.

Basic principles of screening include:

- **Privacy and safety for clients**: Service providers must understand the importance of client's privacy and safety.
- **Confidentiality**: The client and the service providers need to be clear about the confidentiality issue that all matters will be kept confidential.
- **Audio-visual confidentiality**: Both parties (client and service provider) should be clear about the question of confidentiality. There should be no screening through camera, videotape, etc. during screening and counselling.
- **Privacy of information and documents**: All documents must be kept as "confidential documents" and should be preserved in a cabinet providing no access to other than the concerned persons. Survivors' consent must be obtained if any information needs to be shared with a third party in particular circumstances like police and judiciary investigation. Staff member's awareness must be raised through trainings and orientation about the importance of guarding the confidentiality of records.
- **Client services:** It is very essential that every client receive the original services they require when they visit clinics/facilities.

Every clinic must have screening protocols that respect the above fundamental principles. Mechanisms should be in place to monitor its effective implementation by service providers (see Handout 2.4C on "How to Implement a Routine Screening Policy").

2. Case Management

Another important role and goal of service providers is to meet the needs of the client. This will include meeting the practical needs of survivors through assessment, education, referral and follow-up.

- **Needs Assessment**: Service providers should be able to respond appropriately when clients disclose GBV to them. They should be able to assess the practical needs of survivors i.e., medical care, counselling, legal advice, and shelter, in a non-judgmental, caring and sensitive manner. Providers should support, believe and respect the survivors, accepting that the survivor is the best person to identify her needs. The role of the provider is to support the survivor to articulate her needs.
- **Inform/Empower**: Service providers should inform their clients by sharing their knowledge and resources. When women share their experiences of GBV, providers need to increase the survivor's awareness about the link between her symptoms and the GBV she experienced, as well as the ways in which she can take better care of herself. Providers should always tell survivors that they are not alone in their experience of GBV. They may not have made a connection between their

symptoms and GBV or known anyone else who has gone through what they have faced or are currently facing.

- **Referral**: Service providers should inform survivors about the range of services and/or facilities provided by different agencies. Providers must actively assist survivors to access the services needed, including follow-up to assess take-up and the quality of care received.

Effective follow up mechanisms should be put in place to ensure health and welfare needs of all clients are met.

3. Counselling

A service provider is a trusted ***confidante*** who listens, reassures, and accepts the survivors; guides them in exploring options and deciding what, if any, action they wish to take; and advocates for them if they need any assistance. Counselling is mainly done by a psychologist and other trained social service providers to try and address the short and long-term emotional and psychological needs of survivors.

4. Documentation and Record Keeping

Service providers are required to document the information provided by their clients. They should be trained in handling and maintaining their clients' records in accordance with agreed systems and procedures.

Why confidentiality is so important?

- Safety
- Respect of survivor
- Rights

How do you ensure confidentiality of records?

- Locked file cabinets
- Do not leave records lying on desk unattended
- Do not take records home
- Do not discuss clients with family, neighbours or friends.

Source: *Guidelines for medico-legal care for victims of sexual violence*, World Health Organization 2003

Handout 2.4C

How to Implement a Routine Screening Policy

Lessons learned from IPPF/Western Hemisphere Region found that the following steps were important in the process of developing and implementing a routine screening policy. Please note that the list below is simply a summary of the stages, each of which is discussed in more detail in the manual.

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

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

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

Develop a data collection system. Decide how providers will record answers to screening questions. Will dedicated space be printed or stamped onto the clinic history form? Will there be a special registry or additional specialized forms? Will the data system be manual or computerized or both?

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

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

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

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

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

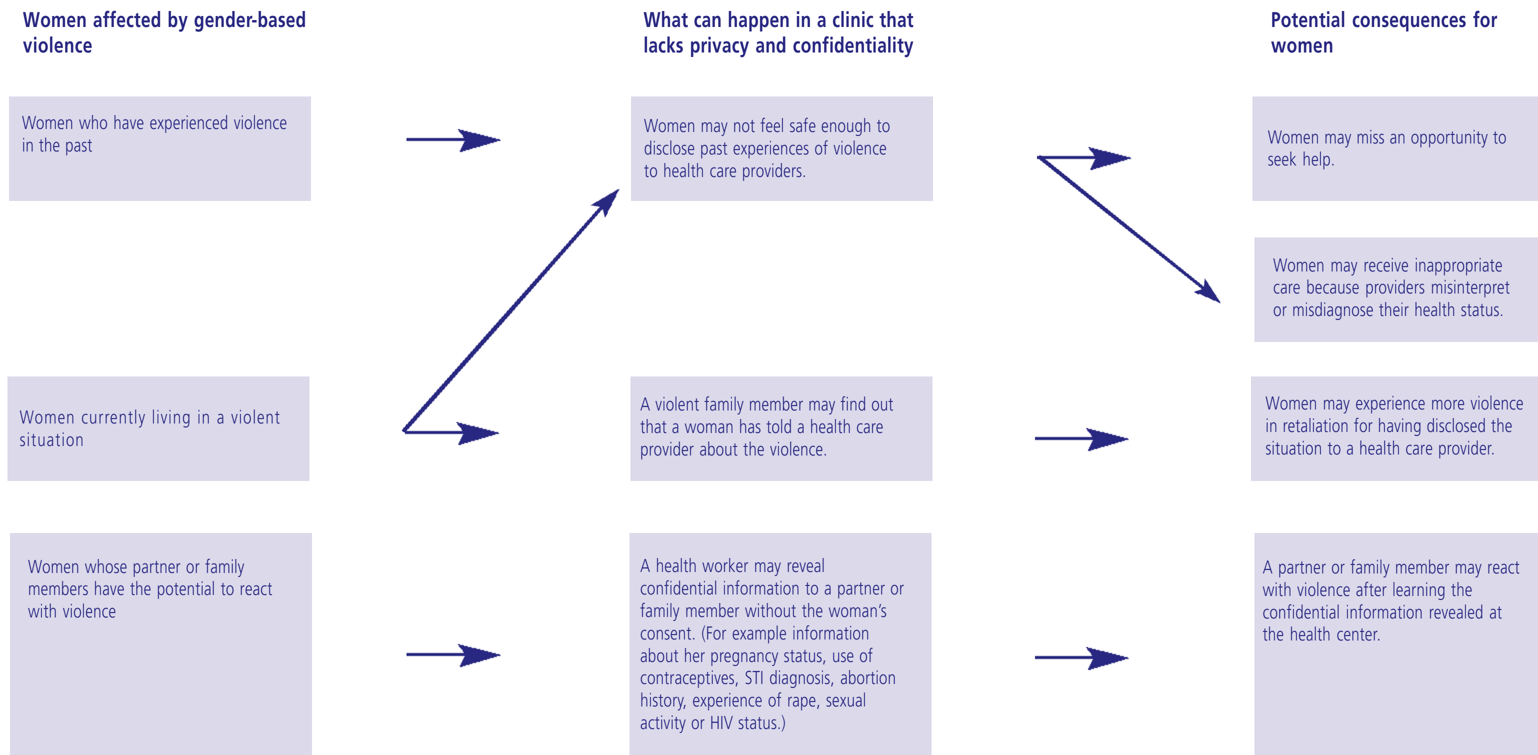
Source: *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Professionals in Developing Countries,* IPPF/Western Hemisphere Region, New York, 2004

Handout 2.4D

Ensuring Privacy

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

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



Source: *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Professionals in Developing Countries,* IPPF/Western Hemisphere Region, New York, 2004

Handout 2.4E

Suggested Steps for Developing a Referral Directory

STEP 1: ***Determine the geographic area to be included in the referral network.*** Where do most of your clients live? How far can they travel to seek services? If the institution has clinics in several parts of the city or the country, each site may need a different directory to ensure that the services are geographically accessible to women.

STEP 2: ***Identify institutions in the area that provide services that are relevant for women and girls who experience violence.*** This list can include medical, psychological, social and legal organizations, as well as local police contacts. You may also want to consider including institutions that address secondary issues related to violence, such as alcohol and drug abuse, as well as those that offer services for children who have experienced or have been exposed to violence. Each institution may be able to name other local institutions that can be included in the directory.

STEP 3: ***Call or (ideally) visit each institution to gather key information about its services.*** To ensure that you gather up-to-date information about each institution, and to have the opportunity to see the services firsthand, it is best to conduct a brief, informal interview in person with a staff member from the organization where services are provided. After describing your own work in the area of gender-based violence, you should ask a series of key questions to identify whether and how the institution can be used for referrals. On the following page is a brief interview guide and format for presenting the information.

STEP 4: ***Organize the information into a directory.*** You can organize information about referral institutions in different ways (for example, by location, type of service offered, etc.). If the number of referral services available in the community is small, then the directory may be very concise. If the directory is long, an index of institutions by name and type of service can make a directory more user-friendly.

STEP 5: ***Distribute the directory among health care providers.*** Ideally, a health program should distribute a copy of the directory to each health care provider so that all staff members who interact with female clients have access to this information. If resource constraints make it difficult to print this many copies, then every clinic should have a directory available to staff in a convenient, accessible place.

STEP 6: ***Gather feedback from providers about how well the directory is working.*** Managers should take the time to discuss the directory with providers soon after it is introduced to make sure that the format is workable and that the providers have not had any difficulties with the process of making referrals. Once providers have used the directory for a period of time, they may know what referral services are or are not in fact accessible to their clients, for example.

STEP 7: ***Formalize relationships with referral institutions.*** After creating a directory, the next step is to create more formal partnerships with other agencies. This may include setting up formal referral and counter-referral systems, as well as collaborating on projects. In some cases, IPPF member associations have negotiated discounted prices for their clients. Ideally, organizations involved in a referral network should be in contact with one another on a regular basis to give feedback, stay up-to date, and provide at least minimal follow-up to selected cases and other issues related to this work.

STEP 8: ***Update the information in the directory on a regular basis.*** It is essential for health programs to update the information in the directory on a regular basis (for example, every six months) to avoid giving women misinformation. Not only can misinformation waste women's time, money and energy, but it can also put them at risk in a number of ways. Remember that services can close, relocate, raise their costs, or change their procedures, especially in resource-poor settings where funding is scarce.

Source: *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Professionals in Developing Countries,* IPPF/Western Hemisphere Region, New York, 2004.

Session: 2.5

Communicating with Survivors

Objectives

At the end of the session, participants will be able to:
- identify barriers to and key elements of interactive communication
- explain the difference between 'advising' and 'informing'
- demonstrate effective interactive communication

Time

1 hr 45 min

Material

Flip chart paper, markers

Process overview

Steps	Method	Time
1. Session Introduction	Plenary	10 min
2. Effective Communication	Discussion, group work	45 min
3. Interactive Communication	Role play, discussion	45 min
4. Session Summary	Plenary	05 min

Handouts

2.5A: Effective Communication
2.5B: Barriers to Good Listening
2.5C: Introduction to Active Listening
2.5D: Advising vs Informing
2.5E: Interaction Technique: 1
2.5F: Interaction Technique: 2
2.5G: Interaction Evaluation Checklist

1. Session introduction — Plenary — 10 min

Introduce session by explaining that communication is one of the most important interventions while fighting GBV. It has an important role in challenging prevailing beliefs and norms that contribute to the acceptability and perpetuation of GBV. Effective communication strategies can contribute to shifting GBV from a "private matter" to one that merits public attention and intervention.

Explain that the session will introduce participants to the basic techniques of personal interaction to help improve communication with clients. It will also help participants to identify further capacity building needs in this area.

2. Effective communication — Discussion and group work — 45 min

Ask participants to freelist what they understand from the term 'communication'.

Summarize group responses to illustrate that communication is the transfer of information and understanding from one person to another person. A significant point of communication is that it always involves at least two people: sender and receiver. One person alone cannot communicate.

Refer participants to the different definitions of communication in Handout 2.5A

Divide participants into 3 groups and ask
Group 1 to identify frequent barriers to effective listening
Group 2 to identify key elements of active listening
Group 3 to identify the differences between 'advising' and 'informing'

Allow 15-20 minutes for the group work

Facilitate a plenary discussion asking each group, in turn, to present their findings, making sure that contents of Handouts 2.5B, 2.5C and 2.5D are covered.

Distribute Handouts 2.5B, 2.5C and 2.5D.

3. Interactive communication — Discussion, role play — 45 min

Explain to the participants that interaction techniques are communication tools to use with a survivor to demonstrate that you are actively listening to what they are saying. The techniques also encourage survivors to share information about their experiences so that service providers may provide appropriate support and guidance.

Distribute interaction technique Handouts 2.5E and 2.5F and allow participants sufficient time to read and digest the contents of the handouts.

Facilitate a short discussion, clarifying key points before moving on to the next step.

Request two participants to volunteer for a role-play. Drawn from their own experience, ask them to design a scenario in which one participant is the survivor and the other is the service provider. Allow them 10 minutes to prepare the role-play, in private, if necessary.

Explain to the rest of the group that they will act as observers to 'assess' the role-play using the Interaction Evaluation Checklist (Handout 2.5G).

Distribute the checklist and allow 5 minutes for review and clarify any questions.

Facilitate a discussion with the observers once the role-play has taken place, Begin with positive feedback making sure that all points in the checklist are covered.

Request the role-play actors for their feedback about the role-play and the observers' feedback. De-role actors.

4. Session summary — Plenary — 05 min

Sum up key learning points from the session.

Handout 2.5A

Effective Communication

I. Defining Communication

Communication is commonly defined as an ongoing, infinite and vital process of the need for all living organisms to survive through the successful exchange or "the transmission of meaning", whether internally, or from person to person. When we consider our personal thoughts, we are said to be talking to ourselves or engaging in intra-personal communication. Interpersonal communication on the other hand is the transmission of meaning from one person to another where at least two persons must be involved.

Some definitions of communication are:

- "...Communication - the exchange of information and the transmission of meaning - is the very essence of social system or an organization" (Daniel Katz & Robert L. Kahn)
- "...as the means by which people are linked together in an organization to achieve a common purpose" (Chester I. Barnard)
- "It is also the means by which behaviour is modified, change is effected, information is made productive, and the goals are achieved" (Koonz, O'Donnell, Weirich)

II. Types of Communication

a. *Intra-personal communication:* when we consider our personal thoughts or talk to ourselves, so to speak. For example, thinking or planning for a particular task.
b. *Inter-personal communication:* communication from one person to another person. For example, counselling a survivor or engaging in a discussion with a colleague.
c. *Small group communication:* conveying or transmitting meaning to a few individuals. For example, addressing a group of survivors or facilitating a community information session.
d. *Large group communication:* transmission of a message to a vast group of people. For example, national level advocacy such as a seminar or roundtable.

Source: Adapted from multiple sources.

Handout 2.5B

Barriers to Good Listening

I. Acoustics

- Background noise
- Interruptions

II. Physical Environment

- Inadequate seating
- Uncomfortable seating
- Lack of privacy in the room

III. Body Language

- Looking away from the individual
- Eyes darting around room
- Crossed arms
- Clenched hands
- Head bowed in hands
- Slouched posture
- Hands on hips

IV. Delivery/Tone

- Slow
- Monotone
- Emotional

V. Language

- Unfamiliar or strange
- Too wordy
- Use of technical/medical terms
- Rambling speech

VI. Appearance

- Sloppy dress
- Unusual clothing

VII. Other Barriers

- Tiredness
- Preoccupation
- Disinterest
- Having a bias against the individual
- Having bias against the subject
- Making assumptions about the individual
- Inappropriate touch

Source: Adapted from *Communication Skills in Working with the Survivors of GBV* Reproductive Health Response in Conflict Consortium, 2004.

Handout 2.5C

Introduction to Active Listening

Active Listening involves listening with understanding and involves total attention. The client will be communicating her message in many different ways, and you must be tuned in to all the methods she is using:

- The client's non-verbal behaviour: posture, expression, speed of speech, silences
- The person's voice: tone, quality
- The person's words and the meaning behind the words
- What is not said

From this you should be able to understand the person's story, their experiences that have caused them to seek services/counselling and the person's feelings and emotions.

In order to be able to listen with total attention, you need to be relaxed while attending. This means that you lay aside your own concerns and preoccupations while you are with your client, and create a space for the client to reveal what is troubling her:

- Relax physically— breathing, posture, etc.
- Allow your manner to be natural— no roles or poses
- Follow what the other person is saying and do not be afraid to ask clarifying questions
- Let your responses indicate to the other person that you are following what she is saying

In working with clients in crisis:

- Be supportive
- Validate the client – believe her
- Work with the client to help her become aware of her needs and coping skills
- Deal with current crisis first, before addressing previous crisis experiences
- Take time to find out what the client wants

Source: Adapted from *Communication Skills in Working with the Survivors of GBV* Reproductive Health Response in Conflict Consortium, 2004.

Handout 2.5D

Advising vs. Informing

Giving advice is:
- Telling someone what you think they should do and how you think they should do it
- Giving your personal opinion

Giving advice is not useful in providing professional services to survivors because:
- You can't know if you are giving the "right" advice.
- You might give the "wrong" advice and it can have a bad outcome for the survivor.

This can lead to a survivor's problems getting worse and to you getting a reputation as a bad helper.

- Counselling is about the survivor's opinions and judgments, not the helper's.
- Providing assistance to a survivor is about empowering survivors to make their own decisions about their own lives. Telling someone what to do does not help a person to understand her/his choices. It is up to the survivor to decide the best way to solve her/his problems.
- A survivor might feel that you are not listening if you tell her/him what to do.
- A survivor might feel you are not respecting her/him if you tell her/him what to do.
- Giving advice is based on your values and beliefs and doesn't help to change behaviour.

Giving information is:
- Telling someone facts so they can make an informed decision about what to do

Giving information is useful because:
- It empowers a survivor to have control over her/his choices.
- It shows you respect a survivor's opinions and judgments.
- The survivor has the responsibility for making the right decisions about her/his life, not the service provider.
- The survivor is the one who will have to live with the consequences of her/his decision, not the service provider.

Source: Adapted from *Sophie Read-Hamilton, Counselling Training Workbook*, IRC Tanzania, 2002.

Handout 2.5E

Interaction Techniques: 1

Therapeutic Techniques	Examples
1. Open invitation to talk	"Maybe you could tell me a little bit about what happened," instead of "have you been raped/beaten?"
2. Using Encouragers	"Yes," "Go on," "and then?"
3. Using Silence	Stay interested and alert, but don't always feel like you have to speak
4. Reflecting Feelings	"Sounds like you feel angry"
5. Seeking Clarification	"I'm not sure that I understand. Could you explain?"
6. Restating/Paraphrasing	Client: "I can't sleep. I stay awake all night" Counsellor: "You have trouble sleeping?"
7. Giving Broad Openings	"There seems to be something on your mind"
8. Exploring	"Could you tell me more about that?"
9. Attempting to Place in Sequence	"What seemed to lead up to this point?" "So this occurred"
10. Offering Self	"I'm concerned about what you are saying"
11. Giving Recognition	"It takes courage to tell me your story"
12. Suggesting Cooperation and/or Collaboration	"Together we can sort out the problems you're facing"
13. Summarizing	"Let's see if I've got this straight – you've said that..."

Source: Adapted from *Communication Skills in Working with the Survivors of GBV,* Reproductive Health Response in Conflict Consortium, 2004.

Handout 2.5F

Interaction Techniques: 2

Less Desirable Techniques	Examples
1. Questioning	"Why did you run away?" "How come you left home?"
2. Reassuring	"I wouldn't worry about that." "You'll do fine." "I'm sure your parents love you."
3. Giving Approval	"That's good." "I'm glad that you..."
4. Rejecting	"I don't want to hear about..."
5. Disapproving	"That's bad." "I'd rather you wouldn't."
6. Advising	"I think you should..." "Why don't you?"
7. Disagreeing	"That's wrong." "I definitely disagree."
8. Challenging	"If you're dead, how can your heart be beating?"
9. Testing	"If you had a pregnancy test, what was the procedure?"
10. Interpreting	"What you really mean is..." "Unconsciously, you're saying..."
11. Lecturing	Giving speeches or telling stories.
12. Introducing Unrelated Topics	Changing the subject.

Source: Adapted from *Communication Skills in Working with the Survivors of GBV,* Reproductive Health Response in Conflict Consortium, 2004.

Handout 2.5G

Interaction Evaluation Checklist

Interpersonal Skills

Greets clients
- Introduces self
- Introduces services and role
- Discusses confidentiality
- Engages clients in conversation
- Attends to clients
- Open
- Relax
- Observes
- Is supportive and non-judgmental
- Shows empathy
- Can deal with difficult emotions

Gathering Information
- Encourages clients to speak
- Uses good questions
- Uses silence where appropriate
- Seeks clarification
- Summarizes main issues

Giving Information
- Gives clear and simple information
- Gives clients time to absorb information and to respond
- Checks for understanding/misunderstanding
- Summarizes main issues

Problem Solving
- Is able to identify problems with clients
- Encourages client to come up with own solutions
- Does not tell client what to do/ give advice

Source: Adapted from *Communication Skills in Working with the Survivors of GBV* Reproductive Health Response in Conflict Consortium, 2004.

Day 3 Module

Working with Partners to Provide Holistic Support to Survivors

Module objectives:

1. To enhance understanding of human rights and sexual and reproductive rights in the context of GBV
2. To acknowledge importance of working collaboratively with other stakeholders in meeting the needs of survivors.
3. To understand the importance of building networks and planning for advocacy.
4. To identify personal action plans.

Session	Time
3.1 Recapturing yesterday	30 min
3.2 Gender, human rights and sexual and reproductive health	1 hr 30 min
3.3 Upholding the rights of survivors: national laws relating to GBV	1hr 45 min
3.4 Working with others to provide holistic support	1 hr 30 min
3.5 Workshop evaluation and closing	1 hr 15 min

Session: 3.1

Recapturing Yesterday

Objectives

At the end of the session, participants will be able to:
- recapture and relate previous day's learning with training objectives
- clarify key learning

Time

30 min

Material

Flipchart paper, markers

Process Overview

Steps	Method	Time
1. Session introduction	Plenary	05 min
2. Discussion on previous day's learning	Discussion	20 min
3. Session summary	Plenary	05 min

1. Session introduction **Plenary** **05 min**

Introduce session objectives

2. Discussion on previous day's learning **Discussion** **20 min**

Welcome participants to the third day and allow five minutes to think about the previous day's learning and ask participants to note down one of the most important learning from yesterday.

Ask the 'eyes' and 'ears' to give a brief presentation of yesterday's proceedings.

Before moving on, ask participants if there is anything from yesterday's learning that needs further clarification.

3. Session summary **Discussion** **05 min**

Appreciate participants for their active participation, enthusiasm and their passion for learning.

Session: 3.2

Human Rights, Sexual Reproductive Health Rights and Gender Based Violence

Objectives At the end of the session, participants will be able to:
- identify key human rights principles
- understand the relationship between human rights, GBV and SRHR

Time 1 hr 30 min

Material Flip chart stand, markers and flip cart paper

Process overview

Steps	Method	Time
1. Session introduction	Plenary	10 min
2. Key principles of human rights	Group work, discussion	30 min
3. Sexual and reproductive health rights and GBV	PPT, group work, discussion	45 min
4. Session summary	Plenary	05 min

Handouts

3.2A: Underlying Principles of Human Rights
3.2B: International Laws Protecting Women's Human Rights
3.2C: Key Components of Reproductive Health
3.2D: IPPF Charter on Sexual and Reproductive Health
3.2E: Sexual and Reproductive Health: Case Studies

1. Session introduction — Plenary — 10 min

Refer back to the previous sessions on Day 1 and 2 and ask participants, why knowledge of human rights is important when working with survivors.

Facilitate a short discussion and explain to participants that all acts of GBV or VAW are violations of fundamental human rights. This session explores human rights in the context of sexual and reproductive health and VAW.

2. Key principles of human rights — Group work, discussion — 30 min

Ask participants to identify key words which define human rights, and note on flip chart.

Divide participants into 8 groups and distribute to each group 1 cue card containing one of the following human rights principles. Ask each group to identify key elements of each principle and give 1 example of how this right may be violated.

- Equality
- Universality
- Human dignity
- Non-discrimination
- Indivisibility
- Interdependency
- Inalienability
- Responsibility

Allow 10 minutes for the group work.

Ask each group to report back to the larger group.

Facilitate a discussion by referring to Handout 3. 2A

Facilitate a brief discussion on the human rights instruments governing women's health and rights e.g. ICPD, CEDAW, CRC, and Beijing PoA, which provide international legal measures to protect women's health and well being including violence. Refer to Handout 3.2B

3. Sexual and reproductive health and rights and GBV — PPT, group work, discussion — 45 min

Deliver a short PPT to inform participants on the key components of reproductive health. Refer to Handout 3.2C
Introduce IPPF's Charter of Sexual and Reproductive Rights, checking for participant's knowledge and awareness of its existence and contents.

Introduce group work on IPPF's Charter of Rights.

Divide participants into 3 groups. Distribute 1 case study and the IPPF Charter to each group. Ask each group to use the case study to identify which rights are being violated and what service providers can do to uphold these rights. Allow 15 minutes for the group work.

Facilitate a discussion asking each group to summarize their discussions and findings for the larger group.

Recap with a PPT on the IPPF Charter.

4. Session summary — Plenary — 05 min

Sum up key learning points from the session.

Handout 3.2A

Underlying Principles of Human Rights

Equality
The equality concept expresses the notion of respect for the inherent dignity of all human beings. As specified in Article 1 of the Universal Declaration of Human Rights, it is the basis of human rights: "All human beings are born free and equal in dignity and rights."

Universality
Certain moral and ethical values are shared in all regions of the world, and governments and communities should recognize and uphold them. The universality of rights does not mean, however, that they cannot change or that they are experienced in the same manner by all people.

Human dignity
The principles of human rights are founded on the notion that each individual, regardless of age, culture, faith, ethnicity, race, gender, sexual orientation, language, disability or social class, deserves to be honoured or esteemed.

Non-discrimination
The Universal Declaration of Human Rights and subsequent international human rights law afford the same rights and responsibilities equally to all women and men, boys and girls, by virtue of their humanity, and regardless of any role or relationship they may have.

Indivisibility
Human rights should be addressed as an indivisible body, including civil, political, social, economic, cultural, and collective rights.

Interdependency
Human rights concerns appear in all spheres of life – home, school, workplace, courts, markets – everywhere! Human rights violations are interconnected; loss of one right detracts from other rights. Similarly, promotion of human rights in one area supports other human rights.

Inalienability
The rights that individuals have cannot be taken away, surrendered, or transferred.

Responsibility
Government responsibility: Human rights are not gifts bestowed at the pleasure of governments. Nor should governments withhold them or apply them to some people but not to others. When they do so, they must be held accountable.

Individual responsibility: Every individual has a responsibility to teach human rights, to respect human rights, and to challenge institutions and individuals that abuse them.

Other responsible entities: Every organ of society, including corporations, nongovernmental organizations, foundations, and educational institutions, also shares responsibility for the promotion and protection of human rights.

Source: Adapted from *International Human Rights Training Program; Participants Manual*, Canadian Human Rights Foundation, Canada, 2001.

Handout 3.2B

International Laws Protecting Women's Human Rights

Gender-based violence is recognized today as a major issue on the international human rights agenda. This violence includes a wide range of violations of women's human rights, including trafficking in women and girls, rape, wife abuse, sexual abuse of children, and harmful cultural practices and traditions that irreparably damage girls' and women's reproductive and sexual health.

In 1993, the *World Development Report* of the World Bank estimated that "women aged 15 to 44 lose more Discounted Health Years of Life (DHYLs) to rape and domestic violence than to breast cancer, cervical cancer, obstructed labour, heart disease, AIDS, respiratory infections, motor vehicle accidents or war." The Global Survey posed a number of questions on gender-related issues. Responses cover five specific areas: protecting the rights of girls and women; women's empowerment; gender-based violence; gender-based disparities in education, and men's support for women's rights and empowerment.

Violence against women and gender based violence violate a number of principles enshrined in international and regional human rights instruments. Several international human rights instruments have specifically addressed VAW including sexual violence and human trafficking.

CEDAW

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted by the General Assembly in 1981, the United Nations Declaration on the Elimination of Violence against Women, adopted by the General Assembly in 1993, and the Beijing Declaration and Platform for Action, adopted in Beijing in 1995, include all forms of discrimination as violence against women and girls and reaffirm the responsibility of States to work towards its elimination.

ICPD

The International Conference on Population and Development (ICPD) Programme of Action (POA) links population action to development with a significant emphasis on women's rights, empowerment and gender equality.

The Programme for Action promotes gender equality in all spheres of life including in the family and community, but decisively places men in the centre of the process if change is to be achieved. It encourages men to take responsibility for their sexual and reproductive behaviour, as well as their social and family roles (ICPD POA, Para 4.27).

It highlights men's special responsibility and promotes their active involvement in: "Shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes. Male responsibilities in the family must be included in the education of children from the earliest stages. Special emphasis should be placed on the prevention of violence against women and children." (ICPD POA, Para 4.27).

At the state level, the ICPD POA calls on countries "to take full measures to eliminate exploitation, abuse, harassment and violence against women, adolescents and children" (Para 4.9).

The ICPD plus 5 further spells out particular action in that, "Governments should give priority to developing programmes and policies that foster norms and attitudes of zero tolerance for harmful and discriminatory attitudes, including son preference, sex selection discrimination and violence against the girl child and all forms of violence against women (Key Action, Para 48)".

Rome Statute of the International Criminal Court

More recently, the 1998 Rome Statute of the International Criminal Court defines rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization or any other form of SV/GBV of comparable gravity as a crime against humanity. United Nations Security Council Resolution 1325 (2000) emphasizes States' responsibility to end impunity for crimes against humanity and war crimes, including sexual and other forms of violence against women and girls.

See also:

- United Nations Convention against Transnational Organized Crime (2000)
- Rome Statute of the International Criminal Court (1998)
- Beijing Declaration and Platform for Action (1995)
- United Nations Declaration on the Elimination of Violence against Women (1994)
- Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1984)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)
- International Covenant on Civil and Political Rights (1966)
- International Covenant on Economic, Social and Cultural Rights (1966)
- Universal Declaration of Human Rights (1948)
- Convention on the Rights of Children

Source: 1. *International Human Rights Training Program; Participants Manual*, Canadian Human Rights Foundation, Canada, 2001.
2. *Gender, Reproductive Health, and Advocacy*, the Centre for Development and Population Activities, CEDPA, Washington DC, 2000.

Handout 3.2C

Key Components of Reproductive Health

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide, if, when and how often to do so.

Following are the key components of Reproductive Health:

- The full spectrum of family planning information and services, including counselling and follow-up services, aimed at all couples and individuals;
- Prenatal, delivery (including assisted delivery) and post-natal care of mothers at the primary health care level with appropriate referral for the management of obstetric complications;
- Prevention of abortion, management of the consequences of abortion, and post-abortion counselling and family planning;
- Prevention RTIs and STIs and treatment of symptomic infections, as part of primary health care, with appropriate referral and follow-up;
- Prevention of HIV as part of primary health care, with appropriate referral for follow-up;
- Prevention of infertility and sub-fecundity, as part of primary health care, with appropriate referral for follow-up;
- Routine screening for women's other reproductive health conditions such as urinary tract infections, cervical infections, and cervical and breast cancer, where primary level treatment is available or referral for follow-up;
- Active discouragement of harmful practices such as female genital mutilation.

Source: *Implementing the Reproductive Health Vision: Progress and Future Challenges,* Office of Oversight and Evaluation, UNFPA, June 1999

Handout 3.2D

International Planned Parenthood Federation (IPPF) Charter on SRHR

The IPPF Charter on Sexual and Reproductive Rights was first published in 1996. The 12 rights, as set out in the Charter, provide IPPF and its member associations (MAs) with a demanding agenda into this century with a strong focus on the promotion and defence of the sexual and reproductive rights of individuals worldwide. The Charter is already being used by a number of MAs to extend their work to fully encompass the recognition of the 12 rights. A synopsis of the Charter is given below:

THE RIGHT TO:

1. Life: to protect all persons, particularly women, whose lives are endangered by pregnancy and/or HIV and AIDS.

2. Liberty and Security of the Person: to protect all persons, particularly women at risk from coercion, genital mutilation or subject to forced pregnancy, sterilization or abortion.

3. Equality and to be Free from all Forms of Discrimination: to protect the rights of all women, especially the girl child, regardless of race, colour, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status. To have equal access to information, education and services related to development, and to sexual and reproductive health and treatment.

4. Privacy: to privacy and to confidentially with regard to personal information given to service providers, for all clients of sexual and reproductive health-care information, education and services as well as all clients of testing and treatment services.

5. Freedom of Thought: to access education and information related to the sexual and reproductive health needs of especially young adolescent girls and women, free from restrictions, legal or otherwise, on the grounds of gender, sexual orientation, thought, conscience and religion.

6. Information and Education: to access full information on the benefits, risks and effectiveness of all methods of fertility regulation and STI/HIV/AIDS prevention, in order that any decisions they take on such matters are made with full, free and informed consent.

7. Choose Whether or Not to Marry and to Plan and Conceive a Family: to protect all persons against any marriage entered into without the full, free and informed consent of both partners.

8. Decide Whether or When to Have Children: to protect the rights of all persons to reproductive health-care services that offer the widest possible range of safe, effective and acceptable methods of fertility regulation, are accessible, affordable, acceptable and convenient to all users, irrespective of their HIV status.

9. Health Care and Health Protection: of all persons to the highest possible quality of health care, including emergency services related to sexual reproductive health, and the right to be free from traditional practices that are harmful to health.

10. Benefits of Scientific Progress: of all persons to access available reproductive health-care technology, including gender specific prevention needs, which independent studies have shown to have an acceptable risk/benefit profile and where to withhold such technology would have harmful effects on health and wellbeing. For example, Mother-to-Child Transmission programs, including treatment for the mother (MTCT+).

11. Freedom of Assembly and Political Participation: to form an association that aims to promote sexual and reproductive health and rights and/or an association of people living with HIV.

12. Freedom from Torture and Ill Treatment: to protect children, women and men from all forms of sexual violence, exploitation and abuse.

Source: *IPPF Charter on Sexual and Reproductive Rights,* International Planned Parenthood Federation, London, 1996.

Handout 3.2E

Case Studies: Sexual and Reproductive Rights

Case Study 1

Renu is a first year BA student when her parents decide that she should get married and find a suitable young boy to marry. Following the first few months of a happy married life, problems start when Renu expresses her desire to complete her studies. Her husband does not approve and asks her to stop her studies. By the end of the year, the tension between them has escalated, but things get unhappier for Renu when she discovers she is pregnant with an unplanned and unwanted pregnancy. The pregnancy means that she will not be able to finish her studies.

Renu tells her husband that she wants an abortion. Her husband is very happy about the pregnancy and forbids her to terminate the pregnancy, and threatens her with divorce.

When Renu attended her first ANC check-up at the FPA India clinic, she was depressed. The nurse noticed that Renu seemed a little quiet and on questioning her further, discovered her unhappiness and her reservations about the pregnancy.

Case Study 2

Bina is 18 years old and married for just 1 year. She lives with her husband's family in a small village just outside of Pokhara. Her husband works sometimes as a labourer. He came home one night drunk and started shouting at her and started a fight with her, and he accidentally hit her abdomen during the fight. During the night she developed abdominal cramps and started to bleed heavily. Early next morning, she went to the local hospital alone, leaving her husband still sleeping. At the hospital, she found the doctor and nurse, rude, unhelpful and disbelieving of her story of how she came to be bleeding so heavily. It was then that the doctor told her that she had been 3 months pregnant and that the feotus was female. Rekha was shocked and very upset about the loss of her baby. Suddenly she felt very scared and terribly alone.

Case Study 3

Mitali, married for two years, has been diagnosed with an STI at the FPA clinic. Her husband, on learning this, gets angry with her and accuses her of having a boyfriend. He beats her for suggesting that he might be the one being unfaithful and throws her out of the house, forbidding her to come back.

She and her one-year old daughter go to her parental home but after a week, they want her to return to her husband. They say her 'real home' is with her husband and she must learn to adjust. She is afraid of going back to her husband who may beat her again, but cannot stay much longer with her parents. Meanwhile, she is undergoing STI management at your clinic.

Session: 3.3

Upholding the Rights of Survivors: national laws relating to GBV

Objectives

At the end of the session, participants will be able to:
- understand the important role of national laws in protecting and upholding rights of women against GBV
- identify their role as service providers in supporting survivors to uphold their legal rights

Time

1 hour 40 min

Material

Flipchart paper and stand, marker

Process overview

Steps	Method	Time
1. Session introduction	Plenary	05 min
2. National laws to protect women against GBV	PPT and discussion	45 min
3. Role of service providers in upholding the legal rights of survivors	Group work, PPT, discussion	45 min
4. Session summary	Plenary	15 min

Handouts

3.3A: Understanding the Legal Issues

1. Session introduction — Plenary — 05 min

Inform participants that this session will examine ways in which national laws provide protection to women against GBV/VAW including sexual violence.

2. National laws to protect women against GBV — PPT and discussion — 45 min

Refer back to the different forms of violence discussed on Day 1 and ask participants to identify acts of violence for which laws exist in their country to protect women from violence.

Deliver a PPT regarding laws in a relevant country to address the following acts of violence against women:
- Physical, mental/psychological and economic abuse
- Rape, incest and sexual harassments
- Dowry demands
- Human trafficking
- Early marriage, abduction, forced marriage and polygamy
- Special laws for preventing violence against women and children

Facilitate a discussion about the opportunities and constraints provided by the laws in upholding the rights of women and/or offering them full legal protection.

3. Role of service providers in upholding the legal rights of survivors — Group work, PPT and discussion — 45 min

Divide participants into 4 groups and ask each group to:
- Identify examples where and how they have helped or supported survivors to access legal measures to protect against GBV
- The constraints or obstacles experienced
- Ethical dilemmas

Allow 30 minutes for the group work.

Facilitate a discussion taking feedback from each group, in turn.

Deliver PPT, referring to Handout 3.3A, covering the following points:
- Need for referral protocols for survivors to access free or low cost legal counselling services.
- Need for SRH providers to be aware of legal requirements in cases of VAW such as rape or early marriage, which pose ethical dilemmas.
- Sensitisation and/or awareness raising with key stakeholders e.g. lawyers, the police, members of the judiciary, policy makers and the media.
- Importance of establishing strong systems to monitor legal outcomes to collect and analyzing data for advocacy purposes.

4. Session summary — Plenary — 15 min

Sum up key learning points from the session.

Note to Facilitator: *It is recommended that a suitable technical resource person(s) is brought in to lead and facilitate this session, such as a lawyer specialising in the area. Handouts containing contextually relevant information should also be provided to all participants*

Handout 3.3A

Understanding the Legal Issues

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

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

While physicians cannot be expected to dispense legal advice, it is important for them to know basic information about the laws, their clients' rights, their own legal obligations as health care providers, the procedures for seeking legal redress, and the best ways to help clients avoid being re-traumatized by an abusive law enforcement system. For example, health care providers need basic legal information in order to adequately handle a case of rape. In many Latin American countries, health care providers can document legal evidence of physical violence, but not sexual violence. In Peru, Venezuela, the Dominican Republic and Brazil, for example, legal evidence of rape must be documented by a physician specifically licensed in forensic medicine; the courts do not consider a medical examination performed by an ordinary physician to be valid as evidence.

This means that health services need to explain the requirements to victims of rape and send them offsite to the specialist in order to preserve the possibility of bringing charges. In many settings, the visit to the forensic doctor is notoriously impersonal and sometimes traumatic. In general, these physicians view their role as strictly limited to collecting evidence; they generally do not feel it is their responsibility to address the victims' needs for STI prophylaxis or emergency contraception, much less their needs for emotional support.

Source: *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Professionals in Developing Countries,* IPPF/Western Hemisphere Region, New York, 2004

Session: 3.4

Working with Partners to Provide Holistic Support

Objectives

At the end of the session, participants will be able to:
- acknowledge the importance of multi-disciplinary work in providing holistic support to survivors
- explore partnership working for engaging in advocacy strategies

Time

1 hr 30 min

Material

Flipchart stand, paper and markers

Process overview

Steps	Method	Time
1. Session introduction	Plenary	10 min
2. Working in partnership	Group work and PPT	30 min
3. Planning for advocacy	Group work and PPT	45 min
4. Session summary	Plenary	05 min

Handouts

3.4A: Providing Holistic Support
3.4B: Planning for Advocacy

1. Session introduction | **Plenary** | **10 min**

Introduce the session topic by informing participants that there are at least two factors that make it essential for organisations to look beyond their clinic when working on the issue of GBV.

First, survivors of violence may have many needs that go beyond health care, including the need for legal advice, police protection, housing, economic support and other social services. These needs may be as or more important than their need for health care, and no organisation can single-handedly address the range of services that survivors may need.

The second reason is to contribute to the broader policy debate and the effort to change attitudes towards women's' rights and gender based violence at the community, regional and national levels. Through legal advocacy and community education efforts, health organisations have an important role to play in challenging the social norms that perpetuate violence against women.

Explain that this session will consider the importance of working with a range of stakeholders to provide holistic support to survivors of GBV.

2. Working in partnership | **Group work and PPT** | **30 min**

Refer participants back to earlier sessions which considered health care needs of survivors (Day 1), and the need for legal protection earlier in the day. This session will consider other needs that a survivor may have.

Request participants to note on distributed cue cards, the kind of help and support a survivor may need to meet her needs and/or to protect her from further violence.

When finished, pin up 5 flipchart sheets each containing one of the five following headings:

- Psycho-social
- Security
- Legal protection
- Economic
- Other

Request participants to read out their responses and jointly agree to which of the 5 themes it corresponds. Continue to add to the list, until all key response services are covered.

Facilitate a discussion about how providers may identify and establish sustainable partnerships which are of mutual benefit. For example, conducting resource mapping exercises, exploring motivation for partnership, etc. Explore the challenges of working collaboratively whilst stressing the need for building alliances that provide synergy to addressing the wider needs of women living in situations of violence. Cite examples of good practice and refer to Handout 3.4A

Note to Facilitator: *Remind participants that providing response services is possible only when clients report incidents of GBV to service providers and seek assistance. Hence, service providers' attitudes towards clients again play a significant role.*

3. Planning for advocacy | **Group work and PPT** | **45 min**

Explain that this session will build on the previous session on the importance of multi-sectoral collaboration through influencing broader policy and practice on protecting women against violence.

Inform participants that the health sector can play an important role in challenging the social norms that perpetuate GBV/VAW through forming strategic partnerships. Explain that the forthcoming activity will focus on the importance of coalition building for advocacy.

Write the word "advocacy" on the flipchart. Ask participants to freelist words that come to mind when they think of advocacy, and record responses. Examples of responses may include the following:

- Defending
- Sensitizing
- Persuasion
- Communication
- Intervening
- Selling an idea
- Attracting
- Influence
- Change
- Exposure
- Providing a solution
- Decision making
- Lobbying
- Attention

Request participants to identify key steps to consider when we plan for advocacy. Note down the ideas on flip chart paper.

Deliver a presentation on the advocacy process. Refer to Handout 3.4B

Divide participants into 2 groups. Allocate a GBV related issue for advocacy or ask each group to identify an issue, makings sure that there is no duplication between the groups.

Request each group to develop an advocacy plan or describe how they would launch advocacy campaigns on sexual violence taking into account the cultural sensitivities, ethics and particular circumstances that prevail in their settings.

Request each group to present their advocacy plan.

Facilitate a discussion, making sure that the advocacy campaigns include the following key points:

- Identification of key messages (taking into account social, cultural and religious factors)
- Use of different communication channels/formats to spread the key message(s).

Introduce the concept of coalitions, informing participants that working in partnership for advocacy is increasingly common in the development sector.

Divide participants into 4 groups and ask each group to identify key elements of **one** of the following:

- What is a coalition?
- What do they do?
- How do they work?
- Why do we hear so much about coalition building these days?

Request participants to give examples of coalitions in which they have participated.

Facilitate a discussion bringing in following key points:

- Coalitions are structures for organizations and individuals that support common goals to work together to achieve those goals.
- Coalitions are universal
- Coalitions are invaluable in policy advocacy
- Can typically include INGOs, NGOs, CBOs, women's groups and professional associations (e.g. physicians, lawyers and activists), as well as local, religious and traditional leaders.

4. Session summary — Plenary — 05 min

Sum up key learning points from the session.

Note to Facilitator: *Explain to participants that partners in different countries use different names for their advocacy groups. Some are called networks and the others are called coalitions. Whatever the names may be, the purpose of networks or coalitions is to advocate for social change.*

Handout 3.4A

Providing Holistic Support

Psycho-social

- Management of trauma
- Emotional support and counselling
- Negotiation skills for safer sex
- Male/partner involvement in SRH
- Support networks

Legal support

- Legal advice and representation (matrimonial law, inheritance, dowry, custody, etc)

Protection

- Report to police and local authority
- Case filing and investigation
- Prosecution against perpetrator
- Emergency shelter

Economic Empowerment

- Income generating activities
- Skills development
- Job training

Other

- Advocacy skills
- Leadership skills
- Esteem building
- Education

Source: *Adapted from multiple sources.*

Handout 3.4B

Planning for Advocacy

Advocacy is essentially about:

- Creating policies
- Reforming policies
- Ensuring good policies are implemented well

It is not:

- Changing public perceptions
- Confrontational, necessarily
- PR or fund raising

A Strategy Planning Tool for Advocacy Campaigns: Ask yourself 9 questions

1. What do we want? (OBJECTIVES)

Any advocacy effort must begin with a sense of its objectives. Among these objectives some distinctions are important. What are the long-term objectives and what are the short-term objectives? What are the content objectives (e.g. policy change) and what are the process objectives (e.g. building community among participants)? These objectives need to be defined at the start, in a way that can launch an effort, draw people to it, and sustain it over time.

2. Who can give it to us? (AUDIENCES; KEY PLAYERS; or POWER-HOLDERS)

Who are the people and institutions you need to move? This includes those who have the actual formal authority to deliver the goods (i.e., legislators). This also includes those who have the capacity to influence those with formal authority (i.e., the media and key constituencies, both allied and opposed). In both cases, an effective advocacy effort requires a clear sense of who these audiences are and what access or pressure points are available to move them.

3. What do they need to hear? (MESSAGES)

Reaching these different audiences requires crafting and framing a set of messages that will be persuasive. Although these messages must always be rooted in the same basic truth, they also need to be tailored differently to different audiences depending on what they are ready to hear. In most cases, advocacy messages will have two basic components: an appeal to what is right and an appeal to the audience's self-interest.

4. Who do they need to hear it from? (MESSENGERS)

The same message has a very different impact depending on who communicates it. Who are the most credible messengers for different audiences? In some cases, these messengers are "experts" whose credibility is largely technical. In other cases, we need to engage the "authentic voices," those who can speak from personal experience. What do we need to do to equip these messengers, both in terms of information and to increase their comfort level as advocates?

5. How can we get them to hear it? (DELIVERY)

There are many ways to deliver an advocacy message. These range from the genteel (e.g. lobbying) to the in-your-face (e.g. direct action). The most effective means vary from situation to situation. The key is to evaluate them and apply them appropriately, weaving them together in a winning mix.

6. What do we have? (RESOURCES)

An effective advocacy effort takes careful stock of the advocacy resources that are already there to be built on. This includes past advocacy work that is related, alliances

already in place, staff and other people's capacity, information and political intelligence. In short, you don't start from scratch, you start from building on what you've got.

7. What do we need to develop? (GAPS)

After taking stock of the advocacy resources you have, the next step is to identify the advocacy resources you need that aren't there yet. This means looking at alliances that need to be built, and capacities such as outreach, media, and research, which are crucial to any effort.

8. How do we begin? (FIRST STEPS)

What would be an effective way to begin to move the strategy forward? What are some potential short-term objectives or projects that would bring the right people together symbolize the larger work ahead and create something achievable that lays the groundwork for the next step?

9. How do we tell if it's working? (EVALUATION)

As with any long journey, the course needs to be checked along the way. The strategy needs to be evaluated by revisiting each of the questions above (i.e., are we aiming at the right audiences; are we reaching them, etc.). It is important to be able to make mid-course corrections and to discard those elements of a strategy that don't work once they are actually put into practice.

Note: A common confusion in the development of advocacy strategy is the difference between "strategy" and "tactics." ***Tactics*** are specific actions – circulating petitions, writing letters, staging a protest – that are the building blocks of advocacy. ***Strategy*** is something larger, an overall map that guides the use of these tools toward clear objectives. Strategy is a hard-nosed assessment of where you are, where you want to go, and how you can get there.

Source: *Advocacy in Action: a toolkit to support NGOs and CBOs responding to HIV/AIDS,* AIDS Alliance, 2002.

Session: 3.5

Workshop Closing

Objectives	At the end of the session, participants will be able to: - review and evaluate workshop learning - state their commitment to carry forward the learning from the workshop
Time	1 hr 15 min
Material	Flipchart paper, markers

Process overview

Steps	Method	Time
1. Session introduction	Plenary	05 min
2. Planning next steps	Individual work, discussion	30 min
3. Post workshop questionnaire	Questionnaire	15 min
4. Workshop evaluation	Plenary	15 min
5. Closing remarks	Plenary	10 min

Handouts

3.5A: Follow up Action Plan
3.5B: Post Workshop Questionnaire
3.5C: Workshop Evaluation
3.5D: Resources Information

1. Session introduction | **Plenary** | **05 min**

Introduce concluding session. This session will review learning outcomes and plan for next steps.

2. Planning next steps | **Individual work and discussion** | **30 min**

Facilitate a brief discussion asking how participants will carry forward key learning outcomes from the workshop. Possible action points could include:

- Replicate this training at their workplace.
- Develop a network to carry on the advocacy programs.
- Conduct this kind of training for community leaders, influential persons and volunteers.

Distribute *Follow-up Action Plan* template (Handout 3.5A) and ask each participant and to write at least two actions they will take once they return to their desks. Allow 15-20 minutes for the exercise.

Facilitate a brief discussion, asking participants to share their action points.

3. Post workshop questionnaire | **Questionnaire** | **15 min**

Distribute to each participant their individual pre-workshop questionnaire and allow time for completion.

Facilitate a brief discussion about key learning outcomes. Enquire if any expectations remained untouched. If so, ask the group to identify how those expectations can be met in other ways.

4. Workshop evaluation | **Plenary** | **10 min**

Distribute final workshop evaluation forms to participants and allow time for completion.

Collect all the completed evaluation form.

Enquire if any participant would like to provide any verbal feedback about the workshop.

5. Closing remarks | **Plenary** | **10 min**

Invite the host organization to make closing remarks. Thank everyone for their active participation and contribution.

Handout 3.5A

Follow up Action Plan

Problem Statement	Recommendation	By Whom	By When

Handout 3.5B

Workshop Evaluation

1. Rate your overall impression of the entire workshop:

   ☐ Excellent
   ☐ Good
   ☐ Fair
   ☐ Poor

2. What was the most useful session of the workshop:

____
____

3. What was the least effective session of the workshop:

____
____

4. Which activity or exercise did you find the most helpful, and why?

____
____

5. Which activity or exercise did you like the least, and why?

____
____

6. Which, if any, of the activities or exercises will you apply in your own work as a health provider, and why?

____
____
____

7. How could this workshop be improved?

____
____

8. Rate your overall impression of the facilitators on the following criteria: (Circle one number in each row)

Facilitators	Poor			Excellent	
a. Knowledge of material	1	2	3	4	5
b. Preparedness	1	2	3	4	5
c. Communication skills	1	2	3	4	5
d. Attentiveness	1	2	3	4	5
e. Comfort level with training material	1	2	3	4	5
f. Ability to engage participants	1	2	3	4	5

Comments:

____
____

9. Did the workshop meet your expectations?

☐ Yes

☐ No

Please explain:

____

____

10. Was the workshop too long or too short? (circle one)

☐ Too long

☐ Too short

Please explain:

____

____

11. Would you recommend this workshop to others?

☐ Yes

☐ No

Please explain:

____

____

12. What other suggestions or feedback do you have at this time?

____

____

____

Thank you! Your comments, suggestions, and feedback are important to us and will help us to improve future workshops

Resources

Resources used in the module are cited below, in order of use

1. *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Professionals in Developing Countries,* IPPF/Western Hemisphere Region, New York, 2004

2. *Multi-country Study on Women's Health and Domestic Violence against Women,* WHO, 2006.

3. de Bruyn, M. & France, N. *Gender or sex: who cares? Skills-building resource pack on gender and reproductive health for adolescents and youth workers.* Chapel Hill: Ipas, 2001.

4. Bhasin, K. *Understanding Gender,* 2002.

5. Oxfam Gender Training Manual, Oxfam, UK, 1994

6. *Guidelines for the Prevention and Response of Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Person,* UNHCR, Geneva, 2002.

7. *Heise, L.et al., 'Violence Against Women: A Neglected Public Health Issue in Less Developed Countries,'* Social Science Medicine, 1994, cited in Local Action, Global Change, Learning about the Human Rights of Women and Girls, UNIFEM and The Centre for Women's Global Leadership, 1999.

8. *Gender, Reproductive Health and Advocacy: A trainers manual,* CEDPA, 2000

9. *Outlook:Violence against Women: Effects on Reproductive Health Volume 20, Number 1,* Path and UNFPA, Dhaka, 2002

10. Beth Vann. *Training Manual Facilitator's Guide: Interagency & Multi-sectoral Prevention and Response to Gender-based Violence in Populations Affected by Armed Conflict.* Global GBV Technical Support Project, JSI Research & Training Institute, RHRC Consortium, 2004.

11. *Training Module on the Management of Violence against Women*, Government of Bangladesh, and UNICEF, 2000

12. American Refugee Committee, Thailand GBV Program, 2004.

13. Adapted from *Community Safety Initiative: Gender Based Violence Program. Gender Base Violence in Conflict Affected Settings Toolkit,* American Refugee Committee International, 2005.

14. *Gender-based Violence: Emerging Issues in Programs Serving Displace Populations,* Beth Vann RHRC Consortium 2002.)

15. Gorton, R. *Safe Horizons, Volunteer Training Materials*, *The Weakest Link in Your Risk Management Program Documentation*, New York, 1999

16. *Communication Skills in Working with the Survivors of GBV* Reproductive Health Response in Conflict Consortium, 2004.

17. Adapted from *Communication Skills in Working with the Survivors of GBV* Reproductive Health Response in Conflict Consortium, 2004.

18. *Counselling Training Workbook*, Sophie Read-Hamilton, IRC Tanzania, 2002.

19. *International Human Rights Training Program; Participants Manual*, Canadian Human Rights Foundation, Canada, 2001.

20. *Gender, Reproductive Health, and Advocacy*, the Centre for Development and Population Activities, CEDPA, Washington DC, 2000.

21. *IPPF Charter on Sexual and Reproductive Rights,* International Planned Parenthood Federation, London, 2003.

22. *Advocacy in Action: a toolkit to support NGOs and CBOs responding to HIV/AIDS,* AIDS Alliance, 2002.

Additional resources are:

23. Institute for Development Studies, Gender Workshop, Brighton, UK, 2001.

24. Declaration of the Elimination of Violence Against Women, 1993.

25. *Mobilizing Communities to Prevent Domestic Violence: A Resource Guide for Organizations in East and Southern Africa*, Lori Michau & Dipak Naker, Raising Voices, 2003.

26. *Communicating Population and Family Planning Information to Policymakers,* OPTIONS Policy Paper Series # 4,1994.

27. *Addressing GBV from the Reproductive Health/HIV Sector: A Literature Review and Analysis.* 2004.

28. *World Report on Violence and Health,* WHO, Geneva, 2002.

29. *GBV Tools Manual for Program Design, Monitoring and Evaluation*, RHR Consortium, 2004.

30. *Guidelines for the Prevention and Response of Sexual and GBV against Refugees, Returnees and Internally Displace Persons*, UNHCR, Geneva, 2003.

31. *Clinical Management of Survivors of Rape*, WHO and UNHCR, 2002.

32. Vann, Beth, Gender-Based Violence: *Emerging Issues in Programs Serving Displaced Population*, RHRC Consortium, 2002.

33. *Population Reports: Ending Violence against Women,*Johns Hopkins University School of Public Health.

34. WHO Fact Sheets (www.who.int/mediacentre/factsheets/ en/)

35. *A Practical Approach to GBV: A Program Guide for Health Care Providers and Managers,* UNFPA, 2001.

IPPF International Planned Parenthood Federation

South Asia Region

DFID Department for International Development