

Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence

A manual for health managers



World Health
Organization

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Preface

This manual is intended for health managers at all levels of the health systems. The manual is based on the World Health Organization (WHO) guideline *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, 2013. Those guidelines inform this manual and its companion clinical handbook for health-care providers, *Health care for women subjected to intimate partner violence or sexual violence*, 2014.

The manual draws on the WHO health systems building blocks as outlined in *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action* (WHO, 2007).

This manual also draws on other manuals and tools for the health sector response to gender-based violence against women that are listed in the bibliography on page 115.

In May 2016 the World Health Assembly, comprising representatives of the ministries of health of 194 Member States, endorsed a global plan of action to strengthen the role of the health system, within a national multisectoral response, to address interpersonal violence, in particular against women and girls and against children (global plan of action on violence). This plan of action urges governments and other national and international partners to take actions in four strategic directions:

- 1) strengthening health system leadership and governance
- 2) strengthening health service delivery and health-care providers' capacity to respond

- 3) strengthening programming to prevent violence, and
- 4) improving information and evidence.

This manual supports implementation of the global plan of action on violence. In addition, this manual, along with the companion clinical handbook, contributes to implementation of the health component of the United Nations Joint Programme on Essential Services for Women and Girls Subject to Violence.

Acknowledgements

This manual was developed by WHO drawing on the work of many people around the world dedicated to addressing violence against women and to the care and support of women subjected to violence.

Claudia García-Moreno and Avni Amin in the WHO Department of Reproductive Health and Research (RHR) led the preparation of this manual and oversaw the development of the final text. Jane Koziol-McLain prepared an early draft of the manual. Floriza Gennari updated a later draft. Manuela Colombini and Emily Schwarz drafted some of the job aids.

We gratefully acknowledge the advice and review of the manual by Wame Baravilala, Myra Betron, Ann Coker, Manuela Colombini, Alessandra Guedes, Kelsey Hegarty, Constanza Hege, Ruxana Jina, Elizabeth Kelman, Michelle Kendall, Berit Kieselbach, Sangeeta Rege and Juan Tello.

Sarah Johnson and Ward Rinehart of Jura Editorial Services were responsible for technical editing and design and layout.

What is this manual?

The purpose of this manual is to strengthen and enable health systems to provide confidential, effective and women-centred services to survivors of violence. Violence damages women's health in many ways, both immediate and long-term, both obvious and hidden. Such violence can include physical, sexual and psychological violence. The violence may be committed by an intimate partner or, in the case of sexual violence, by any perpetrator. The manual focuses on violence against women by men, in particular intimate partner violence and sexual assault, as it remains hidden and often unrecognized by the health system.

Violence leads many women to seek care from health services. Thus, the health system has a crucial opportunity and duty to respond to violence against women. These women need care and support and have the right to the best possible health-care available. This care needs to be available at every level of health-care delivery, from primary care to care in referral/tertiary hospitals. The health system can also be the point of entry to a network of supporting social and legal services.

Intended audience. This manual addresses primarily public sector health services, but it is also relevant for health services in the private sector, including services provided by nongovernmental organizations (NGOs). The intended users are health managers at all levels of the health system who have the responsibility for designing, planning or managing health services for women, including those who have been subjected to violence. This may include:

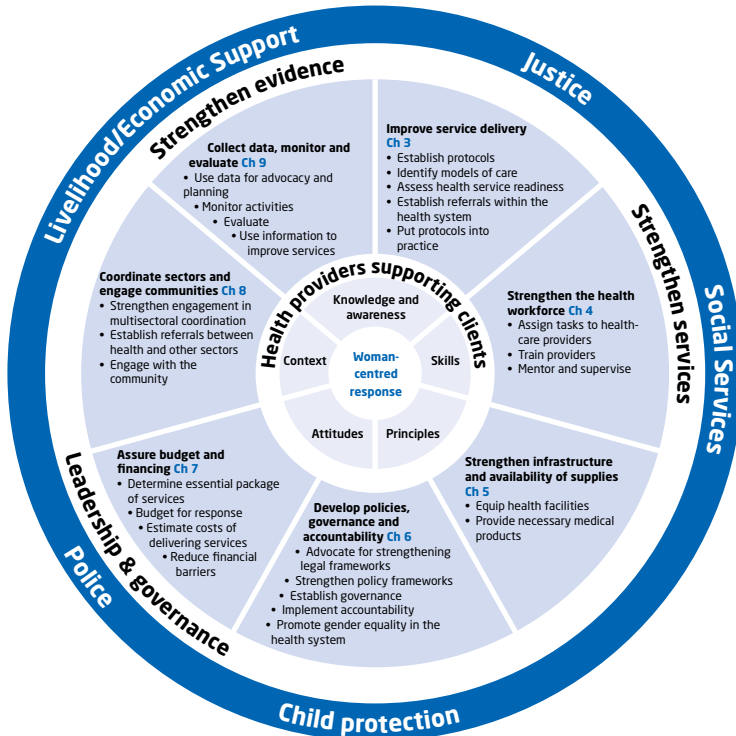
- **Policy-makers** – managers and other decision-makers in ministries of health and ministries in other sectors at the national and subnational levels (that is, provincial, state, district or municipal) who have responsibility for setting policies, developing protocols, designing programmes and planning and monitoring services.
- **Health services managers** at hospital or health facility level (that is, administrators) who have responsibility for facility-level planning as well as day-to-day coordination and management of services.
- **Health-care providers** including doctors, nurses, midwives and allied professionals, especially those who have supervisory, mentoring and coordination roles.
- **Decision-makers** in funding agencies that support health services.

What this manual does

The manual provides operational “how to” guidance to health managers for designing and planning services to meet the immediate emotional/psychological and physical health needs and the ongoing safety, support and mental health needs of women who have been subjected to violence.

This manual offers easy steps, practical tips and job aids to help plan and manage services. It adapts and expands on the WHO health systems building blocks as the foundation for the actions proposed. The manual is organized into four parts covering 10 chapters, with Part 1 providing guidance on getting started, and Parts 2, 3 and 4 corresponding to the health systems building blocks (see figure, next page).

Designing and planning the health system's response to violence against women, based on WHO's health systems building blocks



What the manual does not cover

The guidelines on which this manual is based do not specifically address children, adolescent girls (that is, those under 18) or men. Nonetheless, the actions described in this manual may also be applicable for services for children, adolescent girls or men who have been subjected to violence.

How to use this manual

This manual recognizes that its users have various roles and responsibilities depending on their position and level in the health system or their place of work. Therefore, where content is relevant only for policy-makers or managers in national or subnational ministries, this is indicated with an icon “**policy-maker**”. Where content is only relevant for a local or health facility level manager, this is indicated with an icon “**health services manager**”. In all other places the content is relevant for **all** users.

Policy-maker



Health services manager



While some readers may have specialist knowledge on integrating the response to violence against women into the health system, the primary intended readers are assumed not to be specialists in this topic. The guidance here will need to be adapted to the specific health system contexts and available resources, as well as the legal and policy frameworks in place in different countries.

The first part of the manual assumes that the reader’s health system has little or no integrated response to violence against women. Readers in health systems that are more ready for a health response can skip to Parts 2, 3 and 4 as needed. Readers may access chapters that are most useful depending on their needs and the readiness of their health system to respond to violence against women.

Part 1.

Getting started

Chapter 1.

Build awareness of the need for a health systems response to violence against women

This chapter covers:

- *Why should the health system address violence against women?*
- *What is the role of the health system in the multisectoral response to violence against women?*
- *What is a woman-centred health response?*
- *What does woman-centred care mean in practice?*

1.1. Why should the health system address violence against women?

Violence has major harmful effects on women's health and well-being, including on their sexual and reproductive and their mental health. Violence against women is a serious, but preventable public health problem that is common worldwide. According to WHO estimates, globally approximately one woman in every 3 (35%) has experienced physical and/or sexual violence by an intimate partner or sexual violence by someone else at some point in their lives, most of this by intimate partners.¹

¹ WHO, LSHTM, SAMRC, 2013.

Health services provide a unique resource to identify women subjected to violence, provide them with appropriate care, connect them to other support services and, potentially, contribute to preventing future harm. All women are likely to come in contact with health services at some point in their lives. Women subjected to violence are more likely to seek health services in general, often for conditions linked to violence, even if in most cases they do not disclose the violence. For those who do seek professional help for violence, health-care providers are often women's first and most trusted point of professional contact.

Violence against women also has harmful effects on their children's mental and physical health. Furthermore, growing up in a household with violence may lead to violence in later life. Boys who witness intimate partner violence at home are more likely to perpetrate violence later in life, and girls with childhood exposure to intimate partner violence are more likely to experience violence in later relationships, although this is not an inevitable outcome.

1.2. What is the role of the health system in the multisectoral response to violence against women?

Addressing violence against women requires a multisectoral response. Health systems have a critical role to play in this response. This includes:

- identifying those who are experiencing violence and providing them (and their children) with comprehensive health services;
- facilitating access to supportive services in other sectors that women who experience violence need and want;

- contributing to preventing the recurrence of violence by: identifying early the women who are experiencing violence and their children, providing appropriate care and referrals, and addressing problems associated with violence such as harmful alcohol and substance use;
- integrating into health education and health promotion activities with clients and communities messages about the human rights violations and harmful health and other consequences associated with violence against women, the need to seek appropriate and timely care, and prevention;
- documenting the magnitude of the problem, its causes and consequences, and advocating for coordinated multisectoral prevention and provision of effective responses.

1.3. What is a woman-centred health response?

Care and health services for women who have been subjected to violence should be woman-centred – that is, they should be organized around women’s health needs and perspectives. A woman-centred health response offers care that:

- takes actions to enhance women’s safety;
- minimizes or does no harm and maximizes benefits of how services are designed and delivered;
- takes into account women’s perspectives;
- responds to women’s needs and concerns in humane and holistic ways;
- provides women with information and supports them to make informed choices and decisions;
- empowers women to participate in their own care.

Two fundamental principles guide woman-centred care:

- **respect** for women’s human rights; and
- **support** for gender equality.

1.4. What does woman-centred care mean in practice?



To provide woman-centred care to women subjected to violence, you can plan and manage health-care services that:

- offer women good-quality care that ensures privacy and confidentiality (see box);

Confidentiality, privacy and accountability

- Ensuring privacy and confidentiality is critical for the safety of women who have been subjected to violence. A breach of confidentiality about sexual violence, intimate partner violence or their health consequences (that is, pregnancy, HIV, STI) can put women at risk of additional violence. Women need privacy and confidentiality assured to be able to disclose their experience of violence to health-care providers without fear of retaliation from the perpetrator.
- You may already have a policy to maintain privacy and confidentiality for all service users, or you may need to update it or develop one.
- Also, you need to ensure that infrastructure and patient flows promote safe and confidential consultations. Implement mechanisms of redress for any breaches of privacy or confidentiality.
- Inform women about their rights as clients and hold staff accountable for violations of clients’ rights.

- provide information and services that enable women to have options and make choices about their treatment, care and support and about how they will deal with the violence they have experienced;
- educate your staff to understand how unequal power and social norms perpetuate violence against women;
- encourage health-care providers to respect women's choices and autonomy in making decisions related to their care;
- recognize that a woman subjected to violence may face multiple forms of discrimination – not only because she is a woman and because she has been subjected to violence, but also because of her race, ethnicity, caste, disability, sexual orientation, gender identity, religion, or other characteristic;
- take into account women's personal circumstances (for example, child care or other caring responsibilities, housing, limited mobility, inability to pay, low literacy, linguistic background) by providing services:
 - as close as possible in the community;
 - that are accessible by public transport;
 - with a child-friendly environment;
 - that are open at times convenient for women; and
 - that are free of charge for those who cannot pay;
- take precautions while undertaking any data collection on violence against women, including documentation of reports, so as to protect confidentiality of information and minimize harm.

Chapter 2.

Advocate, analyse and plan

This chapter covers key actions to:

- *Build political will for health system change*
- *Conduct a situation analysis*
- *Develop an action plan.*

2.1. Build political will for health system change



Improvements in the health system's response to violence against women require political will for change. Political will can bring an issue to the top of the policy agenda and encourage change in the health system.

You may first assess whether the health system is ready to undertake efforts to strengthen the health systems response to violence against women (see Job aid 2.1, next page).

Is there political will to improve the health system response to violence against women?

When several of the following conditions converge, a window of opportunity may open to champion a health systems response:

- Are there leaders in health and other sectors who are advocating a stronger response to violence against women?
 - Do attitudes of stakeholders support addressing violence against women? For example, health policy-makers recognize the importance of addressing and prioritizing violence against women.
 - Are there reports of incidents of violence against women that have recently outraged the public?
 - Does the media cover issues of violence against women sympathetically, from women's point of view?
 - Are there major public figures who are speaking out against violence against women?
 - Are grassroots and civil society advocacy organizations lobbying for change?
 - Do stakeholders understand the links between violence against women and poor health outcomes?
 - Has the country signed international conventions that assert women's rights, including their right to be free of violence?
-

Strategies for building political will



Political will requires the commitment of senior management. Advocacy strategies to build political will are outlined below.

1. Build a coalition

Coalitions among advocates inside government programmes or health institutions working together with advocates in civil society, such as grassroots community organizations, can be crucial. For example, managers in the ministry of health can work with managers in other key ministries such as those for women’s empowerment or gender equality, police, justice, finance and planning, as well as with leaders of civil society organizations. Many countries establish a multisectoral national or subnational task force for ending violence against women. Representatives of the ministry of health should be members of such a task force.

2. Enlist champions

Champions are energetic and influential people who promote a cause. They can be crucial to improving the health system response to violence against women. Champions include people both inside and outside government and health systems. They can also be recruited from among well known people to serve as spokespeople – for example, celebrities or “ambassadors”. Different champions can speak to different audiences, and so it is useful to have several champions. A health manager may be a champion herself or himself or work closely with and support a champion. Champions may need support to make a strong case to the public and to decision-makers.

3. Define the issue

Both statistics and personal stories (the “human face”) can make a powerful case for change. Ensure you know the prevalence of violence against women in your country or region and its health impacts. Statistics about your own country will be the most powerful. In addition, the story of a real woman or a composite story based on several women can help to change hearts. Do not reveal her/their identity(ies) unless she/they explicitly agree to it.

4. Create a persuasive argument

Align your argument with strategic targets of issues already identified as high priority, for example, reducing HIV transmission or reducing maternal mortality. Advocate making the health system response to violence against women a national health priority and link it to, for example, sexual and reproductive health or adolescent health, or mental health priorities.

5. Use the mass media

The mass media – both news and entertainment – are useful to disseminate key messages. Link with local and national media to raise public awareness of violence against women. (See examples of key advocacy messages on the next page.)

6. See and open the window of opportunity

Particular events may create windows of opportunity for change, when public attention focuses on violence against women and a consensus for action forms – for example, the release of a national survey on violence against women or a specific case of violence reported in the news media. Be ready when the window of opportunity opens. For example, have fact sheets, draft policies and working groups ready to mobilize.

Key messages for advocacy

As a policy-maker your role gives you the authority to be an advocate and speak about violence against women from the perspective of health. Your potential audiences can be your colleagues, your senior management, officials from other government ministries and the public. You can articulate clear and consistent messages such as these:

- Violence against women is a critical and preventable public health problem.
- Violence against women seriously affects women's health and their children's health.
- Violence against women has great social and economic costs for communities and society.
- The health system has an important role, within a coordinated, multisectoral effort, in preventing and addressing violence against women.
- Sustainable systems need to be in place that support health-care providers' respectful, caring, and effective response to women who experience violence.
- Health policy-makers, managers, service providers and advocates must challenge beliefs and norms that condone gender inequality and violence against women.

2.2. Conduct a situation analysis



Before developing a response, gather information about the epidemiological, social and legal situation as it relates to violence against women in your region or community. An in-depth understanding of the existing gaps in health services and across sectors will help you assess the readiness of your system and develop a more informed response to violence against women. Work with your colleagues in various government ministries, as well as with other partners

including women’s organizations and experts on violence against women in your country or community, to conduct a situation analysis. Job aid 2.2 (see below) describes actions to conduct a situation analysis.

Job aid 2.2

Is there policy-level readiness? Conduct a situation analysis

- Is there political will to address violence against women among different stakeholders (see Job aid 2.1)?**
 - ✓ Determine whether violence against women is considered or perceived to be a priority by policy-makers, in public opinion, by the media.
 - Are there data available on violence against women?**
 - ✓ Identify what quantitative and qualitative data on violence against women are available in your setting – for example from demographic health surveys or other special surveys or studies, or administrative statistics collected by police, hospitals, judicial and social service agencies.
 - ✓ Describe what these data tell you about the burden of violence against women in your setting – for example which groups of women and what types of violence are they most affected by; what are the risk factors and consequences on their health and well-being; and what are their help-seeking patterns.
 - ✓ Gather any information on barriers women face in accessing services (for example, geographic, financial, lack of time, limited mobility, stigma from family and communities, and health service delivery factors).
 - Are there laws supportive of the health system response?**
 - ✓ Find out what forms of violence against women are criminalized in the legal frameworks.
 - ✓ Understand the obligations of the health system in addressing violence against women and legal barriers.
-

-
- Are there policies or plans specifying the health system response to violence against women?**
 - ✓ Identify existing national or subnational policies and plans for a multisectoral or a health system specific response to violence against women.
 - ✓ Assess whether provision of services addressing violence against women is specified in the essential package of health services?

 - Are there existing health services and other sector programmes addressing violence against women?**
 - ✓ Map/list what services and programmes are in place to address violence against women including for medico-legal, psychological support, and social services.
 - ✓ Collect evaluation results and lessons learned from previous or other initiatives that provide services to survivors of violence.

 - Are human, financial and technical resources available?**
 - ✓ Identify any experts and staff who have been trained on violence against women.
 - ✓ Determine whether there are dedicated budgets allocated to addressing violence against women or that can be accessed to provide services.
 - ✓ Assemble any guidelines, protocols and training materials that have been developed on the issue.

 - Is there a governance structure to guide the health system response to violence against women?**
 - ✓ Ascertain if there is a focal point or unit/ministry/department or working group designated/mandated to coordinate the response to violence against women.
 - ✓ Identify any mechanisms for coordination and referral between the health and other sectors on violence against women.

 - Are there institutions/organizations, partnerships, networks, addressing violence against women?**
 - ✓ List which organization or institution is already working on this issue, what they are doing and who can be potential partners.
 - ✓ Identify any networks, partnerships or alliances addressing this issue.
-

2.3. Develop an action plan



A key element of any new effort is to establish clearly stated goals and objectives and link these to activities and indicators to track results. The following steps can be followed to develop an action plan with objectives, strategies and indicators.

1. Identify your goals and objectives

Identify the focus of your efforts. This will establish your overarching goals and key objectives. Goals are broad and state the ultimate aim, such as improving the health and safety of women who have been subjected to violence. Objectives are more specific. They help assure that activities contribute to the goal. Objectives should be SMART: Specific, Measurable, Attainable, Realistic, and Time-bound. Job aid 2.3 (below) provides examples of goals and linked SMART objectives.

Job aid 2.3

Establishing goals and SMART objectives

Area of focus/goal	Example of an objective
Establishing services	Provide an integrated and comprehensive service, including clinical, psychological and forensic care, in at least one health facility per province by the end of 20XX.
Educating key health professionals	In 3 years train, support and supervise at least one health worker in each tertiary-level facility to provide high-quality, woman-centred care.
Enforcing laws	By the end of 20XX, support all women who want to take forward a sexual assault case with admissible medico-legal/forensic evidence.
Raising community awareness	Over the next 12 months conduct at least one community-awareness event in each district to inform communities of services available to women subjected to violence.

2. Develop a logic model

A logic model shows how the effort and resources put into an activity should lead to change. A logic model is based on a series of logical, causal assumptions that, if implemented as intended, should lead to the desired outcomes. A logic model provides a systematic way to:

- explain *how* the intervention will bring about its intended impacts
- make assumptions explicit
- develop appropriate indicators to monitor progress in achieving the objectives and results
- identify sources of data for the indicators.

A logic model consists of 4 elements: impact/goal, outcomes (medium-term and long-term), outputs and inputs/process. Job aid 2.4 (see next page) describes the 4 elements of a logic model and gives examples of each element. You can follow this framework to develop your own logic model. It is best to start by envisioning the impact or goal of the plan and then to consider what outcomes are necessary to achieve that impact; what programme outputs will produce the desired outcomes, and so on. The depth and detail of your logic model will depend on available resources and context.

Framework for the logic model of a plan to strengthen the health system response to violence against women

Term and definition	Examples
<p>Impact/goal: Identifies the purpose of the programme, policy, project or intervention</p> <p><i>Answers: "WHY are we doing it?"</i></p>	<ul style="list-style-type: none"> • Improved health and safety of women subjected to violence
<p>Outcomes: Identifies intended changes attributable to the outputs</p> <p><i>Answers: "WHAT are we accomplishing?"</i></p>	<ul style="list-style-type: none"> • Improved access to and quality of care in services responding to women's needs
<p>Outputs: The direct result of activities</p> <p><i>Answers: "WHAT are we doing?"</i></p>	<ul style="list-style-type: none"> • Increased number of health-care providers with improved knowledge, positive attitudes and skills in providing care • Increased number of health facilities providing clinical care and psychological support
<p>Inputs/process: Activities conducted to produce outputs and the human, financial, material, and information resources invested in the health system response</p> <p><i>Answers: "HOW are we doing it?"</i></p> <p><i>Answers: "WHAT does it take?"</i></p>	<ul style="list-style-type: none"> • Health-care providers trained • Health service readiness improved by: <ol style="list-style-type: none"> i. providing spaces for private consultation; ii. providing protocols; iii. establishing/strengthening referrals iv. establishing a documentation system

3. Develop a monitoring and evaluation plan

Monitoring and evaluation (M&E) must be an integral part of the health systems response. It tells you if the time, resources and effort put into a programme or policy are working and whether you are on track to achieve your goals. It also guides ongoing learning, management and improvement of health services. More is at stake than just the efficient use of resources – a poorly planned and implemented intervention can put women at additional risk or cause unintended harm. Therefore, once you have developed your logic model, develop an M&E plan. The plan should:

- identify indicators to measure progress towards achieving your objectives;
- specify how often M&E data will be reviewed to identify problems;
- specify the stakeholders to ask for feedback on M&E data (for example, health-care providers, members of a multisectoral mechanism or referral network, community members);
- specify how M&E data will be used in supervision and performance assessments and to improve protocols/ standard operating procedures (SOPs) and health-care provider training;
- specify how and when follow-up will be conducted to determine progress in making changes to service delivery based on the M&E data (see also Chapter 9, page 98).

Part 2.

Strengthening services

Chapter 3.

Improve service delivery

This chapter covers key actions to:

- *Establish protocols or standard operating procedures for service delivery*
- *Identify appropriate models of care for service delivery*
- *Assess health service readiness to provide care*
- *Establish coordination and referrals within the health system*
- *Put protocols into practice.*

3.1. Establish protocols or standard operating procedures for service delivery



Standardized protocols or standard operating procedures (SOPs) are important to guide service delivery. Protocols/SOPs support the delivery of safe, good quality, respectful and effective health care that is consistent across locations and over time. They are also useful as training tools. Countries may have one national health protocol/SOP, which can be adapted to suit the subnational or local/community level. In many settings this protocol/SOP, however, covers only sexual violence. If so, countries should develop and update protocols/SOPs to also cover health care for intimate partner violence (and vice versa).

You can develop or update, as well as implement and monitor, protocols/SOPs for provision of health care to women

subjected to violence. To foster ownership, protocols/SOPs should be developed through extensive consultation and consensus building with relevant stakeholders. Stakeholders include policy-makers, managers, hospital administrators, health-care providers, managers from allied services (for example, police, justice and social services), research organizations and community-based organizations and NGOs, including women's organizations working directly with survivors of violence.

The protocols/SOPs should be reviewed to see whether they are realistic, complete and easy to follow. Their implementation should be monitored regularly to identify and solve any procedural challenges that may emerge over time.

What should these protocols/SOPs cover?

Protocols/SOPs need to cover the processes involved in delivering services for women subjected to violence. Job aid 3.1 (see next page) lists the key topics to include in such a protocol/SOP.

Topics to include in a protocol/SOP to address violence against women

Regulations and key principles of care

- Define key terms related to violence against women (see Annex 1, page 126).
- Operationalize the principles of woman-centred care based on human rights, gender equality, privacy, safety and confidentiality (see Chapter 1, pages 9-10).
- Identify what acts of violence against women are criminalized in the law.
- Identify what other laws (for example, related to forensic examination, abortion, mandatory reporting) have implications for providers of health care to women subjected to violence (see Chapter 6, pages 60-61).

Service provision

- Specify the role of each health worker from the time the woman enters the facility to the time she leaves (see Chapter 4, pages 38-39).
 - Indicate how providers will be supported in self-care and coping with burnout.
 - Define the core elements of an essential package of services (see Chapter 7, page 76).
 - Describe patient flow and procedures that promote privacy and eliminate waiting time for women who have experienced violence.
 - Provide a simple pictorial reference for health-care providers that depicts the flow diagrams or algorithms (see Annex 2, page 129).
-

-
- Specify both internal coordination, referral pathways and partnerships within the health sector and external coordination with other sectors (see Chapter 8, page 82).
 - Specify the equipment, commodities and communication materials that will be needed (see Chapter 5, page 56).
 - Specify any special measures to be taken to promote access and adapt service delivery for especially vulnerable populations (for example, women with disabilities, ethnic minorities, women who cannot pay for health services, sex workers, women who are migrants).

Documentation, including data collection and management

- Specify where and how information about violence is to be recorded and stored and what information will be shared with whom, including chain of custody for forensic specimens (see Chapter 9, pages 103-108 and Annexes 9 and 10).
 - Specify how confidentiality of records will be maintained, including who in the health-care system has access to records (see Annex 11, page 155).
 - Specify what information will be compiled, reported and how frequently for purposes of monitoring and improving quality of care (see Chapter 9, pages 106-107).
-

3.2. Identify appropriate models of care for service delivery



Health care for women subjected to violence must be integrated into existing health services as much as possible rather than offered only as stand-alone services. Care to address violence against women may be integrated into:

- primary health centres and clinics
- district and regional hospitals and other tertiary hospitals
- one-stop centres.

As a policy-maker you need to identify appropriate models of care for service delivery. You may need multiple models for the different levels of the health system, as no one model will necessarily work in all contexts. Table 3.1 (page 29) outlines advantages and disadvantages of different models. When choosing a model for your setting, assess potential need by considering the current availability of services and their location, human resources, funding, and the prevalence of reported incidents of violence against women in your setting. One-stop centres, where appropriate, are best located within tertiary level health facilities. They are better suited for areas with high population density, whereas improving coordination in provision of care within or across health facilities may be more cost-effective in most settings.

Whatever model of care is used, the aim should be to reduce the number of visits and the number of providers that the woman has to contact (and tell her story to), and to facilitate access to services she may need, in a manner that respects her confidentiality and prioritizes her safety. Therefore, it is important to involve women who have experienced violence in the decision-making in order to understand what they would want and where services should be located to facilitate access. Encourage local adaptation of the service delivery model in keeping with the principles of woman-centred care.

Give priority to service delivery at the primary care level. While services should be available at all levels of health service delivery, ensure that, at a minimum, first-line support is available at the primary care level. This helps make care as widely and immediately accessible as possible.

Table 3.1 Advantages and disadvantages of models of care for women subjected to violence¹

Model	Advantages	Disadvantages
Primary health centres and clinics	<ul style="list-style-type: none"> • located close to the community • can provide some core services • can improve access for follow-up services and allow for continuity of care • if a good network is established, can improve access to an intersectoral network of services, including legal, social and other services 	<ul style="list-style-type: none"> • may not be able to treat serious injuries or complications; referral needed • may not have laboratory or specialized services; referral needed • in small communities, where providers are community members, confidentiality and providers' fear of retaliation can be a challenge
District, regional and tertiary hospitals	<ul style="list-style-type: none"> • equipped to provide 24-hour-a-day services • may have laboratory and specialized services • care can be centralized in one department (gynaecology, reproductive health, HIV/STI), emergency department, or distributed throughout the hospital 	<ul style="list-style-type: none"> • accessibility may be reduced due to the distance some women must travel • if services are split across departments, can hamper delivery, especially if some services are available only during usual working hours

¹ Source: Adapted from the *Responding to intimate partner violence and sexual violence against women: clinical and policy guidelines* (WHO 2013).

Model	Advantages	Disadvantages
One-stop centres	<ul style="list-style-type: none"> • more efficient and coordinated services • provide a full range of services (sometimes including police, prosecutors, social workers, counsellors, psychological support) • reduces number of times women have to repeat their story and time they spend seeking services 	<ul style="list-style-type: none"> • more space and resources required • client load may be small (in rural areas, for example), raising cost concerns • may draw staff and resources out of other services • may not be fully integrated into general health services • if administered by the judicial system, tend to focus too much on prosecution and not on women's health • costly to sustain

3.3. Assess health service readiness to provide care



There are several requirements, including some minimum requirements, to support health-care providers in provision of care to women subjected to violence. Job aid 3.2 (next page) will help you assess whether your service is ready to deliver care in line with these requirements.

Assessing service readiness

Questions	Ready?	
	Yes	No
Checked items (✓) are minimum requirements.		
Service delivery		
✓ Are there written protocols/SOPs for provision of health care to women subjected to violence?	<input type="checkbox"/>	<input type="checkbox"/>
Is a minimum package of care being provided (that is, identification of survivors of intimate partner violence, first-line support, clinical care for sexual assault, basic psychosocial support)?	<input type="checkbox"/>	<input type="checkbox"/>
Health workforce		
Are there health-care providers whose job descriptions assign them specific responsibilities to address violence against women?	<input type="checkbox"/>	<input type="checkbox"/>
✓ Have health-care providers received training on responding to violence against women?	<input type="checkbox"/>	<input type="checkbox"/>
Are there mechanisms to provide ongoing mentoring, supervision and support to health-care providers?	<input type="checkbox"/>	<input type="checkbox"/>
Infrastructure and medical products		
✓ Is there a space (for example, a room or area) available for private and confidential consultation (that is, that ensures the survivor cannot be seen or heard from outside)?	<input type="checkbox"/>	<input type="checkbox"/>
Are medicines, equipment and other supplies available? (see list in Job aid 5.2, page 56)	<input type="checkbox"/>	<input type="checkbox"/>
Leadership, governance and accountability		
Do health-care providers and health managers support addressing violence against women (for example, willing to provide care, supportive of sending staff to training)?	<input type="checkbox"/>	<input type="checkbox"/>

Questions	Ready?	
	Yes	No
Checked items (✓) are minimum requirements.		
Are there confidential mechanisms to receive feedback from women about services, including any grievances or violations of rights in the health facility (for example, a helpline, ombudsperson, complaint box)?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a work-place policy addressing discrimination and violence, including sexual harassment faced by health-care providers themselves?	<input type="checkbox"/>	<input type="checkbox"/>
Budget & financing		
Is there a budget allocated for provision of care/ services (for example, for staff training, procuring specific commodities)?	<input type="checkbox"/>	<input type="checkbox"/>
Multisectoral coordination and community engagement		
✓ Is there a referral system in place across different health services and between health and other sectors (for example, a referral directory, information offered to survivors about available services)?	<input type="checkbox"/>	<input type="checkbox"/>
Have other services (for example, police) and organizations (for example, local NGOs working on violence against women) been informed about available health services?	<input type="checkbox"/>	<input type="checkbox"/>
Information, monitoring and evaluation		
Are indicators and data to monitor the health response to violence against women being collected, compiled and used to improve services?	<input type="checkbox"/>	<input type="checkbox"/>
✓ Are there intake forms/registers and confidentiality mechanisms (for example, secure storage and removal of identifying information) for recording information about women's experience of violence and care received?	<input type="checkbox"/>	<input type="checkbox"/>

3.4. Establish coordination and referrals within the health system



There are diverse entry points within the health system for women subjected to violence. Many women suffering health consequences of violence, particularly intimate partner violence, are first seen in primary health-care services. They are seen particularly in departments or services that serve women and children (for example, antenatal or postnatal care, family planning or HIV clinics), although they may not disclose their experience of violence. Emergency departments are also frequent entry points, particularly for women with injuries and for survivors of sexual assault. Others may first see a variety of other health-care providers for various symptoms or conditions that occur as a result of violence. These providers can be obstetricians and gynaecologists, psychiatrists, general practitioners or community health workers.

Ideally, a woman experiencing intimate partner violence should be identified at her first point of contact with health services.

Any health service that is the first point of contact should address the woman's most urgent health needs. Other care can follow.

When considering health service delivery sites where care for women subjected to violence can be integrated, identify the strengths and weaknesses of each site. Identify sites that lend themselves to integrating issues of violence into their routine provision of care. This includes those that are better equipped (that is, have the infrastructure and capacity) to deal with women's health problems and those that are most easily and likely to be used by women. Health-care providers at these entry points should be trained to identify a woman who has been subjected to violence and respond appropriately, including provision of first-line support.

A coordination and referral system in place within the health system should ensure that women can obtain the care that they need and with a minimal number of visits to different providers. The following provides a list of potential entry points for women to enter the health system and the types of services they might need.

In hospitals/polyclinics (i.e. secondary or tertiary level facilities):

- outpatient department (OPD)
- accidents and emergencies department (A&E)
- obstetrics and gynaecology department
- mental health/psychiatry department
- HIV testing, treatment and care
- laboratory
- forensics
- ear, nose and throat department
- orthopaedics department
- paediatric department
- social work/welfare or family protection units offering counselling and psychosocial support
- substance abuse prevention and support department

At the primary care level:

- general practice
- antenatal care
- family planning
- STI (sexually transmitted infection clinic)
- HIV testing
- counselling
- mental health
- child health

The following steps will help you establish appropriate coordination and referral mechanisms within the health sector (see also Chapter 8, page 87).

- 1. Map available services:** If certain types of services are not available in your health facility, identify and map what is available elsewhere in your area (that is, within a reasonable distance or catchment area). Specify the geographic distance or catchment area within which you will refer women in order to ensure access.
- 2. Create a directory:** Include contact details of a focal person in each unit, facility or service, as well as a description of the services available and their cost. Provide a copy of this directory to every service or unit/department in the health facility (See Annex 6, page 141).
- 3. Identify a focal person in the health service:** Select a person to be trained as an advocate for women subjected to violence. The focal person is responsible for facilitating access to care at each service delivery point and for following up with women on the care received and referrals made. In some settings where a hospital or health facility has a family protection or social welfare/work unit, the focal person may be assigned from this unit. Good coordination and communication across different units/services within the health system is important. Hence, the focal person should meet regularly with health-care providers from the different health units/departments or institutions to resolve any challenges, maintain positive relationships, review cases and monitor access to and quality of care.
- 4. Establish referral pathways:** Identify whether and where there are health-care providers trained in gender-sensitive care and examination of survivors of sexual assault (see also Chapter 4, page 37). Identify the sequence in which the

woman will be referred to the different units/departments, especially for acute care, based on the pathways of care identified in the protocol/SOPs (see also Annex 2, page 129).

3.5. Put protocols into practice



At the local or health facility level, national protocols/SOPs will need to be adapted for implementation. In some settings additional directives from the ministry of health (for example, to allow nurses to provide testimony in court for sexual assault cases) may help guide local implementation. Local adaptations will need to consider the availability of specific services, resources and gaps (for example, availability of specialist mental health professionals). Conversely, local adaptations should inform revision of the national or subnational protocols/SOPs.

Put the protocol/SOPs into practice by following some or all of the following steps:

- identify the units or departments within health facilities that will integrate care for survivors of violence and so will follow the protocols/SOPs;
- make sure the protocols/SOPs are available in user-friendly formats and easily accessible in health facilities;
- develop job aids for training and for supporting health-care providers in following the protocols/SOPs;
- require training of health-care providers in using the protocols/SOPs;
- conduct regular case reviews to make improvements to the protocols/SOPs;
- enable health-care providers to implement the protocols/SOPs through policies and resource allocations;
- monitor adherence to protocols/SOPs and clients' experiences with quality of care.

Chapter 4.

Strengthen the health workforce

This chapter covers key actions to:

- *Assign the necessary health-care providers to care for women subjected to violence*
- *Train health-care providers to respond to violence against women*
- *Offer mentoring and supervision to support providers' performance.*

4.1. Assign the necessary health-care providers



You will need to assign staff to coordinate, manage and deliver services for women subjected to violence. The staffing plan should align with the overall action plan (and logic model) developed in Chapter 2. You will also need to specify the roles and responsibilities of the different cadres of health-care providers at each level of the health system (see Job aid 4.1, next page).

A health-care provider (nurse, doctor or equivalent) trained in gender-sensitive sexual assault care and examination should be available at all times of the day and night (at location or on-call) at the district/area level. You will need to identify who on your staff can be assigned and trained for this role. An on-call roster system (with appropriate remuneration) may be useful.

Assigning roles and responsibilities to different cadres of health-care providers

Activity/function ¹	Physician at primary health facilities	Physician at district/tertiary hospital/facilities	Nurse	Social worker or counsellor	Other (specify)
Identification, first-line support, history taking and examination					
Identifying survivor of intimate partner violence					
Offering first-line support (psychological first aid)					
Taking/documenting history including emotional state					
Preparing survivor of sexual assault for exam					
Performing head-to-toe exam for sexual assault					
Collecting forensic evidence for sexual assault					
Conducting relevant lab tests for sexual assault					
Prescribing treatment					
Caring for injuries needing urgent or immediate attention					

¹ Where not specified, assume that the function or activity is for both intimate partner violence and sexual assault. Functions that are specific to intimate partner violence only or sexual assault only are indicated.

Activity/function	Physician at primary health facilities	Physician at district/tertiary hospital/facilities	Nurse	Social worker or counsellor	Other (specify)
HIV post-exposure prophylaxis if sexual assault survivor presents within 72 hours					
Emergency contraception if sexual assault survivor presents within 5 days					
STI treatment/prophylaxis for sexual assault survivor					
Vaccinations for hepatitis B and tetanus for sexual assault survivor					
Planning follow-up visits					
Offering basic psychosocial support					
Helping with more severe mental health problems					
Preparing and signing the medico-legal certificate for cases of sexual assault					
Reporting to legal authorities					
Providing/facilitating referrals to other services					

If resources permit, identify staff who can be dedicated to responding to violence against women.

4.2. Train health-care providers



As a policy-maker you can develop a training plan (see Job aid 4.2, next page) and identify training principles (see Job aid 4.3, page 44). Ideally, a training plan should include both pre-service and in-service training. However, pre-service training is often beyond the purview of ministries of health and, hence, your role in pre-service training may be limited to advocacy (see Chapter 6, page 68). Therefore, this section will cover in-service training¹ only.

Training health-care providers on the response to violence against women should be an ongoing process, rather than a one-off event. Building the capacity and changing the attitudes and clinical practice of health-care providers is a long-term endeavour requiring consistent investment. The following section discusses strategies for offering ongoing mentoring and support.

¹ Pre-service training involves building the capacity of health-care providers while they are still in undergraduate training; in-service training involves training of currently employed health-care providers, including residency.

Questions and considerations for a training plan

What are the purpose and outcomes of the training?

- ✓ Determine whether the aim of the training is sensitization, skills building or refreshing knowledge. Some staff (e.g. administrators) may need only sensitization, while others may need sensitization and skills building.
- ✓ Establish expected outcomes of the training (for example, improving health-care providers' ability to respond in a sensitive way to women subjected to violence).

What will the training cover in terms of content?

- ✓ Suggested agendas and topics for training different cadres of staff are listed in Annex 3, page 131. It is important that all staff at the health facility are able to communicate appropriately and confidentially with women subjected to violence.

Who will be trained?

- ✓ Decide which cadres of health-care providers are most likely to come into contact with women subjected to violence, determine what content is appropriate for each of these cadres and prioritize their training.
- ✓ In some contexts women may prefer to be examined by a female health-care provider, especially following sexual assault. You may need to prioritize training female providers. Where female providers are not available, it is important to sensitize and train male clinicians to provide care in a sensitive manner.
- ✓ Take into account staff rotation and attrition.

Who will conduct the training?

- ✓ Identify experts, resource persons and facilitators to facilitate and/or conduct the training. It may be helpful to partner with NGOs that can provide resource persons and facilitators.
-

How will the training be conducted?

Format

- ✓ Trainings can be stand-alone or integrated into another training, depending on the purpose (sensitization or skills building), available resources and time.
- ✓ Stand-alone training may be useful when starting. Over time, training can be institutionalized. For example, a module on responding to violence against women may be integrated into other, ongoing health trainings (such as on reproductive health, HIV, maternal health or mental health).
- ✓ Coordinate trainings with other capacity building or training initiatives, where these exist.

Length

- ✓ Training should be long enough to cover the range of topics and learning methods that build knowledge and skills and improve attitudes.
- ✓ Training can be spaced over time to suit trainees' availability.

Modality

- ✓ Consider a mix of face-to-face training, information provision and web-based or IT-assisted self- or distance learning.
 - ✓ The training methodology should allow for building skills as well as knowledge and also allow for critical self-reflection on personal attitudes towards and experiences of violence against women.
 - ✓ Use a participatory learning approach that combines lectures, case studies, group work, role plays, problem-solving and community activities.
 - ✓ A woman telling (with all the necessary support) her story of violence and her experience with health services can greatly improve providers' understanding.
 - ✓ Videos modelling positive interactions between client and provider can support skills development.
-

What is needed to support and facilitate the training?

- ✓ Establish a schedule and an agenda for training.
- ✓ Identify the resource materials, including job aids.¹
- ✓ Allocate budget and resources for training.
- ✓ Provide credits and certification for completion of training and acknowledgement of trainees' expertise.

Where will the training take place?

- ✓ Where possible, hold trainings within health-care settings to promote attendance, minimize the length of disruption to health-care providers' work and facilitate on-the-job skills-based training.

How will you know that you achieved the objectives and whether the training needs to be improved?

- ✓ Evaluate trainees' knowledge, attitudes and skills/competencies pre- and post-training, and gather feedback on the training from participants.
- ✓ Conduct periodic evaluations/needs assessments to gauge the need for refresher trainings.

How will you sustain quality performance after training?

- ✓ Conduct regular follow-up and offer mentoring and supportive supervision to staff who have been trained.
 - ✓ Offer refresher courses and periodic re-certification. Skills training on how to respond to violence against women can be included in continuing medical education.
 - ✓ Conduct periodic case management reviews.
-

¹ A resource for training is the WHO curriculum for in-service training of health-care providers to respond to violence against women that will be available soon.

Principles for training

- ✓ **Training needs to be ongoing to change health-care providers' practices.** Provide opportunities for continuous learning. This can include case reviews, refresher trainings (for example, to address gaps in knowledge and skills), on-the-job mentoring, supervision and support.
 - ✓ **Training should cover basic knowledge** about violence against women, available services and health-care providers' own attitudes towards violence against women.
 - ✓ **Training should be competency- and skills-based.** It should also address competencies related to respecting cultural sensitivity, promoting gender equality and protecting human rights.
 - ✓ **Training should be consistent with national policies, guidelines and protocols** and the *Responding to intimate partner violence and sexual violence against women: clinical and policy guidelines* (WHO 2013) and *Health care for women subjected to intimate partner violence and sexual violence* (WHO 2014).
 - ✓ **Ideally, training facilitators should be multisectoral,** involving trainers/facilitators and resource persons from health and social services, NGOs, police and judiciary, where available. Establish referral pathways among the different actors.
 - ✓ **Interdisciplinary training is useful.** It can cover topics that are relevant for all professional groups and that require coordination and collaboration across different professional groups. For example, doctors, nurses, counsellors and social workers can be trained together on certain topics. This can be followed by learning that is specific to different professional groups (for example, specific trainings for doctors and nurses on physical examination or specialists on forensic examination). For certain topics, such as medico-legal response, joint training for professionals in the health and police and justice sectors is important.
 - ✓ **It is important to provide support during and after training for health-care providers who are affected by violence,** whether they have been subjected to partner or sexual violence or have witnessed violence or are perpetrators.
-



As a health services manager, you can support training of your staff in the following ways:

- Publicly acknowledge and speak out about the importance and value of training.
- Lead by example: participate in the training yourself and give staff the time to participate in the training. This will motivate staff participation and help you to mentor and supervise them after the training.
- Make available tools such as protocols/SOPs and job aids (for example, computer prompts, pocket cards). These can act as reminders of how to practice the skills learned in training.
- Allocate resources for training.
- Make clear to your staff any institutional policy about protecting staff from violence and harassment at work.
- Facilitate trainings within health-care settings to promote attendance.
- Give public credit and recognition to staff members who complete training and use the skills.

4.3. Offer mentoring and supervision to support providers' performance



Regular follow-up, mentoring and supervision by health services managers are important for sustaining good performance of health-care providers who have been trained. Training alone is unlikely to sustain changes in health-care providers' practices. Returning to their workplace after training, health-care providers are likely to have many questions. Many may reflect on their personal experiences of violence or having seen violence between family members.

Mentoring and supervision support and motivate health-care providers to offer good care, and can help health-care providers to apply what they have learned in training to

their daily practice and to deal with their own experiences with violence. It can also help health-care providers address challenging clinical cases and improve their clinical and communication skills while avoiding vicarious trauma and burnout.

Regular follow-up is a key component of quality assurance. It can help health-care providers set goals for their practice and identify areas for improvement. Having a supervisor and/or mentor also boosts staff morale and motivation to continue offering good health care to women subjected to violence.

Mentors and supervisors should have attended trainings on violence against women.

Mentoring

Definition

- Mentoring involves a more experienced health-care provider (the mentor) supporting a less experienced provider (the mentee) in the clinical setting.
- Mentorship is based on a supportive relationship in which the mentor responds to the mentee's questions, reviews clinical cases with her/him and provides constructive feedback and discussions of how to improve their practice.

Functions of mentoring

- Helping health-care providers to reflect on their attitudes, beliefs and behaviours mirroring societal norms that perpetuate gender inequality, stereotypes and attitudes that condone violence against women.
- Supporting health-care providers who have experienced or are experiencing violence in their relationships and referring them to other services as appropriate.

- Supporting and encouraging health-care providers who are experiencing vicarious trauma or burnout to practice self-care and seek peer or professional help.
- Modelling skills, including communications skills, in the health-care setting.

Supportive supervision

Definition

- Supportive supervision involves a health services manager, who has accountability for the care provided by a group of health-care providers, supporting them in improving their clinical practice on an ongoing basis. This supervision helps to ensure that the new skills are implemented correctly.
- The supervisor's approach should be to improve the knowledge and skills of health-care providers, build a team, use data for decision-making and find solutions to problems rather than finding fault. Supervision should be conducted regularly, with open, two-way communication that is respectful and non-authoritarian.

Functions of supportive supervision

- Supporting health-care providers in setting realistic expectations and goals for their clinical practice.
- Assessing the performance of health-care providers by reviewing their practice against goals and identifying areas for improvement.
- Identifying and helping to solve problems with quality of care – for example, conducting case management reviews and discussing areas for improvement.
- Facilitating on-the-job learning including refresher trainings and opportunities to earn continuing medical education credits or certifications.

To implement effective supervision, address the following:

- Establish a supportive supervision system by training supervisors and developing quality assurance standards¹ and checklists (see Job aid 4.4, below).
- Allocate resources for supervision.
- Plan regular supervisory visits by using monitoring data to prioritize where supervision may be most needed, scheduling supervisions and conducting needs assessment of who has been trained in what, and what skills need updating.
- Conduct supportive supervision visits by reviewing programme monitoring data, observing clinical practice, discussing with health-care providers how to address the problems they face and completing supervision checklists.
- Follow up on the actions agreed with the health-care providers including through feedback and regular programme monitoring.

Job aid 4.4

Checklist for supportive supervision

Assess training needs by asking health-care providers:

- ✓ Have they had any training on violence against women? (yes/no)
- ✓ What kind of training have they had about violence against women? (list)
- ✓ How long did it last?
- ✓ What were the main topics covered in the training? (list)

What, if any, are topics on which they would like to have additional training? (list)

- ✓ Are there any job aids or tools that they find helpful? (list)
 - ✓ Are there other job aids or tools that they would want? (list)
-

¹ A resource for assessing health-care provider performance as part of supportive supervision is the Gender-based violence health services quality assurance tool (JHPIEGO, CDC and WHO, forthcoming).

Assess preparedness to provide care by asking health-care providers:

- ✓ How prepared do they feel to conduct the tasks below? (Not at all, Slightly, Somewhat, Sufficiently or Quite well prepared):
 - Identifying a woman who has been subjected to intimate partner violence
 - Offering validating and supportive statements to a woman subjected to violence
 - Talking to her about needs and options
 - Assessing immediate danger and helping a woman plan to increase safety for herself and her children
 - Documenting the history and findings of physical examinations
 - Referring the woman to support services available in the community

Review documentation of the cases of violence against women to assess how they were managed:

- ✓ Review health information system records from the past 3 months to identify how many cases of intimate partner violence or sexual violence were seen.
- ✓ For the cases identified in the past 3 months, ask health-care providers which of the following actions they took. (Where possible the supervisor/mentor can observe some clinical interactions to note whether these actions were taken.)
 - Offered information about intimate partner violence or sexual violence
 - Offered validating and supportive statements
 - Talked to the woman about her needs and options
 - Documented history and physical examination findings in the patient's medical charts/records. (Review a random sample of patient charts/medical records and verify whether information is recorded appropriately.)
 - Assessed immediate level of danger and, where appropriate, helped woman make safety plans
 - Offered referrals to support services available in the community

Review challenging cases. Ask the health-care providers about challenging cases they have managed. For example:

- ✓ In the past 3 months, were any cases particularly difficult to manage? (Review the documentation of the particular case.)
- ✓ What was challenging about the case? (list)
- ✓ What did they do well in managing the case and what did they not do so well? (list)
- ✓ What advice or support did they get in managing the case? (list)
- ✓ What additional support or advice would have been useful to help them manage the case? (list)

Identify barriers/challenges and areas for improvement and support. Ask the health-care provider to:

- ✓ List the top 3 barriers they are facing in providing care to women subjected to intimate partner violence or sexual violence.
 - ✓ Jointly agree on a list of specific steps/measures for improvements.
 - ✓ Jointly agree on what support is needed to help the health-care providers improve their practice.
-

Chapter 5.

Strengthen infrastructure and availability of supplies

This chapter covers key actions to:

- *Equip health facilities to respond to violence against women*
- *Provide necessary medical products, including medicines, equipment and other supplies.*

5.1. Equip health facilities to respond

Women subjected to violence require a safe, private and confidential space to talk freely with health-care providers. Having adequate infrastructure and the necessary medical equipment and supplies helps trained health-care providers to respond appropriately to the needs of women subjected to violence.

Whether you are a policy-maker or a health services manager, you can take action to assure that infrastructure, equipment and supplies are adequate, including for the health response to violence against women.



As a policy-maker, you can:

- Map which facilities have the necessary infrastructure and which ones require improvements (see Job 5.1, page 53). In particular, identify which locations could provide services all day and night.

- Allocate adequate budgets for infrastructure (for example, equipment, supplies and private examination and consultation spaces in existing and planned health facilities).
- Include in the national essential medicines list the medicines (in the correct formulations) needed, for example, emergency contraception, antiretrovirals for HIV prophylaxis, hepatitis and tetanus vaccines, antibiotics and other treatments for STI prophylaxis.
- Arrange with managers of pharmacies to procure the necessary medicines and supplies and with managers of laboratories to procure the equipment and health products to conduct the examinations and investigations needed.



As a health services manager, you can:

- Allocate or designate a quiet, private space (ideally, close to toilets) for examinations and individual consultations between the health-care provider and the woman.
- Instruct staff to prioritize the use of private space for exams and consultations with women subjected to violence, without labelling it as such.
- Prepare the list of equipment, supplies and medicines needed and distribute it to the different units, departments or wards in your health facility that provide services.
- Ensure there are no stock-outs of medicines, equipment and other supplies.

Infrastructure considerations, barriers and suggestions to overcome them¹

- Requirement: Allocate a private consultation space** – a separate room with 4 walls and a door, where the woman cannot be seen and her conversation cannot be overheard from outside the consultation room. If resources permit, consider having a private, separate or outside entrance to the examination and consultation room and creating a space where children accompanying their mothers can play, watched by other health facility staff.

Barriers: Lack of private consultation rooms that protect confidentiality and privacy.

Overcoming barriers: Many facilities have an unused or little-used room that could be repurposed.

If the room must also be used for other purposes, assure priority for women who have been subjected to violence so they do not have to wait for care.

Instruct staff not to ask about violence in front of anyone, including children. Arrange for staff who are not attending to patients to watch children during the mother's consultation.

- Requirement: Strengthen privacy** by adding doors to existing consultation space to improve privacy. If possible, also insulate walls. If doors are not possible, at least have curtains.

Barriers: In resource-poor settings many consultations can be seen or heard from adjoining areas because doors or walls are thin, or there are only curtains to separate consultation areas.

Overcoming barriers: If the walls are thin or only curtains are available, instruct staff to speak softly so that they cannot be overheard. Ask others to leave the area, if that is feasible.

- Requirement: Reduce stigma** by avoiding explicit names and signs that indicate that those who enter the exam room have been subjected to violence.

¹ Source: Adapted from *Improving the health sector response to gender based violence: a resource manual for health care professionals in developing countries* (Bott S et al 2010).

Barriers: Health-care providers or receptionists may use stigmatizing language, such as directing women to the “room for abused women”.

Overcoming barriers: Instruct staff to be aware and use non-stigmatizing language when discussing or directing women to the consultation area. Use general signage such as “women’s health” or simply a room number.

Requirement: Establish a privacy and confidentiality policy limiting what women are asked or required to disclose in public areas of the health facility.

Barriers: Receptionists or health-care providers may ask women to state the reason for their visit or provide intake information (such as name, address, medical history) in front of others or in waiting rooms.

Some women may be accompanied by the police, which may indicate to others that they have been subjected to violence.

Waiting in a public area for treatment can be difficult for women who have just been subjected to violence.

Overcoming barriers: Consider changing patient flow so that women can bypass public waiting areas. If this is not possible, instruct staff to ask intake information only in a private space or in writing.

Brainstorm with staff how to get the woman alone for a few minutes if family members or the abusive partner accompany the woman.

Instruct staff not to interrupt a consultation between the woman and the health-care provider.

Requirement: Easy access to a toilet. Also, for women who have been subjected to sexual assault, access to a bath or shower would be desirable once forensic evidence has been collected if appropriate.

Barriers: In many resource-poor settings, toilets may be outside the health facility premises, or there may not be clean toilets.

Overcoming barriers: Explore how to install toilet(s) accessible to women subjected to violence on the premises of the hospital or health facility.

5.2. Provide the necessary medical products

The types of medicines, equipment and other health supplies for care of women subjected to sexual violence are based on the *Interagency list of medical devices for essential interventions for reproductive, maternal, newborn and child health* (WHO, 2015) and *Strengthening the medico-legal response to sexual violence* (WHO and UNODC, 2015). They are provided as a checklist in Job aid 5.2 (next page).

The checklist will need to be adapted to the level of health facility. For example, in some settings HIV post-exposure prophylaxis may be available only at district hospitals, and forensic evidence supplies or kits may not always be available or needed at the level of health posts or health centres.

Also, the equipment for collecting forensic specimens from survivors of sexual violence will depend on whether or not the law or policy in your setting requires specialist forensic doctors to conduct such examinations and whether forensic laboratories are available in your catchment area. For instance, there is little point in collecting specimens for DNA analysis if there is no laboratory nearby that can perform DNA testing or there is no way to send specimens to another laboratory for testing. It is assumed that supplies for universal precautions will be the same for services for violence survivors as for other interventions and, hence, are not specified in the checklist.

Checklist of equipment, medicines and other supplies for examination and care of women subjected to violence

Examination equipment and laboratory products

- examination couch (with curtains or screen if needed for privacy)
- secure record storage cabinets
- light source (lamp or torch)
- speculum
- pregnancy testing kits
- rapid tests for HIV, syphilis
- urinalysis kits
- test strips for vaginal infections
- forensic evidence collection kits (depending on forensic laboratory capability), including:
 - swabs & container for transporting swabs
 - microscope slides
 - blood tubes
 - urine specimen containers
 - sheets of paper(drop sheet)
 - paper bag
 - plastic bags for specimens
 - tweezers
 - scissors
 - comb
- digital camera to document injuries

Medicines

- supplies for wound care
- analgesics
- anti-emetics
- emergency contraception
- antiretroviral drugs for post-exposure prophylaxis for HIV prevention
- drugs for treatment or prophylaxis for sexually transmitted infection
- hepatitis B vaccination
- tetanus toxoid

Administrative supplies

- a protocol/SOP for care
- job aids (for example, flow charts, algorithms, pictograms)
- consent forms
- documentation forms (for example, medical intake forms, police forms for forensic evidence, medico-legal certificates)
- referral directory
- communication materials

Disposables

- sheets, blankets and towels
- in case the woman's clothes are soiled or torn or taken for evidence collection
- sanitary pads

Procuring and managing the stock of medical products



To ensure adequate and continuous stock of medical products, you can:

- 1. Estimate, forecast and plan for the quantities of the items on the checklist** (Job aid 5.2, page 56). Estimate the numbers of women who will need services by extrapolating from subnational or national data on the prevalence of sexual violence and intimate partner violence and the number of women of reproductive age in your area. You can also consult with women's organizations or other service providers (for example, police) in your area to get an approximate idea of the numbers of women who are likely to report incidents of violence and may need services.
- 2. Plan ahead in order to avoid stock-outs and mobilize funds.** Monitor the demand for equipment and supplies and use the information to adjust your procurement and avoid both wastage and stock-outs.

Access to emergency contraception is a core element of the response to violence against women. Work with pharmacies to determine which formulations are available on the market and can be procured. Accordingly, determine what information about dosage and timing needs to be provided to women. Ensure that your staff have the correct information and are able to provide this information to women who need emergency contraception. You may consider developing a written policy to support best practices regarding provision of emergency contraception.

- 3. Consult with laboratory staff, including forensic laboratories, to determine which specimens they can process, how samples should be collected and handled and**

- how long the samples will take to process. Identify what supplies will be needed to collect and store the specimens.
- 4. Work with national and local pharmacy managers** to discuss how to procure and restock a regular supply of medical products, including which formulations are available for medicines and in which sizes or quantities. In some settings some of the medical products listed in Job aid 5.2 (page 56) may come in pre-assembled kits known as sexual assault forensic examination (SAFE) kits or post-rape care kits. In humanitarian/emergency settings, they are included in reproductive health kits that are assembled, procured and distributed by the United Nations Population Fund (UNFPA) (Kit number 3 – Post-Rape Treatment Kit) or in the Inter-Agency Emergency Health Kit (IEHK).¹
 - 5. Provide the checklist of medical products** to the unit, department, facility or ward that is caring for sexual assault survivors and ask them to order the individual items in required quantities from a central supplies store.
 - 6. Instruct the responsible health-care providers** to gather equipment and medicines on a shelf, in a file cabinet or in a mobile kit. Establish processes to restock after each client and to check medication expiration dates.
 - 7. Provide oversight** to ensure that all job aids for clinicians (for example, flow charts or treatment algorithms), forms for history taking, examination, documentation and referrals, as well as the directory of referral contacts, are up-to-date and easily available where consultation and examinations take place.

¹ In settings of humanitarian crises, you can contact the UNFPA office in your country to order the necessary quantities of the reproductive health kit including kit number 3 or order the IEHK through WHO, UNICEF or Medecins Sans Frontieres offices in your country.

Part 3.

Leadership and governance

Chapter 6.

Develop policies, governance and accountability

This chapter covers key actions to:

- *Review, implement and advocate to strengthen legal frameworks addressing violence against women*
- *Review and strengthen policy frameworks*
- *Establish a structure of governance*
- *Implement accountability measures*
- *Promote gender equality in the workplace.*

6.1. Review, implement and advocate to strengthen legal frameworks addressing violence against women

Many countries have legal frameworks that respect women's right to be free from violence and their right to access services and remedies in case of violation of these rights. These legal frameworks may be aligned with international human rights norms related to violence against women to which your country may be a signatory. Check which of these international human rights instruments your country has signed on to.¹ A number of laws, both criminal and civil, and

¹ There are a number of international and regional instruments, such as the Convention on the Elimination of Discrimination Against Women (CEDAW), the Istanbul Convention, the Belem do Para Convention and the Maputo Protocol, that your country may have signed on to and that obligate you to address violence against women according to the provisions in these instruments.

regulations can affect women subjected to violence. While some laws and regulations may protect women subjected to violence and improve their access to health services, others may act as barriers or have other harmful or unforeseen adverse effects. The health system is required to provide services in accordance with its country’s legal frameworks. The following 3 steps can help to align the health system response with existing legal frameworks:

- Gather information about existing laws and regulations.
- Align the health system response with the legal frameworks.
- Advocate to improve and strengthen the legal frameworks.

Gather information about existing laws and regulations



To help you to determine the obligations of the health system to care for survivors of violence and to identify legal and regulatory barriers to these services, you can start by reviewing the existing relevant laws and regulations (see Job aid 6.1).

Job aid 6.1

Checklist to assess your legal frameworks

Action	Yes	No
1. Gather information about the following laws and regulations:		
• Are there criminal law provisions related to violence against women (for example, in the penal code of the country)?	<input type="checkbox"/>	<input type="checkbox"/>
• Are there laws protecting women from domestic or family or intimate partner violence?	<input type="checkbox"/>	<input type="checkbox"/>
• Are there laws related to sexual violence including rape and child sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>

Action	Yes	No
• Are there court orders and regulations that protect women subjected to the violence from violent partners or stalkers?	<input type="checkbox"/>	<input type="checkbox"/>
• Does the law allow women subjected to intimate partner violence or sexual assault/rape to be provided with abortion services?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, are there other regulatory or policy barriers that limit their access to abortion (for example, third party authorization)?	<input type="checkbox"/>	<input type="checkbox"/>
• Are there regulatory or policy barriers that limit access to emergency contraception for women subjected to sexual assault/rape?	<input type="checkbox"/>	<input type="checkbox"/>
• Are there laws related to sexual violence and sexual harassment in the work place?	<input type="checkbox"/>	<input type="checkbox"/>
2. Identify the legal obligations of health-care providers in relation to addressing violence against women. For example:		
• Do laws specify provision of health care to survivors of intimate partner violence or sexual assault/rape?	<input type="checkbox"/>	<input type="checkbox"/>
• Do laws or regulations mandate reporting individual cases of sexual assault/rape or intimate partner violence to the police?	<input type="checkbox"/>	<input type="checkbox"/>
• Do laws mandate reporting data/statistics on violence against women to health or other authorities?	<input type="checkbox"/>	<input type="checkbox"/>
• Which providers are authorized to perform forensic exams and provide testimony in court in cases of sexual assault/rape? (list)	<input type="checkbox"/>	<input type="checkbox"/>

Align the health system response with the legal frameworks



As a health services manager, to advance women's rights you need to align the service delivery with your country's laws related to violence against women. This can involve:

- raising health-care providers' awareness of the laws related to violence against women including by developing and distributing user-friendly tools that help health-care providers understand their obligations as duty bearers under the law;
- adapting and applying protocols/SOPs that, while in line with existing laws, promote women's rights where existing laws impede access to services (for example, mandatory reporting of partner violence to police);
- identifying and redressing any institutional procedures or policies that pose barriers to access (for example, third-party authorization for providing abortion or requiring police reports before providing emergency contraception);
- instructing your staff about the need to fully inform women about their choices and any limitations of confidentiality that may be imposed by the law (for example, mandatory reporting requirements).

Advocate to improve and strengthen the legal frameworks

As a policy-maker or a health services manager, you can advocate for strengthening relevant laws in order to promote women's access to non-discriminatory health services and to justice. This involves:

- advocating changes in laws and regulations that pose barriers to access to and provision of health services to women subjected to violence;

- advocating laws or regulations that specify the obligations to provide services to women subjected to violence;
- advocating amending laws or regulations to:
 - recognize marital rape as an offence;
 - ensure access to abortion for women subjected to sexual assault/rape;
 - allow nurses trained in forensics, as well as doctors, to provide evidence in court;
 - give women a choice about reporting their experience of violence to the police and offering help to those who want to report (that is, not having mandatory reporting requirements; see box below);

WHO does not recommend laws that require health-care providers to report cases of partner violence and sexual violence to the police without the woman's consent.

They do recommend, however, that health-care providers inform women of their legal rights and offer to report to the police, should the woman want this.

- remove medically unnecessary procedures as part of sexual assault examinations such as virginity testing (also called '2-finger testing' or 'per vaginal' examination);
- include unmarried and cohabiting couples in the coverage of laws criminalizing sexual violence and domestic or family violence.

6.2. Review and strengthen policy frameworks



Policy-makers have the power to prioritize issues, develop policies, plans and strategies, and commit time, energy and funding to the health system response to violence against

women. Consider the following 3 overarching steps to strengthen the policy frameworks in your specific setting:

- Review existing policy frameworks.
- Strengthen policies or plans or strategies.
- Advocate stronger policies addressing violence against women in other sectors.

Review existing policy frameworks

Assess how well current policies or plans or strategies support the health system response to violence against women (see Job aid 6.2).

Job aid 6.2

Do existing policies support the health system's response to violence against women?

Question	Yes	No
1. Does the health plan or policy or strategy include violence against women?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a multisectoral plan on violence against women that addresses the health response?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there an explicit objective or goal in the violence against women plan or policy or strategy to address the health response?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the policy or plan or strategy include a budget allocation for a health response to violence against women?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the policy or plan or strategy designate a focal point or unit in the ministry of health at the relevant levels?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the policy or plan or strategy specify the capacity building needs of staff to address violence against women?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are there indicators in the policy or plan or strategy to track progress in the health system response to violence against women?	<input type="checkbox"/>	<input type="checkbox"/>

Strengthen policies or plans or strategies

Based on need and existing policy frameworks, efforts to strengthen a national or subnational policy framework can focus on either or both of the following:

- strengthening the health component in the multisectoral policy, plan or strategy on violence against women. Many countries have multisectoral national action plans to address violence against women. Multisectoral plans need to include the health sector and should clearly identify the role that it will play in the broader multisectoral response.
- integrating or strengthening the response to violence against women in existing overall health or disease/health condition-specific policies, plans or strategies. In countries where no explicit policy framework addresses violence against women, provisions about violence against women could be integrated into national or subnational health policies, strategies or plans. If there are no national policies on violence against women, the health system response can still apply international standards. Integrate violence against women into plans, strategies or policies related to maternal and child health, sexual and reproductive health, HIV, adolescent health and mental health. Clearly stated objectives to address violence against women in the health strategy or plan or policy will help establish the issue as a priority for health ministries.

Job aid 6.3 (below) identifies the elements of a national action plan or policy or strategy. (See the bibliography for resources to guide the development of the plan, policy or strategy, pages 115–125.)

Suggested elements of a national or subnational action plan or strategy or policy

What and how

- Rationale:** Why is it important for the health sector to address violence against women?
 - Terminology:** What are clear definitions of concepts related to violence against women?
 - Legal context:** What laws are applicable to violence against women?
 - Vision and goals:** What is the overall aim?
 - Quantifiable objectives:** What should the strategy achieve and by when?
 - Activities:** What steps will be taken to achieve the objectives?
 - Schedule:** What is the sequence and the timing of the activities?
 - Resources required:** What inputs and funds will be needed? Where will those funds come from?
 - Output:** What will be produced? How much?
 - Barriers:** What could stand in the way of success? How could these barriers be overcome?
-

Who

- Management:** Who will coordinate the overall plan (for example, which ministry or department)?
- Accountability:** Who will be responsible for which objectives or activities?
- Workforce:** How many people will be needed, and with what skills?
- Collaborators:** Who else are partners in the implementation (for example, professional associations, NGOs, UN agencies)?
- Stakeholders:** Who is interested in the outcome and who should be involved in planning and monitoring?

Measurement

- Indicators:** How will progress be measured and monitored? How will we collect data on these indicators?
 - Targets:** What numbers are the indicators expected to reach?
-

Advocate for stronger policies addressing violence against women in other sectors



As a policy-maker you can sensitize counterparts in other sectors to the need for preventing and responding to violence against women. In particular, you can:

- Work with ministries and administrators of institutions responsible for undergraduate (that is, pre-service training) or residency training of doctors, nurses and midwives to include training on prevention and response of violence against women. You can:
 - identify what competencies (knowledge and skills) are expected of health-care providers; identify curriculum content and design, including learning objectives, for undergraduate students;¹
 - support undergraduate institutions in developing competency-based accreditation; and
 - advocate for inclusion of competencies in responding to violence against women in health registration, examinations, accreditation and requirements of professional bodies.
- Support or collaborate with ministries of education, women’s empowerment or gender equality and youth development in implementing efforts to:
 - challenge harmful gender norms that perpetuate male control over women and condone violence against women (through, for example, behaviour change and communication campaigns, community mobilization and comprehensive sexuality or life-skills education for young people); and
 - offer economic and livelihood support to women.

¹ A WHO curriculum for pre-service or undergraduate training of doctors, nurses and midwives to respond to violence against women is under development.

- Advocate to police, justice and other relevant ministries working to reduce the availability of and access to firearms, alcohol and drugs – all of which are risk factors for intimate partner violence and increase danger levels for women experiencing ongoing abuse.

6.3. Establish a structure of governance



It is important to establish at all levels of the health system the structure of governance to lead and manage the health system response to violence against women. Governance and leadership responsibilities include:

- advocacy and championing to raise awareness and generate political will (see Chapter 2, page 13);
- convening and mobilizing key stakeholders;
- strategic planning;
- ongoing programme and policy development;
- managing knowledge;
- representing the institution and its efforts to higher levels and/or other institutions;
- mobilizing and allocating health resources across services and locations;
- ongoing overall management;
- facilitating capacity strengthening;
- directing programme implementation and scale-up;
- negotiating, coordinating and maintaining effective collaboration within the health system and with other sectors; and
- ensuring accountability through programme monitoring and evaluation.

These responsibilities may be delegated, provided that clear accountability and reporting to the senior management team are maintained.

Various governance structures are possible. Which one is most appropriate depends on the administrative level and setting. Examples include:

- **a focal point or coordinator** (at a senior decision-making level) or unit, with assigned responsibility for coordinating and performing programme management duties. This includes participating in multisectoral coordination mechanisms and monitoring programme performance. The job description should specify these responsibilities (see Annex 4, page 137);
- **a task force or working group** consisting of managers representing various health services and programmes (for example, reproductive health, mental health, essential medicines), who participate in planning and management. It can also include representatives from outside government or outside the health system (for example, from NGOs, police, social services, child protection services, legal services). This group should have clear terms of reference (see Annex 5, page 139);
- **champions from senior management** with the authority and political will to convene stakeholders and mobilize resources. They should have the authority to decide the allocation of resources across the health system for addressing violence against women.

6.4. Implement accountability measures

Overall accountability for the health system response to violence against women must rest with the most senior policy-maker at each level (for example, Secretary of Health, Director of Health, District Health Officer) or health services manager (for example, Chief of Hospital).

Accountability requires:

- regular monitoring and evaluation of the health system's performance in delivering quality services (see Chapter 9, page 98);
- mechanisms for ensuring that the health system itself does not mistreat or discriminate against women seeking health services (see Job aid 6.4, next page); and
- workplace policies designed to prevent and respond to violence experienced by staff in the health workplace.

Implementing accountability measures¹

The purpose of accountability should not be to punish individuals for poor performance, but rather to identify and correct structural reasons for failure of the health system to respond to violence against women. You can facilitate accountability as follows:

- ✓ develop codes of conduct for health staff and raise awareness of their obligations;
 - ✓ develop a patients' rights charter and make it available in health facilities in local languages;
 - ✓ put in place confidential mechanisms for service users and communities to provide feedback (for example, a complaint box) and inform them about these mechanisms;
 - ✓ follow up to address complaints and provide remedies (for example, compensation or access to judicial remedies) if there is proof of harm;
 - ✓ include indicators on availability, access, acceptability and quality of services for women subjected to violence as part of routine monitoring;
 - ✓ involve communities, including women's organizations, in the monitoring;
 - ✓ address areas of weakness identified in routine monitoring of services, including making a concerted effort to reach groups that may be left behind;
 - ✓ agree to independent oversight of the health system's response by national human rights institutions and/or other organizations (for example, national women's commissions).
-

¹ Source: Adapted from the *Summary reflection guide on a human rights-based approach to health: health policy-makers* (OHCHR, 2015).

6.5. Promote gender equality in the workplace

Violence against women is rooted in differences in power and resources between women and men (that is, gender inequality). Women are often blamed and stigmatized for violence; they may feel shame and low self-esteem, and therefore not want to tell health-care providers about the violence. Health-care providers may make the situation worse if they are not trained to ask and respond appropriately and if the health-care system is not equipped to respond appropriately. In some situations women experiencing abuse at home may experience abuse by health-care providers as well. Moreover, some health-care providers themselves may be subjected to inequality and violence in their homes and in the health workplace.



As a policy-maker, you can develop and implement workplace policies that both model and promote gender equality. These policies protect staff and clients from abuse in health-care settings and offer redress and services for those who do experience violence, be it staff or clients. This can involve policies that:

- promote equality of opportunity for female and male candidates in hiring and promotion;
- pay women and men equally for comparable work;
- create awareness of what behaviour is inappropriate in the health-care system;
- develop and make known a clear policy forbidding violence of any kind in the workplace, including sexual violence and sexual harassment; this policy should include mechanisms of redress for those subjected to violence and clear disciplinary procedures for those found to be perpetrating it;

- develop and endorse workplace policies that support a balance of work and family life (such as maternity and paternity leave and flexible work hours);
- support staff who have experienced violence at home or elsewhere (by, for example, providing health and other services, leave days to attend court and workplace safety measures).

Chapter 7.

Assure budget and financing

This chapter covers key actions to:

- *Determine the core elements of an essential services package*
- *Allocate a budget for the health system response to violence against women*
- *Estimate the costs of delivering services*
- *Reduce financial barriers to access.*

Essential packages of health services typically do not cover services for violence against women, such as post-rape care. Even where such services are provided, their coverage is usually limited, and few women are likely to benefit.



As a policy-maker you will need to identify funds and allocate resources to provide care for women subjected to violence. You will need to plan to minimize the financial hardship that paying for these services may cause women. Furthermore, services must be accessible to the most vulnerable groups of women. A plan on the response to violence against women needs to include a budget for the health component and to identify the funding sources for the activities. Also, budgets for activities to address violence against women should be integrated into existing health programme budgets for such areas as maternal health, sexual and reproductive health including family planning, HIV and mental health.

7.1. Determine the core elements of an essential services package



Services for women subjected to violence need to be considered a core function of the health system. As a policy-maker you can advocate inclusion of the core elements of services for women subjected to violence as part of an essential package of services and as part of universal health coverage. While the essential package of health services may vary according to country context, consider the following elements:

- **identification** of women subjected to intimate partner violence;
- **management/treatment** of any immediate or urgent medical conditions associated with the violence;
- **provision of first-line support** to women subjected to intimate partner violence and sexual violence, including supportive listening, safety planning and enhancing social support through referrals;
- **clinical care for sexual assault** that includes taking history; medical examination and, where appropriate, forensic examination and investigations; tests and treatment for management of injuries; prevention of pregnancy, STIs and HIV; and follow-up care; and
- **provision of mental health care** to women subjected to intimate partner violence or sexual violence that includes basic psychosocial support as well as assessments, management and referrals for more severe mental health problems.

7.2. Allocate a budget



Developing a budget requires estimating the costs of providing services (see next section, page 78) and identifying the sources of funds to cover these costs. In many countries programmes and services for violence against women have been financed largely from overseas development assistance. Allocations of domestic resources are necessary to sustain these services.

A sufficient and sustainable health system response requires that governments assume the bulk of the responsibility for financing programmes and services to address violence against women.

How important is a specific line-item budget?

Many countries integrate the costs of services for violence against women into existing health budget lines, such as those for sexual and reproductive health. However, there are several advantages to having a specific line-item budget. An explicit line item can be particularly important when a new service is getting started or when some policy-makers or managers question the importance of services for violence against women. Once such services become accepted as a routine responsibility throughout the health system, a specific budget line may become less important. A specific line-item budget:

- can make the service visible and show the government's recognition that services for women subjected to violence are a standard part of health-care delivery;
- indicates continued political commitment;

- discourages policy-makers from reprogramming funds to other uses;
- provides a means to monitor costs; and
- promotes a sustainable funding stream.

As a practical matter there is the option to include certain costs under broad categories, such as routine services and clinic supplies (which may include, for example, gloves, specula and medicines). However, additional costs may need to be budgeted specifically. These may include providing on-call services for women who seek care for sexual assault after clinic hours, in-service training, having a dedicated staff member (such as a counsellor, advocate or sexual assault nurse-examiner), procuring post-rape care kits or producing communication materials. Some of these costs may be new items in health budgets.

7.3. Estimate the costs of delivering services



Several steps are needed for estimating the costs of service delivery. For example:

- **Estimate the need for services for violence against women.** This can be done by looking at numbers of cases reported to or identified by health services. You can also estimate the need by using prevalence data on sexual violence and intimate partner violence in your area and the number of women of reproductive age.
- **Define/identify the essential package of services** to be provided (see previous section).
- **Gauge what services and resources are now available** (for example, facilities, staff and staff time, medical equipment, medicines, referral networks) and where.

- **Estimate the component costs of available services** (see Job aid 7.1, next page).
- **Identify gaps between “where we are now” and “where we want to be”**. An action plan with objectives and indicators may help with this (see Chapter 2, pages 18–19).

Depending on whether services are being started or already exist but need to expand, some costs may be initial set-up costs for new functions (for example, training, developing protocols, communication materials, documentation forms, procurement of specific medicines for post-rape care) or to expand services geographically. Others may be ongoing costs (for example, staff salaries, facility rental or maintenance costs, equipment and medicines). As services are launched or expanded, there is likely to be an increase in demand due to wider availability and publicity. Further cost considerations include:

- expanding to provide services around the clock; and
- expanding services to populations that have been poorly covered, such as women in slums and migrant or refugee camps and women with disabilities.

When developing a budget for services to women subjected to violence, you should account for the costs listed in Job aid 7.1 (see next page). You can expand this chart to include specific line items.

Estimating costs for service delivery to women subjected to violence		
Quantities	Unit costs	Total costs
Programme management and administration (salaries)		
Meetings with stakeholders for coordination, planning		
Improving privacy and confidentiality in clinics (for example, private spaces)		
Computer hardware, software and Internet, communication costs		
Human resources: staff salaries and benefits for dedicated staff		
Human resources: staff salaries (in % of time spent by non-dedicated staff)		
Human resources: experts to provide technical support		
Clinic supplies and equipment		
Drugs and commodities		
Training of staff and post-training refreshers		
Ongoing supervision and mentoring visits		
Advocacy and outreach efforts		
Printing and dissemination of communication materials, job aids, forms		
Community or interagency meetings		
Resources to collect, analyse and disseminate M&E data		

7.4. Reduce financial barriers to access

Financing health services for women subjected to violence is critical to reaching universal health coverage. Women subjected to violence are particularly likely to be left out of universal health coverage. They have less ability to pay for services because they often do not have money of their own or their partners control their spending. They are less likely to be formally employed and, therefore, to be covered by insurance schemes. Financial barriers to services need to be reduced for all women exposed to violence and especially for those who face multiple forms of discrimination (for example, women who work in informal sectors or are dependants of those who do, women who are migrants, women with disabilities, and those from the poorest parts of society).

There are several ways to make services more affordable.

For example:

- Reduce or eliminate out-of-pocket payments such as user fees at the point of service delivery.
- Waive fees for women who do not have access to or control over their money and for women who suffer from chronic conditions (for example, mental health conditions) as a result of violence.
- Include medicines for post-rape care in the list of essential medicines.
- Include services for violence against women (for example, post-rape care) in the essential package of health services.
- Include services for women subjected to violence (both acute and chronic care) in the benefits package covered by mandatory and voluntary insurance schemes. See that insurance schemes cover pre-existing conditions that may be related to violence (for example, mental disorders) and chronic health sequelae of violence. Advocate that insurance companies cover days of inability to work due to violence.

Chapter 8.

Coordinate sectors and engage communities

This chapter covers the following key actions:

- *Strengthen engagement of the health sector in multisectoral coordination mechanisms*
- *Establish coordination and referrals between health services and services of other sectors*
- *Engage with the community.*

The overall aim of multisectoral coordination is to provide woman-centred, accessible, prompt, confidential and appropriate services that meet all the needs of a woman subjected to violence.

Women subjected to violence have needs beyond health care. They need, among other things, safety, social support, economic security, housing and legal protection. To make comprehensive services available, a multisectoral response is necessary.

8.1. Strengthen engagement of the health sector in multisectoral coordination mechanisms



Health policy-makers should establish and/or participate in multisectoral coordination mechanisms. In many settings a national or subnational multisectoral mechanism such as a

coordinating committee or a task force may already exist to coordinate working relationships among ministries or sectors. Coordination at a national or subnational level also provides the framework for collaboration at the community level among service providers in different sectors.

The participants in multisectoral mechanisms are typically ministry or organization representatives who have decision-making authority in their institutions (for example, senior-level managers).

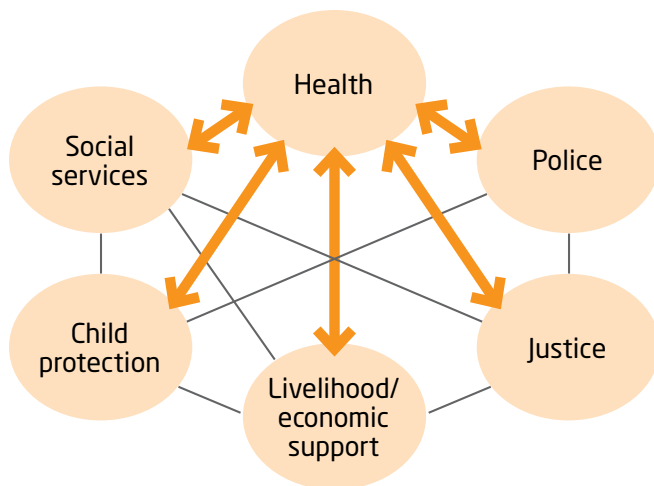
Two overarching actions that should be taken to improve coordination of health with other sectors include:

- participation in multisectoral coordination mechanisms; and
- establishing standard operating procedures for coordination and referrals.

Participate in multi-sectoral coordination mechanisms

A senior manager in the ministry of health with decision-making authority should be designated to participate in the multisectoral coordination mechanism. In some settings the health sector may chair this multisectoral group. In others this responsibility falls to the ministry responsible for gender equality or women's empowerment. It is important to specify the role and contribution of the health sector in a multisectoral mechanism. Figure 8.1 (next page) suggests sectors with which the health sector should coordinate its response to violence against women.

Fig. 8.1. Coordinating the health sector response with other sectors



The role of the health policy-maker in multisectoral coordination mechanisms should be to:

- ensure participation of the health sector in national or subnational multisectoral coordination activities;
- support and contribute to development of protocols for multisectoral coordination at the national and subnational levels; this includes identifying for other sectors the points of entry and pathways to give women timely access to health services;
- ensure that health policy-makers and managers work with counterparts from other sectors to build understanding and dialogue, resolve disagreements and improve coordination;
- contribute to monitoring the performance of the multisectoral response by identifying and addressing any health system gaps or weaknesses in coordination; and

- identify and resolve contradictions between the policies of the health sector and other sectors that impede timely access to care (for example, a requirement that a woman who has been sexually assaulted must file a police report before receiving health care).

Establish standard operating procedures for coordination and referrals



Members of the multisectoral coordination mechanisms need to establish SOPs for coordination and referrals across sectors, including referrals to and from the health sector. Coordination needs to be established between the health programmes or services and, at least, social service, legal, police, child protection and economic support/livelihood programmes or services (see Figure 8.1, page 84). Establishing coordination can involve the following actions:

- 1. Develop principles for coordination and referrals** for women-centered care that responds to women's multiple needs and at the same time protects their confidentiality and safety and minimizes the harms and burdens to them.
- 2. Identify clear roles and responsibilities of the health sector** in the multisectoral response to ensure that women's needs are fully covered. The statement of roles and responsibilities could specify how to monitor or review cases and make improvements.
- 3. Identify a focal point with clear terms of reference** who will be responsible for overseeing coordination within the health sector and with other sectors.
- 4. Specify the types of services needed for referrals.** Establish protocols for working with these services, including:
 - when and how referrals will be made from and to the health sector;

- types of documentation, what information to cover, how it will be shared and with whom; how confidentiality will be maintained;
- whether women being referred will be accompanied by an advocate or social worker;
- how follow-up will be conducted;
- how costs and cost-sharing will be done so that women are minimally burdened; and
- how quality assurance across different services will be monitored.

5. Specify mechanisms for coordination with the police and justice sectors. These should include communication procedures and arrangements for timely referrals in either direction. Procedures concerning forensic evidence for sexual assault cases should also be specified, including:

- evidence collection (what evidence will be collected);
- the chain of custody (how evidence will be passed from the health services to the police or prosecutors);
- storage;
- reporting (when and how cases will be reported);
- documentation (for example, the medico-legal history form);
- protecting confidentiality of the information and documentation shared; and
- providing testimony in court (for example, who will testify).

6. Work with other sectors to specify standards for data collection, monitoring and reporting of statistics on violence against women to ensure that the information collection is efficient and harmonized (that is, there is no duplication and standard definitions are used) and that confidentiality is protected (see Chapter 9, page 108).

8.2. Establish coordination and referrals between health services and services of other sectors



The multisectoral coordination that occurs at the national or subnational level must be replicated locally – that is, within a geographically specified community and at the level of service delivery within that community. Many of the processes for coordination and referrals between health services and other sector’s services are the same as processes within the health sector (see Chapter 3, page 33).

There can be many entry points to care and services for women who experience violence. In some instances, a health facility may be the first point of contact, or a woman may be referred to health services from, for example, the police or a women’s shelter. At the local/community/health facility level, coordination should facilitate referrals of women between health services and services in other sectors (for example, legal or social).

You can take the following actions to improve coordination and facilitate referrals between the health sector and other sectors’ services:

- 1. Identify and map available services:** In addition to health care, women who have been subjected to violence often need services in other sectors (for a list of health services, see Chapter 3, page 34). Identify and map the available services or organizations in your community or catchment area, particularly those that are reasonably accessible in terms of distance, availability of transport and cost. Services or organizations to consider include the following:

Police/law enforcement

- police
- forensic/medico-legal investigations

Justice services

- legal aid, including representation and provision of information

Social services

- psychosocial support including crisis counselling
- securing/replacing identity documents
- safe accomodation, including shelters for women and their children
- transportation assistance
- child care
- interpreters
- programmes for men who perpetrate abuse
- community-based organizations providing information, education and mobilization and facilitating access to formal services (for example, women's groups, peer support groups, faith-based organizations and organizations working with marginalized groups or special needs populations or people with disabilities)

Economic/livelihood support

- financial aid including livelihood or income generation, vocational training, microcredit loans
- food assistance

Child protection services

- 2. Create a directory:** Include contact details of a focal person in each referring and receiving service, as well as a description of the services available and the costs of services. Ensure that all health facilities have a copy of the

directory (see Annex 6, page 141) and if possible develop personal contacts with receiving services.

3. Develop collaborative multisectoral referral networks:

Establish or participate in a network of stakeholders across different services and organizations that are responsible for coordination and referrals across sectors. The network of stakeholders will need to decide on leadership and terms of reference. A national or subnational multisectoral guideline may guide their work. Members should share a common aim, guiding principles and approaches. For example, the common aim might be to provide timely, comprehensive and good quality services to women subjected to violence.

4. Establish informal or formal agreements: This might take the form of a memorandum of understanding (MOU) among services or organizations that specifies the roles and responsibilities of each service, unit, department, facility, or institution and the terms of engagement (see Annex 7, page 143). Within the health facility, identify a focal person who is or will be trained as an advocate and champion for women subjected to violence and who is responsible for facilitating their access to care in each receiving unit, facility, service, or institution; documentation; and follow-up of referrals. The focal person within the health facility and those from other services or organizations should meet regularly to resolve any challenges, maintain positive relationships among the agencies, review cases and monitor access to and quality of care.

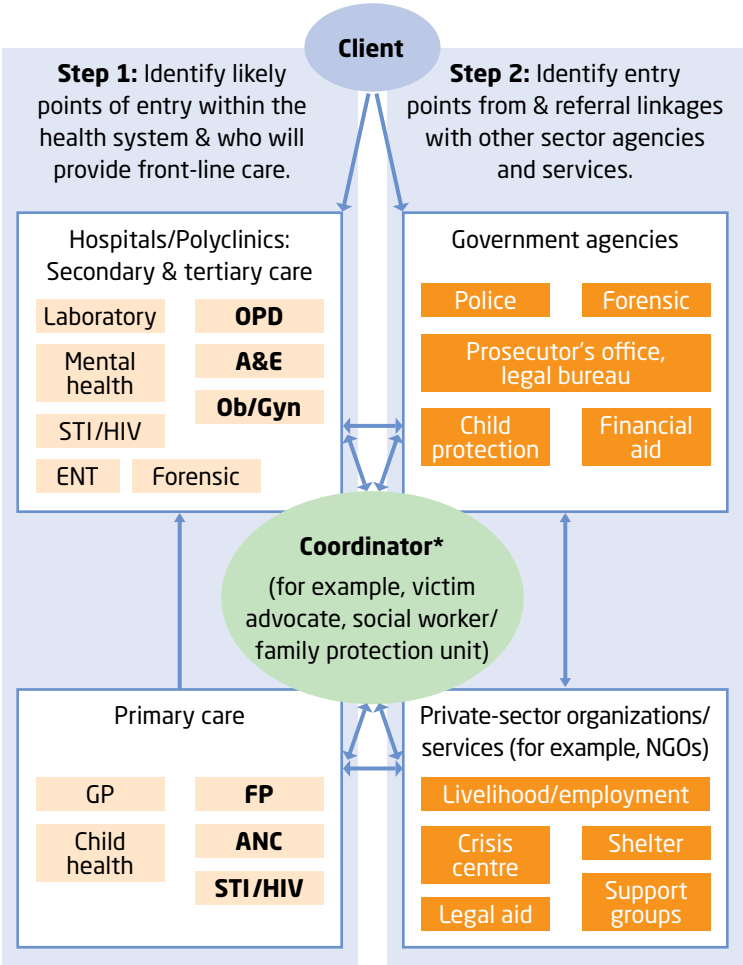
5. Establish referral pathways that respond to women's multiple needs:

Develop referral pathways based on available resources and whether the receiving facilities, services or institutions are in a remote or urban area and near or far from a referring facility, service or institution.

Identify the pathways of care, that is, the sequence in which the woman will be referred to different units, services or organizations when needed (see Job aid 8.1, next page).

- 6. Monitor referrals and coordination mechanisms:** You can ask stakeholders from the different services, as well as clients, for their views on how the referral process of the health service or facility could better meet the needs of women subjected to violence. Develop tools for monitoring referrals and coordination including referral cards and documentation forms that assure confidential transfer of medical information, and that enable you to monitor whether women are able to access different services and receive quality care.

Steps for developing your referral pathways for care of women subjected to violence

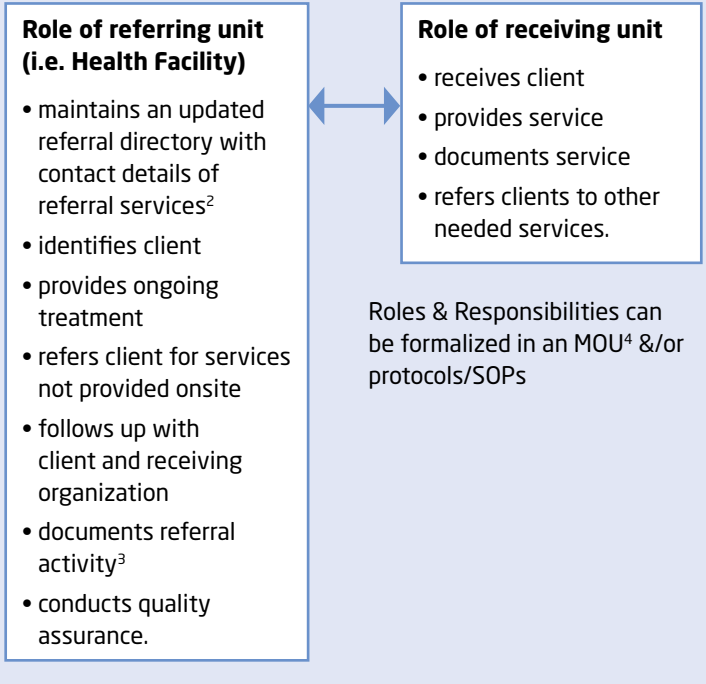


Step 3: Identify the person/unit responsible for coordinating* access to care and services and the contact details.

*See Annex 4 for coordinator's role and responsibilities including terms of reference/job description.

The services that are highlighted in bold are the likely entry points within the health system for providing front-line care.

Step 4: Specify roles and responsibilities, name, contact details, and forms to be used between referring and receiving unit.¹



¹ Adapted from: Soukhya. *Training manual on domestic violence response for health care providers*. Mumbai: St. Johns Hospital and CEHAT Mumbai; 2012.

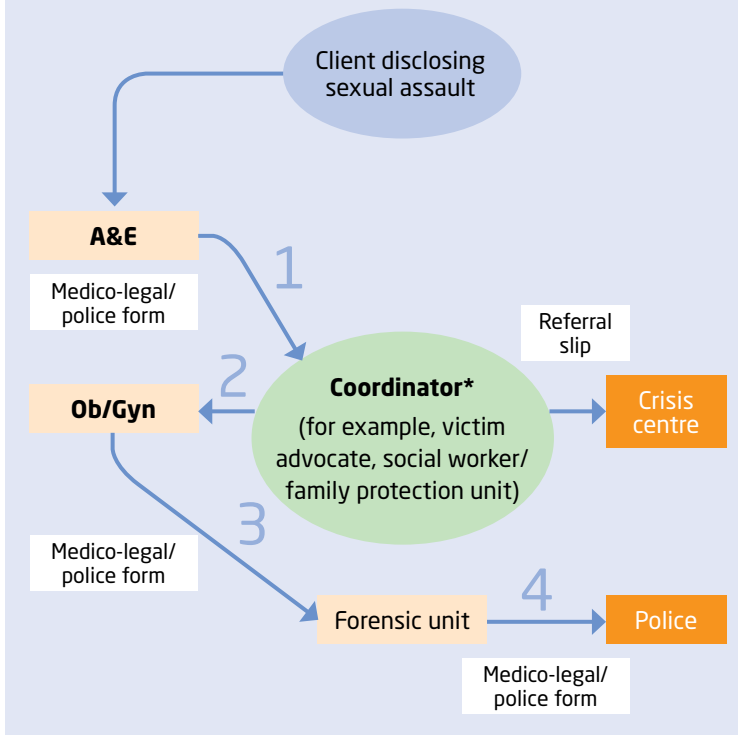
² See Annex 6 for a sample referral directory.

³ See Annex 10 for a sample facility register that includes space to document referrals provided.

⁴ See Annex 7 for a sample MOU.

Step 5: Specify the sequence in which referrals will be provided to other services (for example, for sexual assault survivors – from accidents and emergencies to coordinator to gynaecologist to forensic unit to police. See example below.) This sequence may be different for survivors of intimate partner violence.

Step 6: Specify the forms that will be shared/passed between services (for example, police/medico-legal forms, referral slips/forms).



8.3. Engage with the community

Community participation is key to delivering health services that meet people's needs. To provide women-centred care, it is critical to engage with women directly and with women's organizations in order to learn what matters to women who experience violence. You will know whether your services address women's needs only by asking them, listening to them and adapting accordingly.

Community engagement requires participatory planning, advocacy and accountability.



1. Participatory planning involves engaging the community, and particularly women from the community, in the design, planning, delivery and monitoring of the services. This can be done through community dialogue, by consulting with advisory groups and by involving local community organizations in coordination mechanisms and work planning processes.



2. Advocacy includes raising awareness with communities as well as with women who come to clinics for general health care about available services to address violence against women and the need to seek timely health care. Also important is challenging stigma in the community against women who come forward to seek care. You and your staff should engage communities in discussions about violence against women with simple messages (see Job aid 8.2, next page). Advocacy activities can be carried out through community outreach workers, development and dissemination of information, education and communication (IEC) materials and community meetings – when possible, in partnership with community-based organizations. Displaying IEC materials, albeit discreetly, in the clinic can also make information available and in a manner promoting safety.

Educational materials may serve several purposes in a health centre. They promote the services provided, offer support, send messages about the unacceptability of violence and provide information for individuals in high-risk situations who may need to conceal the information. Materials that women can take home must be small and easily concealed (for example, brochures, small cards, unmarked merchandise with numbers of helplines). Women must be made aware of the possible risk to their safety of carrying such information.

3. Accountability involves mechanisms for monitoring and evaluation of services as well as for feedback from the community about the quality of services. It also includes redress if health facilities fail to provide adequate services or if they mistreat women who seek care (see Chapter 6, pages 71–72).

Job aid 8.2

What should communities know about the health response to violence against women?

- ✓ What is violence against women?
 - ✓ What are its health consequences?
 - ✓ How can violence against women be prevented?
 - ✓ How should community members respond to women subjected to violence?
 - ✓ What health services are available for women subjected to violence, where are they located and when do they operate?
 - ✓ What are the obligations of health-care providers to respond to women subjected to violence?
 - ✓ Why is it important for women who are sexually assaulted to seek care as soon as possible?
 - ✓ What rights do women subjected to violence have with respect to health care, and what redress and grievance mechanisms are there if these rights are violated?
 - ✓ What is the process to undertake legal action?
-

Part 4.

Strengthening evidence and scaling up

Chapter 9.

Collect and use data, monitor and evaluate

This chapter covers key actions to:

- *Use data for advocacy and planning*
- *Conduct programme monitoring*
- *Conduct an evaluation*
- *Use information to improve services.*

9.1. Use data for advocacy and planning

The value of data on violence against women

It is essential that a health system collect and use data on violence against women at every level. Accurate data are required in order to provide and coordinate appropriate care for women who have experienced violence. Furthermore, for women who decide to file reports in the legal system, the success of their case may depend on the existence and admissibility of documentation in their medical record.

Data also are necessary for quality improvement at every level of a health system, both to understand the current state of services and to track progress (that is, monitoring and evaluation). At the national and subnational levels, public health surveillance on violence against women provides crucial data. These data can highlight the importance of funding, serve as the basis of awareness and advocacy campaigns,

and guide development of achievable quality indicators and standards. Similarly, monitoring and evaluation can contribute to the body of evidence on promising (or harmful) practices.

Data are powerful tools to sensitize your peers and colleagues, health-care providers and the public to the importance of addressing violence against women. They can help you obtain the political support and resources needed for the health system response to violence against women. They can also help you direct the response to those who need it most. Review available data for your country (or region, if country data are not available) and incorporate the information into:

- activities to raise public awareness and influence public opinion to challenge the acceptability of violence against women;
- advocacy with peers, colleagues, staff and political decision-makers to strengthen and enforce laws prohibiting violence against women, to develop and implement policies and plans and to allocate budgets to prevent and respond to such violence;
- designing your plans, programmes and services to reach women subjected to violence;
- health worker training manuals and capacity building activities.

Types and sources of data

It is important to use existing, agreed-upon definitions and indicators when gathering data on violence against women. This will ensure comparability, contribute to the body of evidence on effective response, and help policy-makers and health-services managers to make informed decisions. (See bibliography for resources on definitions and indicators.)

Examples of the types of data you can look for and use

- prevalence of intimate partner violence/domestic violence;
- prevalence of sexual abuse (among adults);
- prevalence of sexual abuse in childhood;
- reported cases/incidents of different types of violence that are compiled by the police or other authorities, ministries or NGOs providing services to abused women;
- health consequences of violence, including the types of health conditions that women report;
- attitudes and beliefs concerning violence against women reflecting social norms.

Sources of data on violence against women

- **Population-based surveys:** These provide representative statistics about the nature, prevalence and incidence, causal and risk factors, protective factors, and the consequences of violence against women. Data on programme impact usually come from population-based surveys. More than 100 countries have some prevalence data on violence against women from population-based surveys. Methods to collect such data include:
 - *WHO Multi-country Study on Women’s Health and Domestic Violence Against Women (WHO MCS)*, and other national specialized surveys;
 - *Demographic and Health Surveys (DHS)* and *Reproductive Health Surveys (RHS)*, which include a module on violence against women;
 - *Crime-victimization surveys*, which can also provide data, although these tend to underestimate prevalence significantly.

- **National or subnational crime statistics:** These include case reports compiled by ministries such as those responsible for law enforcement (for example, police or criminal justice); national ministries for women's empowerment and gender equality, or from telephone help lines or hotlines for reporting incidents of violence.
- **Programmatic data gathered by NGOs:** These include information about services for women subjected to violence. These data do not estimate prevalence, but rather they reflect service use. In fact, the majority of women subjected to violence do not seek any help from an institution.
- **Qualitative data can also be powerful:** Personal stories, narratives or interviews that women give researchers, NGOs or the news media about their experiences raise awareness and sensitize people to the importance of a health system response to violence against women. Statistics can change minds, but stories can change hearts.

9.2. Conduct programme monitoring

Many countries lack reliable data on the health burden of violence against women and on the health system response to it – its infrastructure, service delivery, outcomes and impact. However, a great deal of valuable information for programme monitoring could come from routinely gathered data in surveillance and health information systems. Chapter 2 highlighted the importance of developing a monitoring and evaluation plan as a key step in planning the health system response to violence against women. This chapter elaborates the steps in programme monitoring.

Identify indicators for programme monitoring



As a policy-maker you can use existing indicators (preferably) or (if necessary) develop indicators (see Annex 8, page 144) that help to track:

- how many women need services to respond to violence and what kinds of services do they need? (service need);
- what is the coverage and quality of service delivery? For example:
 - how many health facilities provide services for women subjected to violence, and how many of these services meet minimum standards of quality care? (inputs);
 - to what extent have health-care providers' knowledge, attitudes and skills improved? (output);
- how many women who have reported violence have received appropriate care? (outcome);
- to what extent has women's satisfaction with services improved? (outcome); and
- to what extent have services improved the health and well-being of women subjected to violence? (impact).

Data to track progress on these indicators can come from a range of sources, including:

- routinely collected data from surveillance and health information systems (on a monthly or quarterly basis, for example);
- baseline and follow-up surveys to assess health-care providers' knowledge, attitudes and competencies and regular feedback from health-care providers, including in performance reviews;
- periodic health facility surveys (for example, reviews of clinic records);

- feedback from users of services, obtained through, for example, client exit interviews asking women to describe and rate the care they received or from the communities. Occasional special research studies can gather information that is difficult or too burdensome to collect routinely, such as women's reports on the barriers they face in accessing services.

Strengthen the surveillance and health information system



A strengthened surveillance and health information system can contribute to routine programme monitoring. It can gather data on how many women subjected to violence either present to health facilities or are identified by health-care providers. It can also provide data on the treatment and care they receive.

Strengthening the surveillance and health information systems should involve:

- training the staff responsible for collecting, reporting and analysing the data about violence against women and sensitizing them about the importance of programme monitoring on this topic
- designing the systems for recording, reporting and analysing information about violence against women to address the privacy, confidentiality and safety of survivors (see box on page 108 on the importance of privacy and confidentiality);
- developing standardized definitions (see Annex 1, page 126) and forms, with instructions, for data collection, aggregation and reporting.

Data collected routinely could include information about:

- the basic characteristics of women (as collected for all clients) and the type of violence (that is, physical, sexual, psychological/emotional);
- the woman's relationship to the perpetrator;
- the type of health complaint, assessments conducted and the treatment provided; and
- referrals and other types of support offered.

A client record form (see Annexes 9 and 10, pages 147 and 152)¹ and an aggregating/reporting form (see Job aid 9.1, next page) should be developed to capture this information. From routinely collected service data, the number and type of cases can be aggregated per service unit and included in monthly or quarterly reporting. Such statistics can inform managers of who receives services, where and how services are provided, and trends in any of these indicators.

¹ Two formats are presented in Annexes 9 and 10 – one is an interface for electronic records and a second is an interface for paper-based facility registers.

Aggregated reporting of intake and care of women subjected to violence

for the period from _____ through _____
(dd/mm/yy) (dd/mm/yy)

	Number	%
Reporting		
Provider asked about violence		
Client disclosed/reported violence		
Provider suspects violence		
Referred by		
Self		
Family/acquaintance		
Other health facility/unit		
Police		
Other government unit		
NGO		
Presenting symptoms/conditions		
Injuries		
Sexual/reproductive health conditions		
Mental/emotional problems		
Other		
Type of violence		
Physical violence		
Rape (completed)		
Other sexual violence		
Psychological/emotional		
Other (specify)		
Perpetrator		
Intimate partner		

Family member in household		
Family member/acquaintance living elsewhere		
Stranger		
Assessments & clinical care provided to all survivors		
First-line support		
Safety assessment		
Injuries & wound care		
Tetanus prophylaxis		
Other		

	Number	%
Additional care given to rape survivors seen within 72 or 120 hours		
Head-to-toe & genital examination		
Emergency contraception		
Pregnancy test		
PEP for HIV		
HIV test		
STI prevention/treatment		
Forensic evidence collected		
Other		
External referrals		
Clinical care at higher-level facility		
Crisis intervention/counselling		
Police		
Shelter or housing		
Legal aid		
Child protection		
Livelihood support		
Other		

Instructions

1. In each specific row for example, “Client disclosed/reported violence”), add the number of entries on the registry form or reporting forms with that code or with “Y” showing. Enter that number in the “Number” column for this row.
2. Add together the numbers in each row under a category. (Category rows are in **dark type**, for example, “**Reporting**”.) Write the total in the “Number” column.
3. Divide the number in each specific row by the number in the category row. Enter the resulting % in the “%” column of that specific row.

Example: Information is available on “Reporting” for 25 clients. Of these 25, 5 clients reported or disclosed the violence. Divide 5 by 25 = 20%. Enter “20” in the “%” column in the “Reporting” row.

Facilitate programme monitoring activities



Monitoring as well as evaluation should be integrated into existing programmes for responding to violence against women and not be considered separate activities. It is important to allocate resources for monitoring and evaluation, with an explicit budget line item for related activities. These related activities include establishing a data collection and reporting system, training staff to document and report data, analysis of data and dissemination of data for improving services.

Privacy and confidentiality in data collection, sharing and reporting

Privacy, confidentiality and safety are key principles (see Annex 11, page 155) to consider in developing health information and surveillance systems for documenting cases of violence and for programme monitoring. Implementing these principles is important for protecting the client from further harm in the form of stigma, discrimination or retaliation by the perpetrator.

Establish a privacy and confidentiality policy that specifies:

- who will be responsible for collecting and recording information
- where and how information will be collected and recorded
- how information will be stored
- who will have access to the information, including what information will be shared within the health facility or with third parties (for example, other service providers within a referral network)
- the need to obtain women's consent before sharing any information and informing them about limits to confidentiality where applicable (for example, in case of mandatory reporting)
- if women are given any medical records to take home with them, information about their experience of violence should not be mentioned.

9.3. Conduct an evaluation



Evaluation involves periodic and in-depth assessment of performance and progress toward objectives, either of the programme as a whole or a major aspect of the programme.

An evaluation can facilitate quality improvements by asking the following questions:

1. What progress are we making? For example:

- Have we taken the actions that we had decided to take?
- How far are we from the objectives that we set? Are we making progress?
- Have we achieved the objectives or progress toward the objectives within the time frame and budget/resources that were planned?

2. How will we know that a change is an improvement (that is, what data should we collect)? For example:

- Have the interventions changed outcomes for women?
- Has the health system response supported women?
- Has it contributed to any unintended harmful consequences for women?
- Has it supported the staff?

3. What changes can we make that will result in improvement?

Evaluations usually require gathering data at the start of a service or programme (that is, baseline data) and then at key milestones in the course of a programme. For example:

- a year after services to address violence against women have been introduced or a major improvement has been made
- before expanding a programme or service from a pilot phase
- at the end of a funding period.

One approach to conducting evaluations is establishing quality assurance standards (for example, availability of private spaces, medical products, and trained health-care

providers) and measuring progress against those standards in comparison with a baseline.¹

9.4. Use information to improve services



Monitoring and evaluation data should be used to review and track health system performance and make improvements in service delivery as follows:

- revise or adjust your planning for existing services or inform plans for expanding services;
- provide feedback to your staff on the findings from programme monitoring and discuss with them ways to improve quality of service delivery;
- share or disseminate the findings in the community and discuss how to make quality improvements with community members, including local women's organizations, service organizations in other sectors and community leaders;
- refine protocols or SOPs;
- provide additional training to health-care providers;
- improve the infrastructure for service delivery and strengthen referral pathways.

¹ See Gender-based violence health services quality assurance tool (JHPIEGO, CDC and WHO, forthcoming).

Chapter 10.

Prepare to scale up

This chapter covers key actions to:

→ *Design and plan the scale-up of a health system response to violence against women for nationwide impact.*

Scaling up requires deliberate efforts to increase the impact of successfully tested innovations to benefit more people and to sustain policy and programme improvements. Scaling up can involve institutionalization of an intervention or service through changes in the health system as defined in Chapters 3–9 of this manual. It can also involve expansion of a new or improved service to new areas, which is the focus of this chapter. It is important to plan from the beginning for pilot-testing and scaling up. The expansion of appropriate health services for women subjected to violence can proceed in various directions – for example:

- from a select set of interventions implemented in a pilot area to addition of new interventions;
- from pilot-test areas to other, similar communities;
- from one province to other provinces;
- from urban or densely populated areas to rural or less densely populated areas;
- from higher to lower levels of the health system (for example, from referral/tertiary hospitals to primary health clinics);
- from the NGO sector to the public sector.

10.1. Design and plan the scale-up of a health system response to violence against women

Planning to expand promising services to new locations involves assessing how easily these services can be adapted to the new locations and whether these locations are ready to absorb these new practices (see Job aid 10.1 below).

Job aid 10.1

Scalability questions¹

Question	Yes	No	Need more info
1. Is there a gap that needs to be addressed (for example, a gap in the coverage of available services)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is input about the scaling-up of services/ interventions being sought from a range of stakeholders (for example, policy-makers, health-care providers, NGOs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do key stakeholders understand the importance of having evidence on the feasibility and outcomes of the pilot intervention before scaling up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the intervention/service been pilot-tested in the variety of socio-cultural and geographic settings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¹ Source: Adapted from *Beginning with the end in mind: planning pilot projects and other programmatic research for successful scaling up* (WHO and ExpandNet, 2011).

Question	Yes	No	Need more info
5. Has the socio-cultural and geographic context been taken into account in the scaling-up plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there a need to make changes in policies, protocols and tools?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is there readiness to support scaling up services in the sites selected? (See Job aid 3.2, page 31.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Will adequate human, technical and financial resources be available during scale-up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is there engagement with funders and technical partners to build a broad base of financial and technical support for scale-up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is there a plan and mechanisms (for example, indicators and health information systems) to monitor and evaluate progress and improve quality during the scaling-up process?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tips for scaling up

- Identify promising practices in health services for women subjected to violence.
- Test promising practices on a small scale, monitor their implementation and adapt according to findings.
- Recognize useful adaptations that providers have made and apply them in other places.
- Begin scaling up in an area that is receptive and has champions for the issue.
- Consider the local context and likely barriers that you will face.

- Gradually expand services to new areas with ongoing monitoring and adaptation of approaches based on learning what has worked or not.
- Share good practices and lessons learned from one site or location with those in neighbouring locations or health facilities. This creates peer-based learning and support.

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Annex 1. Glossary of terms¹

Clear definitions are important for assessing whether violence is occurring and for staff to understand and use appropriate terms. Clear definitions also are important for developing policies, SOPs and protocols.

First-line support refers to the minimum level of (primarily psychological) support and validation of their experience that all women who disclose violence to a health-care provider (or other provider) should receive. It shares many of the elements of “psychological first aid”² in the context of emergency situations involving traumatic experiences.

A **health system** refers to all the activities whose primary purpose is to promote, restore and/or maintain health and to the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities.³

Intimate partner violence refers to ongoing or past violence by an intimate partner or ex-partner (a husband, boyfriend or lover). Women may suffer several types of violence by a male

¹ Unless otherwise indicated, the definitions in this glossary are derived from Responding to intimate partner violence and sexual violence against women: clinical and policy guidelines. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf).

² Psychological first aid: guide for field workers. Geneva: World Health Organization; 2011 (http://www.who.int/mental_health/publications/guide_field_workers/en/).

³ The world health report 2000 – Health systems: improving performance. Geneva: World Health Organization; 2000 (http://www.who.int/whr/2000/en/whr00_en.pdf?ua=1).

partner: physical violence, sexual violence and emotional/ psychological abuse.

Logic models are a frequently used aid to planning, implementing and evaluating interventions.¹ A logic model is based on a series of logical, causal assumptions that, if implemented as intended, should lead to the desired outcomes.

Mandatory reporting refers to legislation passed by some countries or states that requires individuals or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of known or suspected domestic violence or intimate partner violence. In many countries mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.

Physical violence includes acts such as slapping, hitting, kicking, beating, pushing, strangling or hurting with a weapon.

Sexual violence is 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. It includes sexual assault or rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.²

¹ Results-based management handbook: harmonizing RBM concepts and approaches for improved development results at country level. New York: United Nations Development Group (UNDG); 2011 (<https://undg.org/wp-content/uploads/2016/10/UNDG-RBM-Handbook-2012.pdf>).

² The world report on violence and health. Geneva: World Health Organization; 2002 (http://www.who.int/violence_injury_prevention/violence/world_report/en/).

Standardized protocols, or standard operating procedures usually describe a series of steps to follow to guide service delivery, such as the steps for a client's first visit or the steps in performing a physical examination or medical procedure. Protocols/SOPs support the delivery of safe, good quality, respectful and effective health care that is consistent across locations and over time. They are also useful as training tools.

Universal health coverage is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when accessing these services. To move closer to universal health coverage, health financing requires raising funds, reducing financial barriers to access and allocating or using funds to promote efficiency and equity.¹

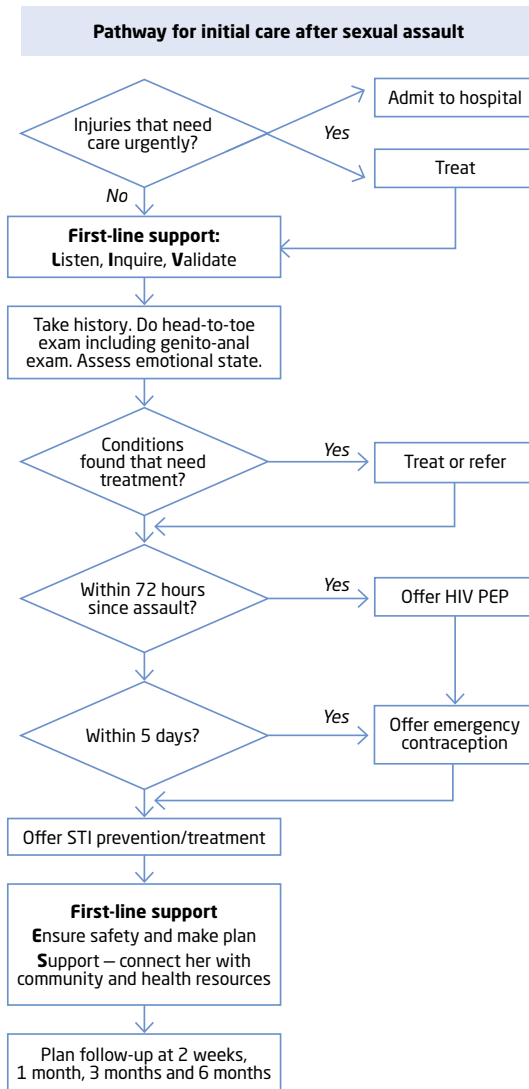
Violence against women is any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women. This includes threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.²

Woman-centred care refers to services that are delivered in a way that respects the wishes, choices and autonomy of the woman; respects her dignity; is sensitive to her needs and perspectives; and respects and promotes her right to privacy, confidentiality and informed consent. It is underpinned by the principles of women's human rights and gender equality.

¹ Universal health coverage. Geneva: World Health Organization (http://www.who.int/healthsystems/universal_health_coverage/en/) (Accessed on 11 September 2017).

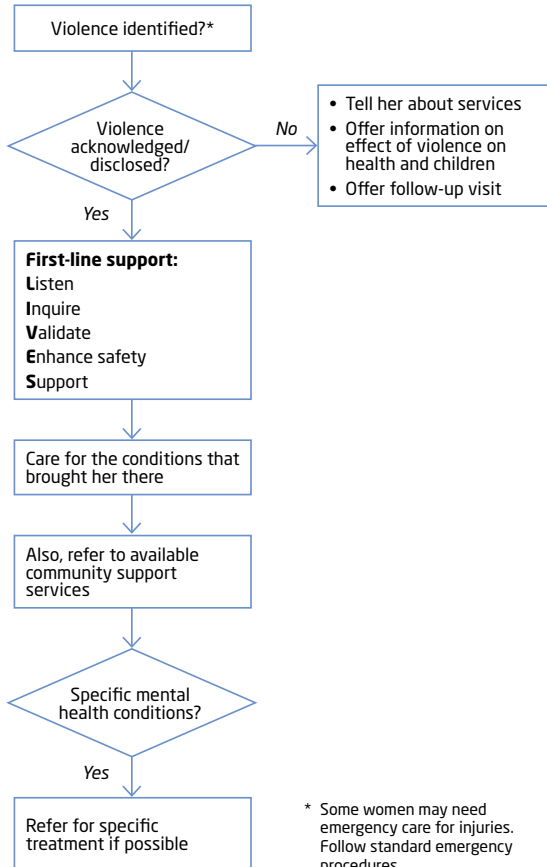
² United Nations General Assembly. Declaration on the Elimination of Violence Against Women. New York: United Nations; 1993 (<http://www.un.org/documents/ga/res/48/a48r104.htm>).

Annex 2. Pathways of care for sexual assault and intimate partner violence¹



¹ Health care for women subjected to intimate partner violence or sexual violence. Geneva: World Health Organization; 2014 (<http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/>).

Pathway for care for violence by intimate partner



Annex 3. Sample training agenda

Note: This annex provides a sample schedule for in-service training of health-care providers and health-services managers. The core content for health-care provider training requires a minimum of two days (based on 6 hours/day). Ideally, in order to cover all the content including supplemental sessions, three days are needed. The core content for health-services managers also requires two days. On the first day, both health-care providers and health-services managers can participate together. On the second day, parallel sessions would be needed for the two cadres based on their different roles and functions. The resources for the training are as follows:

- the clinical handbook *Health care for women subjected to intimate partner violence or sexual violence* (WHO 2014);¹
- in-service curriculum for training of health-care providers (WHO, forthcoming); and
- this manual for contents that are aimed at health-services managers on day 2.

¹ Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: World Health Organization; 2014 (http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf).

Session no	Time	Day 1: Sessions and content	Participant categories
	30 min	<ul style="list-style-type: none"> • Registration & pre-training questionnaires. 	All
	30 min	<p>Opening</p> <ul style="list-style-type: none"> • Welcome remarks. • Participant introduction. • Expectations & working norms. • Training goal and objectives. • Pre-training questionnaires. 	All
1	15 min	<p>Orientation</p> <ul style="list-style-type: none"> • Why address violence against women? • What is the role of the health sector? • What are barriers faced by health-care providers in addressing violence against women? 	All
2	30 min	<p>Overview of violence against women</p> <ul style="list-style-type: none"> • Understanding definitions, magnitude, risk factors, consequences. • Knowing national laws and policies and available resources and tools to guide response. 	All

Session no	Time	Day 1: Sessions and content (continued)	Participant categories
3	60 min	<p>Experience of survivors</p> <ul style="list-style-type: none"> • Understanding barriers women face in accessing care. 	All
4	90 min	<p>Perceptions and beliefs that impact care for survivors</p> <ul style="list-style-type: none"> • Understanding how one's own beliefs affect provision of care. • Distinguishing between myths and facts. 	All
5	30 min	<p>Guiding principles</p> <ul style="list-style-type: none"> • Understanding the concepts and practical implications of providing woman-centred care. 	All
6	45 min	<p>Provider-survivor communication skills</p> <ul style="list-style-type: none"> • Improving skills in active listening and communicating effectively with the patient 	All
Session no	Time	Day 2: Sessions and content	Participant categories
	15 min	Review day 1.	All
Parallel session 7a	90 min	<p>Identification of Intimate Partner Violence</p> <ul style="list-style-type: none"> • When and how to ask about intimate partner violence? 	Health-care providers

Session no	Time	Day 2: Sessions and content (continued)	Participant categories
Parallel session 7b	90 min	<p>Improving health service readiness</p> <ul style="list-style-type: none"> • Assessing service delivery readiness. • Strengthening political will. • Using data for advocacy and planning. 	Health services managers
Parallel session 8a	120 min	<p>First-line support: LIVES (part 1)</p> <ul style="list-style-type: none"> • Understanding what is first-line support and why it is important. • Practicing skills in empathic listening, inquiring about needs, and offering validating response. 	Health-care providers
Parallel session 8b	120 min	<p>Strengthening service delivery</p> <ul style="list-style-type: none"> • Adapting and applying SOPs/protocols. • Developing action plans and costing services. • Improving health workforce capacity. 	Health services managers
Parallel session 9a	120 min	<p>First-line support: LIVES (part 2)</p> <ul style="list-style-type: none"> • Performing safety assessment and planning/support. • Where and how to refer for support? 	Health-care providers

Session no	Time	Day 2: Sessions and content (continued)	Participant categories
Parallel session 9b	120 min	<p>Strengthening service delivery</p> <ul style="list-style-type: none"> • Strengthening infrastructure and availability of commodities. • Engaging the community and being accountable to them. • Monitoring and evaluation of services. 	Health managers
10	30 min	<p>Know your settings: coordination and referrals</p> <ul style="list-style-type: none"> • Establishing coordination mechanisms and referral pathways. 	All
11	30 min	<p>Documenting violence against women</p> <ul style="list-style-type: none"> • Why is documenting violence against women important? • What are guiding principles for documentation? • How and where should information be recorded? 	All
Session no	Time	Day 3: Sessions and content	Participant categories
	15 min	Review day 2.	Health-care providers
12	45 min	<p>Clinical care for sexual assault survivors</p> <ul style="list-style-type: none"> • Taking history and medical examination (role play). • Providing treatment and follow up care. 	Health-care providers

Session no	Time	Day 3: Sessions and content (continued)	Participant categories
13	30 min	<p>Self-care for health-care providers</p> <ul style="list-style-type: none"> • Accessing support. • Managing one's self. 	Health-care providers
14	30 min	<p>Conclusion</p> <ul style="list-style-type: none"> • Next steps for putting training into action. • Closing remarks. • Post-training assessment and evaluation. 	All
Session no	Time	Supplemental sessions	Participant categories
15	30 min	<p>Additional care for mental health</p> <ul style="list-style-type: none"> • Assessing depression and PTSD. 	Health-care providers
16	30 min	<p>Principles for forensic examination in sexual assault cases</p> <ul style="list-style-type: none"> • When to collect forensic evidence? • Tips for conducting an examination. • Documenting findings. 	Health-care providers
17	45 min	<p>Additional care related to family planning and HIV</p> <ul style="list-style-type: none"> • Addressing reproductive coercion and contraceptive choices. • Addressing HIV status disclosure in the context of violence. 	Health-care providers

Annex 4. Violence against women focal-point or coordinator's role: sample terms of reference for job description

Skills

- Knowledge of the health-care system.
- Management skills (project work, working with health data, committee work, report writing).
- Works well with health-care staff and community.

Responsibilities

Reports to the senior management in ministry of health on these responsibilities:

- work closely with and oversee a working group on health care for women subjected to violence to support implementation of an action plan;
- prepare regular reports to the working group on the progress and outcomes of the activities;
- manage the plan for training health staff;
- compile and analyse data on women who seek care and the services they receive;
- ensure that staff members are aware of protocols and have a mechanism for supervision;
- ensure that quality improvement activities (for example, case reviews) are performed and reported at regular intervals;
- contribute to the multisectoral response to violence against women by representing the ministry of health in multisectoral working groups;

- network with national, regional, international and donor organizations to provide periodic updates on progress in implementing the programme and to support consistency across areas;
- support development of training and communication materials.

Annex 5. Sample terms of reference for a task force or working group to guide the health system response to violence against women

Note: To increase efficiency and promote integrated care, the working group may have responsibility for the response to both violence against women and child abuse and neglect.

Roles and responsibilities

- Advocate for and champion the health system response to violence against women.
- Support development of action plans, policies and protocols on the health system response to violence against women.
- Support development of monitoring systems for health-related data on violence against women.
- Support resource mobilization for services and allocate resources including human, financial, and technical.
- Develop a plan for capacity strengthening to respond to violence against women.
- Facilitate multisectoral coordination and collaboration with other services and organizations outside the health sector.
- Report to senior management on the performance of the health system in addressing violence.

Members

- permanent secretary for health or director of public health;
- director of hospital services;
- representative from health promotion or social welfare;

- representatives of medical and nursing staff from key services (for example, emergency department, obstetrics and gynaecology, antenatal care, reproductive health, midwifery, mental health, public health and paediatrics);
- community members;
- representatives of NGOs working on violence against women.

Annex 6. Sample referral directory form

Need	Name of agency &/or contact person	Contact	Responsible for follow-up	Form
Victim advocate/Family protection unit/Social worker		Phone: E-mail:		
Counselling/Crisis centre/		Phone: E-mail:		
Support groups		Phone: E-mail:		
Mental health care		Phone: E-mail:		
Reproductive health care		Phone: E-mail:		
Laboratory services		Phone: E-mail:		
Child care		Phone: E-mail:		
Child protection		Phone: E-mail:		
Police		Phone: E-mail:		

...continued

Need	Name of agency &/or contact person	Contact	Responsible for follow-up	Form
Forensics		Phone: E-mail:		
Shelter/housing		Phone: E-mail:		
Financial aid		Phone: E-mail:		
Legal aid		Phone: E-mail:		
Livelihood/ employment		Phone: E-mail:		
[Other]		Phone: E-mail:		
[Other]		Phone: E-mail:		

Annex 7. Developing a Memorandum of Understanding (MOU)

What is an MOU?

Coordination and referrals can be facilitated through formal or informal agreements. Formal agreements can include MOUs or memoranda of agreement, letters of agreement or interagency guidelines or policies. An MOU is an agreement among 2 or more organizations to collaborate in service provision, financial responsibility or other responsibilities. It is a nonbinding agreement between organizations, not a legally enforceable contract. Representatives from health facility administration, including those responsible for legal and financial matters (where relevant), may be involved in negotiating the MOU.

What can the MOU address?

- what services will be provided;
- clear roles and responsibilities of each organization;
- financial compensation or resource allocation;
- time frame for the agreement;
- conditions of termination;
- time frame for periodic review.

Annex 8. Example of indicators, data sources and reporting frequency¹

Indicator	Data source	Frequency
Service needs:		
a. Number of cases of physical, sexual and psychological/emotional violence presenting or identified at health facilities (disaggregated by type of violence, age, relationship to the perpetrator).	Health information system database – for example, facility registers or client record forms (see Annexes 9 and 10, pages 147 and 152)	Quarterly
b. Number of different types of health symptoms/ conditions presenting or diagnosed linked to experience of violence (disaggregated by type of symptom or condition).	documenting the type of violence, symptoms or conditions presenting, treatments offered	

¹ Bloom S. Violence against women and girls: a compendium of monitoring and evaluation indicators. Chapel Hill, North Carolina: MEASURE Evaluation; 2008 (<https://www.measureevaluation.org/resources/publications/ms-08-30>).

...continued

Indicator	Data source	Frequency
Inputs & process (service readiness): a. Proportion of health facilities that are assessed to be ready to provide care to survivors of intimate partner violence or sexual violence in line with the WHO guidelines ¹ as follows: i. have a space for private and confidential consultation; ii. a written SOP/protocol available; iii. at least 1 trained health-care provider available; iv. have established referral linkages; v. have a confidential mechanism to record incidents of violence.	Health facility survey	At baseline and the end line of an intervention to improve service delivery
b. Number of health-care providers trained to identify and provide care for intimate partner violence or sexual violence.	Training records by cadre of personnel trained	Annually
Output (service coverage): a. Increase in proportions of health-care providers with (a) knowledge, (b) positive attitudes and (c) skills in identification and provision of care to survivors of intimate partner violence.	Health-care provider survey on knowledge, attitudes and competencies	Before and after initiating an intervention to train providers

¹ Responding to intimate partner violence and sexual violence against women: clinical and policy guidelines. Geneva: World Health Organization; 2013.

...continued

Indicator	Data source	Frequency
b. Percentage of health facilities providing appropriate medical care for rape survivors (that is, STI and HIV prophylaxis, emergency contraception, abortion to the full extent of the law) and psychological care and support (that is, first-line support or LIVES, referrals to counselling and other services as needed).	Health facility survey	Annually
Outcome (service access and quality):		
a. Proportion of sexual assault/rape survivors who received appropriate medical care (that is, STI and HIV prophylaxis; emergency contraception, abortion according to law) and psychological care and support (that is, first-line support, referrals to counselling and other services as needed)	Health information system database – for example, review of facility registers or client record forms	Semi-annually
b. Proportion of survivors who were satisfied with the care they received	Interviews with clients – for example, exit interviews; also, focus-group discussions with community members	Annually

Annex 9. Sample intake/record form for clients subjected to intimate partner violence or sexual assault

Date (dd/mm/yr) _____/_____/_____		Client number _____
Client's family name _____		Client's given name _____
Client can be reached at _____		
Sex	<input type="checkbox"/> F <input type="checkbox"/> M	Date of birth (dd/mm/yr) _____/_____/_____
		<input type="checkbox"/> Married/cohabiting <input type="checkbox"/> Not married/ not cohabiting
Reporting	<input type="checkbox"/> Provider asked about violence	<input type="checkbox"/> Client disclosed/ reported violence <input type="checkbox"/> Provider suspects violence
Referred by (if first visit)	<input type="checkbox"/> Self	<input type="checkbox"/> Other health facility/unit (specify) _____
	<input type="checkbox"/> Family/ acquaintance	<input type="checkbox"/> Police <input type="checkbox"/> Other government unit

...continued

Presenting symptoms/ conditions	<input type="checkbox"/> Injuries	<input type="checkbox"/> Sexual/reproductive health conditions	<input type="checkbox"/> Mental/emotional problems	<input type="checkbox"/> Other (specify)
Type of violence	<input type="checkbox"/> Physical violence	<input type="checkbox"/> Sexual violence <input type="checkbox"/> Rape <input type="checkbox"/> Rape – arrived within 72 hours	<input type="checkbox"/> Psychological/emotional	<input type="checkbox"/> Other (specify)
Perpetrator	<input type="checkbox"/> Intimate partner	<input type="checkbox"/> Family member in household	<input type="checkbox"/> Family member/acquaintance living elsewhere	<input type="checkbox"/> Stranger
Assessments and clinical care for all survivors	<input type="checkbox"/> First-line support ¹ <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Safety assessment	<input type="checkbox"/> Injuries & wound care	<input type="checkbox"/> Tetanus prophylaxis
Additional care for rape survivors seen within 72 or 120 hours	<input type="checkbox"/> Head-to-toe & genital examination <input type="checkbox"/> PEP for HIV (within 72 hours)	<input type="checkbox"/> Emergency contraception (within 120 hours) <input type="checkbox"/> HIV test	<input type="checkbox"/> Pregnancy test <input type="checkbox"/> Forensic evidence collected	<input type="checkbox"/> STI prevention/treatment <input type="checkbox"/> Other (specify)

¹ First-line support includes basic counselling or psychosocial support using **LIVES**, which involves the following steps: Listen, Inquire, Validate, Enhance safety and Support. See instructions for more explanation.

...continued

SEE BACK FOR MORE ROWS, INSTRUCTIONS AND DEFINITIONS

External referrals

- Clinical care at higher-level facility
- Crisis intervention or counselling
- Police
- Shelter or housing
- Legal aid & services
- Child protection
- Livelihood support
- Other (specify)

Provider's initials

Instructions and definitions

Reporting: Check only one box.

Referred by: Applies only to first visit to this facility. Check only one box.

Presenting symptoms: Check all boxes that apply.

Sexual and reproductive health conditions include sexually transmitted infection (STI), unwanted pregnancy, vaginal bleeding, pelvic pain, sexual dysfunction, pregnancy terminations, adverse birth outcomes.

Mental/emotional problems include symptoms of stress, anxiety, depression, post-traumatic stress disorder (PTSD), sleep disorders, suicidality or self-harm (including thoughts, plans or acts), misuse of alcohol or drugs.

Other symptoms can include chronic headaches, pain syndromes, gastrointestinal problems, kidney and bladder infections, cognitive problems, hearing loss.

Type of violence: Check all boxes that apply.

Physical violence includes hitting, slapping, beating, kicking, shoving/pushing, hurting with a weapon.

Sexual violence includes using force, intimidation or coercion to have sex or to perform sexual acts that the woman does not want. It also includes harming a person during sex. It includes rape, and attempted rape, which involves use of physical force, intimidation, coercion or drugs/alcohol to obtain penetration of the vulva/vagina, anus or mouth by one or multiple perpetrators including by an intimate partner.

Intimate partner violence includes any physical or sexual violence or emotional/psychological abuse by current or former married/cohabitating partner or boyfriend.

Psychological/emotional violence includes criticizing repeatedly, calling names or insults, threats to hurt loved ones or to destroy things that the person cares about, belittling or humiliation in public.

Perpetrator: Check only one box.

Assessments and clinical care for all survivors: Check all boxes that apply.

First-line support includes basic counselling or psychosocial support that can be implemented using the **LIVES** approach, which involves empathic **L**istening, **I**nquiring about needs and concerns, offering a **V**alidating response to survivors' experience, assessing and helping her **E**nhance her safety, and **S**upporting her by connection to information, services and social support.

Additional care given to rape survivors seen in 72–120 hours: Check all boxes that apply. This care is in addition to the assessments and clinical care offered to all survivors of violence, which includes first-line support, safety assessment, injuries and wound care and tetanus prophylaxis.

PEP is post-exposure prophylaxis for HIV.

External referrals: Check all boxes that apply.

Clinical care at higher-level facility could include, for example, care for mental health, forensic evidence collection or treatments for conditions that cannot be managed within the primary health facility.

Annex 10. Sample facility register for recording cases of violence against women

Department/unit _____ Month Year Page _____ of _____

Health facility name _____ District name _____

Instructions: Please complete the register for all clients who are identified or who disclose intimate partner violence or sexual violence and who receive a service from your department/unit.

Personal information (to be kept separately under lock & key)							
S/N	Client number	Client's name	Client can be reached at	Sex (M, F)	Date of birth (dd/mm/yy)	Married/cohabiting (Y, N)	Other ¹

¹ Other information may be added depending on the country context or setting.

Codes

Reporting	Code	Referred by	Code	Perpetrators	Code
Provider asked about violence	A	Self	S	Intimate partner	IP
Client disclosed/reported violence	D	Family/acquaintance	F	Family member in household	FH
Provider suspects violence	S	Other health facility/unit	OH	Family member/acquaintance living elsewhere	FLE
		Police	P		
		NGO	N	Stranger	S
		Other government unit	OG		

Annex 11. Privacy and confidentiality in documentation

Confidential documentation and record-keeping are vital to the safety of patients experiencing intimate partner or sexual violence. Records may take the form of paper, external computer hard drives or CDs, or they may be network-based. Regardless of format, all types of files must be secured.

This checklist will help you make sure that records are secure.

How can we create secure records in practice?

- All staff members understand the importance of confidentiality and secure record-keeping, and staff members who routinely care for women subjected to violence have been trained to keep records secure.
- Identifying information about a woman, including her name and contact information, is not visible or accessible to those not caring for this patient.
- Staff members do not leave documents where a patient (unless requested), those accompanying the patient or anyone else might see them. Staff members do not carry charts open or lay them on shared desks or counters.
- When documenting information from women about their experience of violence, staff members avoid asking for or writing this information on records in a public place.
- Staff members do not write a notation indicating intimate partner violence or sexual violence on the first page of a record, which is more likely to be seen if flipped open.
- Staff members use a code, such as an abbreviation or symbol, to indicate cases of intimate partner violence or sexual violence on charts (recommended option). They do not write “DOMESTIC VIOLENCE SUSPECTED” or “RAPE” or other explicit wording in large print across the chart. Some countries (such as Malaysia) use a

colour coding system on medical records that is known only to the relevant health staff.

- Any sensitive information that needs to be destroyed is shredded by an authorized staff member.

How can we create secure records in storage?

- We have a secure site to store files.
- Documents are locked up at all times.
- Only a limited number of designated staff members have access to patient records.
- Staff members who need access to records have received training on record confidentiality and storage practices.
- Staff members authorized to access stored files have a means of access that is not available to others. (As the setting allows, this may be a key to a room, an electronic password or a security code to enter a room, or another method of obtaining access to a restricted area.)

For more information, please contact
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