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Integrating Intimate Partner Violence Screening and Counseling with Family Planning Services: Experience in Conakry, Guinea

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Acronyms and Abbreviations

AGBEF	Association Guinéenne pour le Bien-être Familial
AGUIAS	Association Guinéenne des Assistantes Sociales
CONAG-DCF	Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes
FP	family planning
GATHER	greet-ask-tell-help-explain-return/refer [counseling model]
GBV	gender-based violence
GLP	global leadership priority
HIV	human immunodeficiency virus
IPV	intimate-partner violence
IPPF	International Planned Parenthood Federation
IRB	institutional review board
IUD	intrauterine device
MOHPH	Ministry of Health and Public Hygiene
OPROGEM	Office de Protection du Genre, de l'Enfance et des Moeurs
RH	reproductive health
SRH	sexual and reproductive health
STI	sexually transmitted infection
SV	sexual violence
TA	technical assistance
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Executive Summary

Background

On September 28, 2009, the Guinean armed forces repressed a peaceful political demonstration in Conakry, resulting in hundreds of women becoming victims of sexual violence (SV). With funding from the Guinea Mission of the U.S. Agency for International Development (USAID), RESPOND partnered with the Ministry of Health and Public Hygiene (MOHPH) and the Ministry of Social Affairs and the Promotion of Women and Children to implement the Guinea Gender-Based Violence Project. This 18-month program conducted the following activities:

- Provided support services to SV survivors of September 28, 2009
- Built local capacity to prevent gender-based violence (GBV)
- Improved the health sector's ability to respond to GBV

Based on the results of this project, RESPOND received new funding from USAID (the Gender Global Leadership Priority [GLP]) in 2013 to pilot the integration of screening and counseling for intimate-partner violence (IPV) into family planning (FP) services. For the purposes of the new project, IPV was defined as a pattern of abusive behaviors and actions perpetrated by one person on his/her intimate partner; IPV includes physical, sexual, and psychological harm.

Objectives of the IPV/FP Project

The objective of the new project was to support improved reproductive health (RH) by integrating IPV screening and counseling into FP services in a low-income setting. Specifically, RESPOND pilot-tested a curriculum and supportive supervision model that trained providers to:

- Discuss IPV with the FP client in a safe and supportive space
- Explore FP options with the IPV survivor, taking into account the potential effect of IPV on method choice and use
- Educate clients about medical, legal, psychosocial, and other services available to IPV survivors
- Discuss personal safety with the IPV survivor and help her develop a safety plan for the future
- Provide relevant medical services on-site and refer the client to other services as needed

The project took place at an FP clinic in Conakry administered by the Association Guinéenne pour le Bien-être Familial (AGBEF, Guinean Association for Family Welfare), a member association of the International Planned Parenthood Federation (IPPF). Conakry is the capital and largest city in Guinea.

Approach and activities

The IPV/FP integration approach was based on creating a safe and enabling environment in which clients feel comfortable disclosing any experience of violence. It built on the "GATHER" model for FP counseling (Rinehart, Rudy, & Drennan, 1998), which the AGBEF clinic was already using, while providing additional consideration for IPV screening, counseling, and referral. The approach combined the basic tenets of respectful and informed client interaction with guidance on where and how to integrate IPV screening and counseling.

Project activities included the following:

- Conducting formative research (consisting of facility audits and provider interviews at seven AGBEF clinics) to guide the approach and training curriculum
- Developing a curriculum, based on the continuum-of-care model (de Graft-Johnson et al., 2006), that integrated IPV screening and counseling into FP services
- Field-testing the curriculum by training providers from the AGBEF adult FP clinic in Conakry
- Providing the clinic with follow-up facilitative supervision and technical assistance (TA) to help it integrate IPV screening and counseling into existing FP services
- Evaluating the results of the training, facilitative supervision, and TA
- Revising the curriculum based on the pilot experience
- Disseminating the revised curriculum along with the evaluation findings, lessons learned, and an account of the process

Main Results

From March 25 to June 2, 2014, 181 FP clients visited the clinic, and 171 were screened for IPV. Of the 171, 157 (91.8%) screened positive for IPV, meaning they had suffered one or more types of IPV. This percentage reflects both the sensitivity of the screening tool (which was intentionally broad to be inclusive of any experience of IPV) and actual experience of IPV within this community. Eighty-five percent of clients who screened positive for IPV reported experiencing more than one form of violence, with psychological violence being the most prevalent (79.6%), followed by sexual violence (68.2%) and physical violence (47.8%).

Injectable contraceptives were by far the most preferred contraceptive method among women who screened positive for IPV (67%), followed by the pill (12%), the intrauterine device (IUD) (6%), and the hormonal implant (2%).

Among women who screened positive for IPV, 87.3% completed a safety plan, and all received information about referral services, including the names and addresses of referral sites. The project documented only one case of a screened client's accepting referral.

Lessons Learned and Recommendations

- Integration of IPV screening and counseling into FP services in a low-income setting is feasible.
- In addition to initial training of providers, capacity building should include on-the-job training, supportive supervision, and TA to facilitate the operationalization of learning.
- Collaborating with local IPV service partners can both familiarize providers with referral services and help to establish linkage coding systems to track client visits to referral sites.
- To maximize the benefit for victims, FP organizations should envisage a broad response to IPV that includes not only screening and counseling for IPV survivors, but also medical and psychosocial services.

Introduction

Overview of the RESPOND Project

The RESPOND Project is a USAID-funded global project, led by EngenderHealth, that seeks to increase the use of high-quality FP services by ensuring a wide range of contraceptive options, including the informed and voluntary use of long-acting and permanent contraception.[1]

RESPOND helps health care services:

- Increase their FP knowledge
- Support the full range of FP methods and other RH services in a manner consistent with informed choice and clients' rights and with full attention to gender equity, quality, and the fundamentals of care

RESPOND Activities in Guinea

On September 28, 2009, the Guinean armed forces violently repressed a peaceful political demonstration in Conakry, the capital and largest city in Guinea. Guineans and international observers alike were shocked by the violence, which included brutal rapes. In fact, hundreds of women were victims of SV on that day.

The incident underscored the urgent need for more and better-quality services throughout the country for survivors of SV and other forms of GBV. The Guinea Mission of USAID tasked RESPOND to partner with the MOHPH and the Ministry of Social Affairs and the Promotion of Women and Children to implement the Guinea Gender-Based Violence Project. The program conducted the following activities:

- Providing support services to survivors of the September 28, 2009, SV
- Building local capacity to prevent GBV
- Improving the health sector's ability to respond to GBV

RESPOND worked under the guidance of a local, multisectoral steering committee.

Over the 18 months of project implementation, from January 2011 to June 2012, the project far exceeded its targets:

- One hundred fifty-three SV survivors received psychological, medical, and social assistance, including economic reintegration.
- GBV prevention committees reached 8,892 men and women in the communes of Conakry.
- Fifty-three providers from 21 health facilities in Conakry, Labe, and Kissidougou were trained to respond to SV.

[1] Long-acting methods are the IUD and hormonal implants; permanent methods are male and female sterilization.

In endline interviews, a majority of survivors expressed great appreciation for the services they received. At the end of the project, a number of survivors reported that they were earning an income with the business and vocational skills they learned through the project.

While the training led by RESPOND in 2011–2012 addressed the services that survivors need after an incident of SV, little has been done in Guinea to address the broader RH needs of GBV survivors, including survivors of IPV; these clients often do not know about services that could help them or are hesitant to disclose their GBV experience to health care providers. Despite the well-documented links between IPV and negative FP/RH outcomes (Miller et al., 2014; Okenwa, Lawoko, & Jansson, 2011; Alio et al., 2009), FP providers in Guinea, as in many countries, are not typically trained to address IPV or other forms of GBV.

Background of the IPV/FP Project

Based on the results of the Guinea Gender-Based Violence Project, RESPOND received new funding from USAID (via the Gender GLP) in 2013 to pilot the integration of IPV screening and counseling into FP services. For the purposes of the new project, IPV was defined as a pattern of abusive behaviors and actions perpetrated by one person on his/her intimate partner; IPV includes physical, sexual, and psychological harm. The project took place over six months, from January through June 2014, and was conducted in partnership with the MOHPH and AGBEF, the local member association of the IPPF.

Project Overview

The objective of the Guinea IPV/FP Project was to support improved RH by integrating IPV screening and counseling into FP services in a low-income setting. Specifically, RESPOND pilot-tested a curriculum and supportive supervision model that trained AGBEF providers to:

- Discuss IPV with the FP client in a safe and supportive space
- Explore FP options with the IPV survivor, taking into account the potential effect of IPV on method choice and use
- Educate clients about medical, legal, psychosocial, and other services available to IPV survivors
- Discuss personal safety with the IPV survivor and help her develop a safety plan for the future
- Provide relevant medical services on-site and refer the client to other services, as needed

The project took place at AGBEF's adult FP clinic in Conakry.

Project activities included the following:

- Conducting formative research (consisting of facility audits and provider interviews at seven AGBEF clinics) to guide the approach and development of the training curriculum
- Developing a curriculum, based on the continuum-of-care model (de Graft-Johnson et al., 2006), that integrated IPV screening and counseling into FP services
- Field testing the curriculum by training providers from the AGBEF adult FP clinic in Conakry
- Providing the clinic with follow-up facilitative supervision and TA to help it integrate IPV screening and counseling into existing services
- Evaluating the results of the training, facilitative supervision, and TA
- Revising the curriculum based on the pilot experience
- Disseminating the revised curriculum along with the evaluation findings, lessons learned, and an account of the process (including a description of how the formative research findings shaped the approach)

Inception of the Guinea IPV/FP Project

The IPV/FP Integration Approach

The IPV/FP integration approach was based on creating a safe and enabling environment in which clients feel comfortable disclosing any experience of violence. To ensure such an environment, the pilot project trained providers and other clinic staff to improve their communication skills with clients and to foster a culture of confidentiality that protects the client's privacy (e.g., storing and accessing case files in a manner that protects privacy, and maintaining client confidentiality beyond the clinic).

The approach used in this pilot built on the GATHER model for FP counseling (Rinehart, Rudy, & Drennan, 1998), which the AGBEF clinic was already using, while providing additional consideration for IPV screening, counseling, and referral (Table 1). This approach combined the basic tenets of respectful and informed client interaction with guidance on where and how to integrate IPV screening and counseling.

Table 1. GATHER model for FP counseling, with additional steps for IPV screening

	FP model	IPV integration add-ons
G	Greet the client respectfully.	• Explain the clinic's commitment to the holistic care of clients. • Explain the need to ask private and sensitive questions about IPV.
A	Ask the client about her FP needs; assess her risk for HIV and other sexually transmitted infections (STIs).	• Screen for potential incidences of IPV.
T	Tell the client about different FP methods.	• Explain the STI/HIV risks and IPV risks resulting from each option.
H	Help the client make an informed and voluntary decision regarding FP.	• Take into consideration the impact of IPV. • Help the client develop talking points to be used with her partner.
E	Explain and demonstrate how and when to use the method of contraception.	• Take into consideration the impact of IPV, and develop strategies for harm reduction.
R	Return/refer; schedule a return visit and follow up with the client.	• Remind the client that she may return or call the clinic with any problem or concern. • Discuss a safety plan with the client. • Refer the client to community-based IPV services.

Within the clinic, IPV screening and counseling were conducted in a manner that respected both the regular client flow and the need for privacy when screening and counseling women for IPV. The client flow had two main steps:

- **Step 1:** The FP counselor greeted the client, introduced her to clinic activities, and counseled her about FP methods available at the clinic. This step typically ended with the client having selected a contraceptive method; she was then referred to the nurse or nurse-midwife for specific counseling about the chosen method.

- **Step 2:** In the second step, the nurse-midwife continued the client visit with in-depth method counseling and IPV screening. Screening was conducted only with the woman's consent. The nurse-midwife used an IPV questionnaire to determine if the client was currently experiencing, or had experienced, psychological, sexual, or physical violence at the hands of an intimate partner. If the woman screened positive for IPV, the nurse-midwife:
    - Provided specific FP method counseling, taking into account the impact of IPV on method use
    - Helped the woman develop a personalized safety plan
    - Referred the woman to providers of IPV services in the community

The appendix of this report includes various documents used in the screening and counseling process.

Collaboration, Stakeholder Buy-In, and Formative Research

The project was a collaboration between the RESPOND Project and the local IPPF affiliate in Guinea. The goal of the partnership was to test the integration of IPV screening into FP clinics of AGBEF, the Guinean IPPF member association.

Given the success of the Guinea Gender-Based Violence Project, RESPOND decided to fund additional programming through the Guinea IPV/FP Project. This programming was intended to pilot-test an approach to integrating IPV screening services at an IPPF clinic. RESPOND and AGBEF worked together to conduct formative research at AGBEF clinics across the country to guide the development of the curriculum and inform the pilot approach. Conducted through a series of focus group discussion with clients and interviews with clinic providers and managers in May 2012, the research found that both clients and providers agreed that IPV screening would be a positive addition to AGBEF's services. In particular, respondents cited the convenience of the services for the client and the confidentiality with which those services would be offered; they also believed that clients had a high need for IPV services. Clients participating in focus group discussions noted that some clients might be reluctant to open up about IPV to FP providers. The analysis also identified several clinics as potential pilot sites. Because rural areas have fewer available services for IPV survivors than urban areas do, only one clinic, AGBEF's adult clinic in Conakry, was chosen as the intervention site.

RESPOND and AGBEF staff met with officials at the MOHPH to gain their support and involvement in the steering committee responsible for monitoring project implementation. Committee members came from the ministries of health, social affairs, security, and justice and from various partner organizations conducting GBV work in Guinea (the United Nations Population Fund [UNFPA] and other nongovernmental organizations).

The role of the steering committee was to:

- Participate in the planning of project activities
- Conduct field visits to monitor activities when needed

- Discuss the IPV/FP integration approach and expand the list of referral services
- Provide comments and suggestions on the French version of the IPV-FP service integration protocol
- Review the project's progress
- Analyze the results of the intervention and amend the integration protocol

The first meeting of the steering committee was held on December 31, 2013, at the RESPOND offices in Conakry. During this meeting, the committee recommended that the protocol be submitted to the local institutional review board (IRB), provided feedback on the protocol, and gave authorization for the project. The second meeting of the committee, planned for March 2014, was cancelled because of an outbreak of Ebola fever. However, the committee members were regularly updated by e-mail on the project's progress. At the last meeting, held in July 2014, staff disseminated the results of the pilot, and the group discussed the future of IPV work in Guinea.

The Project's Major Activities

Developing the Integration Protocol and the Curriculum

Developing the integration protocol

RESPOND hired a consultant with experience in IPV screening in a clinical setting to draft the IPV-FP integration protocol using international guidelines (see appendix). The purpose of the protocol was to inform the process of integrating IPV screening and counseling services into existing FP services and to provide materials for use in that process. The draft protocol was reviewed by RESPOND staff and shared with USAID/Washington and the RESPOND Guinea office. The consultant revised the original document several times based on feedback from EngenderHealth and RESPOND staff and USAID colleagues. The draft was then translated into French. The steering committee reviewed the French versions at its December 2013 meeting. The amendments of the steering committee were then integrated into the English version of the protocol and a final French version was also created for use during project implementation.

Developing the training curriculum

After validation of the IPV-FP integration protocol, the consultant drafted the training curriculum. The curriculum development process drew on the project's formative research, during which respondents recommended the management tools, provider training, and supervision and support that would be necessary for IPV screening and counseling. The curriculum guide was originally designed for a training-of-trainers activity. However, given that the project would be implemented at only one clinic in Conakry, the training curriculum was adapted accordingly.

The curriculum provided participants with a general understanding of gender norms, thereby enabling them to make the links between inequitable gender norms and IPV. After presenting the causes and consequences of IPV and the relationship between IPV and FP, the curriculum continued with sessions aimed at operationalizing IPV screening and counseling within AGBEF clinic operations (e.g., combining the GATHER framework and IPV screening, exploring FP options with IPV survivors, documenting IPV, and providing referrals for IPV survivors).

Training AGBEF Staff

Training workshop

From January 10 to 14, 2014, RESPOND facilitated a training workshop for AGBEF clinic staff in Conakry. The purpose of the workshop was to build the capacity of AGBEF staff to carry out IPV screening and counseling as part of the clinic's regular FP counseling services. The workshop was facilitated by EngenderHealth's senior program associate for Gender/Men As Partners and was cofacilitated by a local consultant hired by RESPOND.

AGBEF staff participants were the regional coordinator, two nurse-midwives, the clinic's FP counselor, and one laboratory assistant. Two representatives from Jhpiego-Guinea also attended the workshop.

Learning objectives for participants included the following:

- Explain why FP health centers are good entry points for screening survivors of IPV
- Identify challenges that may arise when serving IPV survivors and how to overcome these challenges
- Acquire skills to deliver five key IPV services to FP clients (Figure 1)
- Describe how the five key IPV services can be integrated within the GATHER framework
- Explain the importance of maintaining confidentiality and the minimum components of confidentiality procedures when serving IPV survivors
- Explain the importance of informed consent and voluntary decision making for IPV survivors

Training Day 5: Presentations by representatives from different referral services

Figure 1. Five key IPV services for FP clients

1. Screening clients for IPV
2. Educating and counseling clients on IPV issues
3. Exploring clients' FP options and providing contraceptive methods to IPV survivors, taking into account the possible effect of IPV on method choice and use
4. Delivering other RH services needed by IPV survivors
5. Referring IPV survivors for other medical, psychological, and legal services

On the fifth day of the workshop, participants learned about the connections that AGBEF had established with referral services for IPV. Representatives from the Association Guinéenne des Assistantes Sociales [Guinean Association of Social Workers] (AGUIAS), the Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes [National Guinean Coalition for the Rights of Women] (CONAG-DCF), and the Office de Protection du Genre, de l'Enfance et des Moeurs [Office for the Protection of Gender, Children and Morals] (OPROGEM) attended the first part of the day and presented the services they offer to IPV survivors. The session was also an opportunity for the guests to learn about AGBEF's efforts to provide IPV screening and counseling to its clients.

Evaluation of the training

Participants completed a pretest at the start of the workshop and a comparable posttest at the end of the workshop. After training, the participants demonstrated improvements in several areas: understanding IPV and gender norms; defining a safety plan; and understanding the main elements of effective/active listening. Areas requiring further strengthening included the impacts of IPV on FP and sexual and reproductive health (SRH), the purpose of a safety plan, clinic responsibility for clients experiencing IPV, the definition of confidentiality, the positive and negative impacts of provider attitudes and values on service delivery, and the integration of the five key services for IPV-FP clients into the GATHER framework. Although the participants were not able to correctly link all of the GATHER stages with each of the five key IPV-FP services, several participants were able to make some of the linkages.

The participants struggled with the large amount of new theory communicated in a relatively short time span. They felt that too much new information had been presented and were concerned that they might not be able to recall all of the content well enough to provide screening. The participants expressed the need for more time to review the information provided and to practice the newly acquired skills. It was also apparent from the evaluation that the providers would need close technical supervision during the first few weeks of implementation (see the discussion of facilitative supervision below).

Follow-on training

Based on the posttraining feedback, RESPOND and AGBEF decided to provide an immediate follow-on training. A two-day session was organized to provide AGBEF staff with the following:

- A review of the IPV screening process (including documentation and use of screening tools); education and counseling skills; the impact of IPV on FP and SRH; the purpose of a safety plan; the importance of client confidentiality; specific links between each step of GATHER and the five key services for IPV-FP clients; and referral for IPV services
- Development of a simpler and shorter safety plan format
- Simulated client consultations to allow AGBEF nurse-midwives to practice delivering the five key services for IPV-FP clients

Follow-on training: IPV screening simulation by providers (interview and documentation)

The follow-on training was held on March 5 and 6, 2014, at the AGBEF adult clinic in Conakry. It was conducted by local consultants, one of whom had served as cofacilitator during the initial five-day training. Three members of the clinic staff (an FP counselor and two nurse-midwives) who would be directly involved in delivering FP/IPV services participated in the follow-on training. Although the FP counselor was not designated to

provide IPV screening, she still received the same amount of training as the nurse-midwives, in case a client asked her about IPV issues.

The participants reported that the follow-on session was very useful, as it gave them more time to practice the skills they acquired during the initial workshop. At the end of the follow-on training, AGBEF and RESPOND decided that:

- One simple code would be used to identify the FP-IPV client on the screening form, on the clinic's FP register, and on the FP client sheet. This facilitated referrals and data management. No new register would be used for the project; thus, the project's procedures would align with existing AGBEF clinic procedures.
- For IPV clients, providers would complete the following documentation:
    - IPV screening form
    - Data disclosure consent form
    - Referral sheet
    - Safety plan
    - Clinic's FP register
    - Client's FP sheet

In addition, before the start of IPV screening and counseling activities, AGBEF and RESPOND decided to conduct additional simulated client visits, both (a) to ensure that providers had mastered the essential skills and (b) to check the providers' attitudes toward IPV survivors. RESPOND asked AGBEF to decide when it felt ready to begin screening and to begin only when the providers and regional coordinator felt that they were ready.

To further prepare staff to provide referrals and to help them become familiar with referral organizations, providers visited the AGUIAS and CONAG-DCF offices in Conakry. These visits provided an opportunity to discuss referral mechanisms and collaboration during the project. As a result of the discussions, AGUIAS learned about AGBEF's planned IPV screening activities and shared its hotline number for distribution to AGBEF clients.

Facilitative Supervision and Technical Assistance

Level of support needed and provided

During both the original training week and the follow-on training, it became apparent that the providers would need a substantial amount of facilitative supervision as they transitioned into implementation. Close supervision not only was recommended by project staff but was also welcomed by clinic providers. The goal was to ensure a clear understanding of the IPV screening and counseling process and a smooth flow of service provision for clients.

Additional simulated client visits

Based on the recommendation of the project consultant, four days of additional simulated client visits were conducted between March 11 and March 18, 2014. The purpose was to improve providers' skills in screening, counseling, documentation, and referral. Of the three providers who would potentially provide screening, two (one nurse-midwife and the FP counselor) participated in all sessions; the third provider (a nurse-midwife) was absent for

personal reasons. The third provider never returned during the implementation period; should she return in the future, AGBEF would need to provide additional training for her.

The two providers conducted simulated client visits several times per day for four days, under the supervision of the technical consultant. Providers took turns acting as either the client undergoing the IPV screening or the provider conducting the screening with documentation, safety planning, and referral. In the end, only one provider (one nurse-midwife) was responsible for IPV screening and counseling; however, the FP counselor participated in the additional simulated visits so that she would be prepared to discuss IPV issues with clients who inquired about them.

After each simulation, the consultant provided feedback on how to avoid mistakes, correct deficiencies, and improve skills. By the end of the additional simulated visits, providers had made considerable progress. When the main provider felt fully able to conduct a screening session, discuss a security plan, document the process, and provide referrals, AGBEF decide to officially begin offering IPV screening and counseling services.

Several tools were developed to support facilitative supervision and additional training, including an assessment tool to evaluate the provider's performance in implementing each task of IPV screening. Project staff and consultants used this tool to provide corrective feedback to providers.

Technical assistance

In the initial project proposal, project staff planned to conduct two TA visits a month during the first three months of the project, followed by one visit a month for three additional months. However, lessons learned during the initial and follow-on training led the RESPOND team and the local consultants to plan more TA visits: twice a week for the first three months, and then once a week for the following three months. With additional TA, providers were able to become more familiar with the approach at the beginning of implementation and to build their skills and confidence once actual client visits began.

To facilitate documentation, RESPOND developed a TA visit checklist. Local consultants used the checklist to:

- Document how closely AGBEF staff were following the IPV screening and counseling steps they learned during training
- Record any challenges experienced by AGBEF staff when conducting IPV screening and counseling
- Document the extent to which the clinic had institutionalized the FP-IPV integration protocol
- Provide weekly programmatic monitoring data

By the end of the pilot, the two local consultants (either separately or together) had conducted more than 20 TA visits to the AGBEF clinic in Conakry.

Challenges and lessons learned

The additional simulated client visits and the use of the assessment tool during those visits helped improve providers' ability to integrate IPV screening and counseling into FP services. The visits strengthened providers' ability to run a client-centered counseling session; they were especially helpful for the staff member who would be primarily responsible for IPV screening and counseling. Also, other AGBEF staff viewed the TA visits positively.

Because of a personal emergency, one nurse-midwife who would have been responsible for IPV screening and counseling was absent for the duration of the pilot. As a result, the other nurse-midwife was responsible for all IPV screening and counseling, in addition to her regular clinic duties. These tasks were burdensome, not only because of the added workload, but also because of the emotional stress inherent in IPV screening. Further, the two providers who received full training expressed feelings of concern and helplessness because most clients who screened positive for IPV did not want to be referred to external services. Even so, the strong technical support and frequent presence of the RESPOND consultants helped to increase the providers' confidence and gave them an opportunity to continually improve their skills.

Project Results

IPV screening and counseling started at the Conakry AGBEF clinic on March 25, 2014. As of June 2, 181 clients had visited the clinic, and 171 were screened for IPV. The 10 who refused screening reported that they did not have sufficient time. Out of the 171 screened, 157 (91.8%) screened positive for IPV (Table 2), meaning they had suffered one or more types of IPV (Table 3). Three kinds of IPV were identified: sexual, psychological, and physical. Eighty-five percent of clients who screened positive for IPV reported experiencing more than one form of violence (Table 3). Of the three kinds of violence, psychological violence was the most prevalent (79.6%), followed by sexual violence (68.2%); about 48% of women suffered physical violence (Figure 2). It should be noted that psychological violence is inherent in all forms of IPV; as a result, it typically has a higher prevalence than the other two types of IPV.

The nurse-midwife primarily responsible for providing IPV screening and counseling offered safety planning to all clients who screened positive for IPV. A total of 137 clients completed safety planning (Table 2). The remaining women did not complete safety planning because of time constraints or a perceived lack of need.

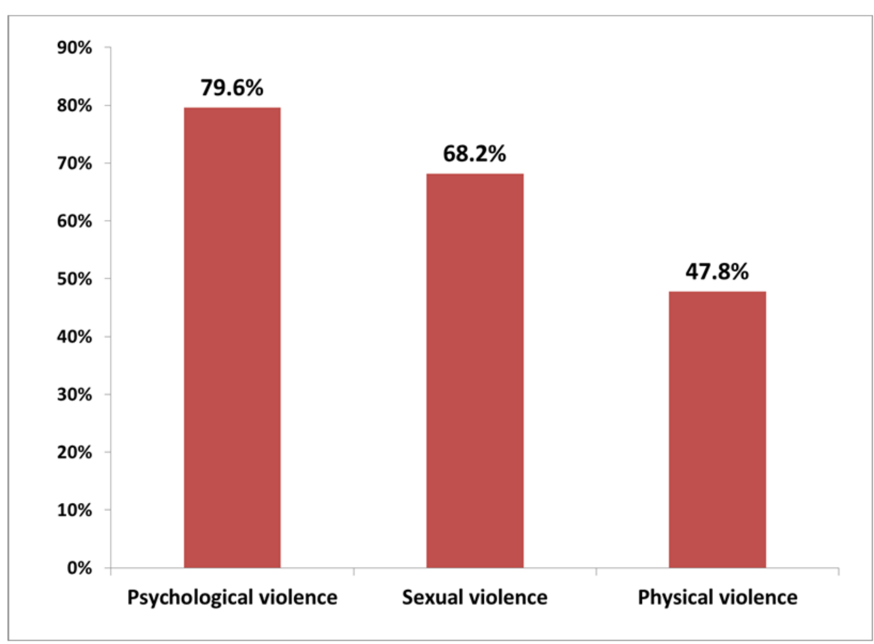
Table 2. Number of IPV screening and counseling activities among FP clients at AGBEF adult clinic, Conakry, March–June 2014

Frequencies (per month)						
Activity	**March**	**April**	**May**	**June**	**Total**	**%**
No. of visiting clients	13	66	76	26	**181**	—
No. screened	11	63	74	23	**171**	94.5% (171/181)
No. IPV-positive	10	56	70	21	**157**	91.8% (157/171)
No. who created a safety plan	0	44	70	23	**137**	87.3% (137/157)
No. referred	0	0	1	0	**1**	0.6% (1/157)

Table 3. Number and percentage of types of violence reported by IPV-positive FP clients at AGBEF adult clinic, Conakry, March–June 2014

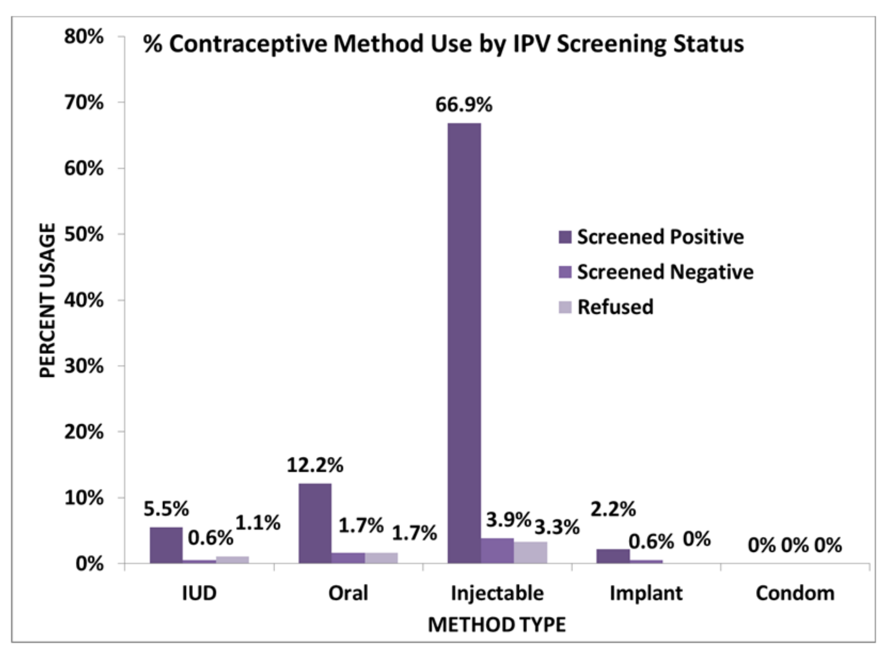
No. of types of violence	**No.**	**%**
1	23	14.6
2	78	49.7
3	56	35.7
Total	157	100.0

Figure 2. Percentage of IPV-positive FP clients reporting having experienced various types of violence, AGBEF adult clinic, Conakry, March–June 2014



Injectable contraceptives were by far the most preferred contraceptive method among women who screened positive for IPV (66.9%), followed by the pill (12.2%), the IUD (5.5%), and the implant (2.2%) (Figure 3). As Figure 4 shows, this pattern of contraceptive use was already common among AGBEF clients, and no changes in method mix were observed among clinic clients for the duration of the pilot.

Figure 3. Contraceptive methods used, by IPV status, among FP clients at AGBEF adult clinic, Conakry, March–June 2014



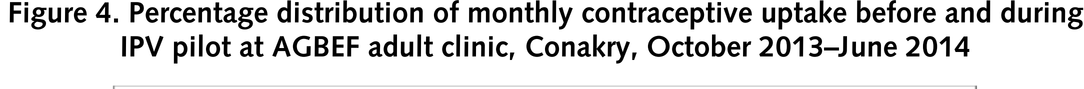
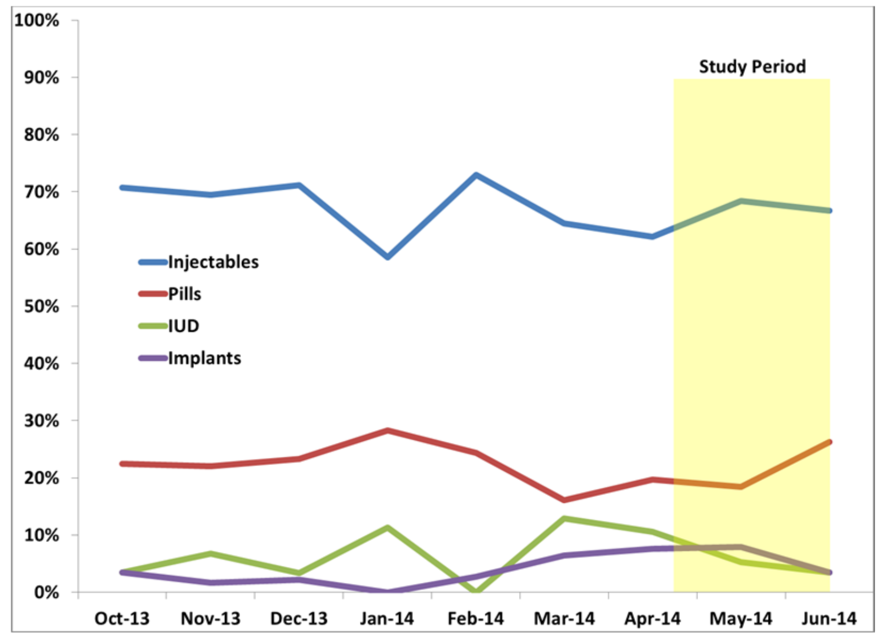


Figure 4. Percentage distribution of monthly contraceptive uptake before and during IPV pilot at AGBEF adult clinic, Conakry, October 2013–June 2014



All women who screened positive for IPV received information about referral services, along with a list of contact numbers and addresses. However, the project documented only one case of a woman accepting referral. The Lessons Learned section of this report discusses possible reasons for the low rate of referral uptake.

Project Evaluation

Client Exit Interviews

Exit interviews with clients were conducted to gauge the following:

- Experience with IPV screening and counseling
- Impressions of the provider's services
- Feelings about the integration of IPV screening and counseling within an FP clinic

Over the course of four weeks in May 2014, every client who received IPV screening and counseling was asked to participate in a brief exit interview at the end of the clinic visit. If the client agreed to participate, informed consent was obtained, and the client was interviewed privately by a data collector in a separate room. Each interview lasted approximately 15–20 minutes, and no compensation was provided. In total, 59 women (out of 59 approached) agreed to be interviewed, and 53 completed the entire interview.

Tables 4 and 5 show the interviewees' education and age. Most clients who were interviewed had completed at least a primary education, and 41% had some secondary education or higher. The women's mean age was 29 years, and the interviewees were fairly evenly distributed across age-groups, with the exception of 25–29-year-olds.

Table 4. Percentage distribution of interviewees, by level of education, AGBEF adult clinic, Conakry, May 2014

Level of education	N	%
None	14	23.7
Incomplete primary	11	18.6
Complete primary	9	15.3
Secondary	19	32.2
University	6	10.2
Total	59	100.0

Table 5. Percentage distribution of interviewees, by age-group, AGBEF adult clinic, Conakry, May 2014

Age-group	N	%
15–19	11	18.6
20–24	12	20.3
25–29	5	8.5
30–34	14	23.7
35–39	9	15.3
≥40	8	13.6
Total	59	100.0

Overall, women reported a very positive experience with IPV screening and counseling. Clients were asked to rate their experience via a series of statements, with scores ranging from 1 (strongly disagree) to 4 (strongly agree). Nearly every participant gave the maximum allowable positive score (4 out of 4) for each statement (Table 6). As with all client exit interviews, however, there is the possibility of a positive response bias.

Table 6. Mean score of clients on their experience with IPV screening and counseling, AGBEF adult clinic, Conakry, May 2014

Statement	Score (out of 4)
The provider explained things in a manner that I could understand.	3.96
The provider took the time to let me ask questions.	3.66
The provider told me that our conversation would be confidential.	3.83
The provider listened attentively when I had something to say.	4.00
The provider did not judge or blame me.	4.00
I believe the information I received is accurate.	3.98
I am confident that the provider will keep our discussion private.	3.74

Note: Scores could range from 1 (strongly disagree) to 4 (strongly agree).

When asked whether they thought IPV screening and counseling should take place during FP visits, all clients responded affirmatively. When asked why they believed IPV screening should be conducted, women noted the importance of raising awareness about violence among women and of providing a safe space for women to discuss this difficult topic. These responses may reflect the fact that women have few places to discuss IPV; simply being able to discuss this problem with a supportive and empathetic provider was perceived as a benefit. Responses hint at larger cultural issues that perpetuate the tolerance for violence within the community.

> "[IPV screening] is a good thing for women. We suffer, but we do not know what to do. Even if we suffer, parents say we must accept it so that our children can succeed tomorrow. What you started here is very good for us."
>
> —*Client, age 34, no education*

> "It helps us understand what violence is."
>
> —*Client, age 24, primary education completed*

> "Because this is a problem, we do not talk a lot. At home, a woman must accept everything. So I enjoyed today's discussion. I know that I can now entrust myself to the lady I talked with on this issue."
>
> —*Client, age 19, some secondary education*

> "[Violence] affects the majority of women. It is necessary that all women are helped to overcome it." —*Client, age 20, some secondary education*

All women interviewed said that they would recommend the clinic to other women. While some expressed general satisfaction with the overall clinic experience, others specifically identified IPV screening as their main motivation for a recommendation. Women also

expressed satisfaction with the FP services provided at the clinic, indicating that adding IPV screening did not dilute the quality of care provided.

> "If a person is suffering like me, I will have to tell her to come here for good advice." —*Client, age 35, no education*

Provider Interviews

As part of the evaluation, RESPOND project staff conducted in-depth interviews with the nurse-midwife who performed the IPV screening and counseling, the FP counselor who was trained and sensitized to the screening, and the independent consultant who cofacilitated the initial five-day training, led the follow-on training, and provided close supervision for the duration of the pilot. Even though the FP counselor was not primarily responsible for screening and counseling duties, she was asked the same questions as the nurse-midwife, since she had received the same training.

The interviews covered several topics, including:

- Did the providers feel prepared to implement IPV screening and counseling? Did they feel they had gained the skills needed?
- Which program elements were most helpful in preparing providers for IPV screening and counseling?
- What lessons were learned as a result of the pilot?
- How could future curricula and programs be improved?
- What was the positive or negative impact of IPV screening and counseling on FP services?

Preparedness, skills, and future intent to provide IPV screening and counseling

Both the nurse-midwife and the FP counselor felt that they were well-prepared to provide IPV screening and counseling as a result of the training and supervision they received. The two providers specifically cited the value and importance of both the original and follow-on trainings, supervision, simulated client interviews, and other practical experiences (e.g., filling out registration forms). Furthermore, when asked which type of support helped them the most, they both mentioned moral support *first* (followed by technical support/training and routine supervision). The consultant echoed the providers' views, citing the simulated client interviews and practice completing registration forms as keys to developing screening skills.

> "[I felt adequately prepared to provide IPV screening] because I participated in the training, then performed simulations during the follow-on session that took place before the start of clinic activities." —*Nurse-midwife*

As a result of the training, the providers said, they gained new skills in several areas: how to integrate IPV screening into routine FP services; how to screen women for IPV; how to counsel women on a variety of FP methods; and how to communicate with women about sensitive topics without causing harm or upset. The nurse-midwife noted that she felt comfortable providing referral services because of (a) visits to referral sites and (b) an IPV services mapping exercise conducted during training.

The two providers said they intended to continue providing IPV screening and counseling services after the pilot was over. As the nurse-midwife reported:

> "Yes, we will continue to follow women already screened; then, if we have management tools, we will continue to do the screening. Because it is very interesting, and women feel not only listened to, but also protected."
> —*Nurse-midwife*

Benefits of IPV screening and counseling

Providers reported several benefits of IPV/FP integration. Screening was seen both as a means of providing an important service to women in the community and as an additional way for providers to meet clients' needs.

> "I know that women are interested, and I feel useful to my community. And I help women like me, because we are all victims of violence." —*Nurse-midwife*

> "The screening helps our women who do not know their rights [with respect to violence]." —*FP counselor*

The nurse-midwife believed that IPV/FP integration had helped to increase clinic attendance and to improve the quality of FP services (e.g., improved counseling, client relations, and management of client records).

Challenges and suggestions for improvement

Respondents identified several ways in which training and implementation could be improved. They believed that the original training curriculum was too dense for a five-day period and overemphasized theory (instead of practical skills building). Providers reported having some difficulty in properly filling out screening and register forms and implementing security planning. In particular, they felt that the long safety plan (seven pages) was cumbersome for both themselves and clients. Furthermore, although the nurse-midwife did provide safety planning and IPV-related FP counseling, she felt stress at being unable to further address the issues that emerged during screening.

Both the consultant and the providers suggested the following improvements to the pilot:

- Extend the period of training to allow enough time to gain knowledge and to practice skills (e.g., conducting simulated client interviews, filling out forms, reviewing gender concepts)
- To continue the activity beyond the pilot period, provide sufficient copies of tools for client management (e.g., the implementation protocol, screening questionnaires, safety planning forms)
- Provide monetary compensation for providers who take on extra responsibilities
- Shorten the safety planning form, eliminating parts of it that do not pertain to the particular clinic's clientele (e.g., work safety planning)
- Provide emotional support to providers responsible for IPV screening and counseling (according to the nurse-midwife, "we realized that after screening, for a long period, you tend to be depressed")
- Provide psychosocial counseling at the clinic so that women can receive some IPV services on-site

Key Stakeholder Interviews

At the end of the project, steering committee members and clinic managers were asked their opinions about the pilot and their impressions about the scalability of similar activities in the future. Of the nine committee members interviewed, two were involved with the pilot at the clinic, and a third member visited the clinic to observe the pilot. Due to complications with an Ebola outbreak in Guinea during the pilot, the second committee member meeting was canceled, and thus some committee members had limited knowledge of the pilot results at the time of the interview.

Benefits of the pilot and the need for scale-up

Stakeholders identified several successful aspects of the pilot. Respondents felt that the training and close supervision were effective in creating a high level of technical competence and were simple enough to adapt and replicate in other settings. The data management tools were also singled out as effective means of collecting important client data for program use.

> "Despite the short duration of the project, our conclusion is that the project has not only affected a number of women, but it has strengthened the technical skills of providers and supervisors involved in the project."
>
> —*Steering committee member representing the MOHPH*

Beyond having programmatic benefits, the pilot was viewed as an essential service to women in the community. Stakeholders acknowledged the need to integrate IPV screening into FP services in Conakry and felt that future scale-up of the approach could benefit women across Guinea.

> "We realized that the need [for IPV screening] is there and it is real; the project is consistent with the needs of the population. Scale-up is necessary to benefit more women." —*Steering committee member representing the MOHPH*

> "Intimate partner violence is a scourge, and if we continue the integration [of IPV services into FP], it will permit effective care of family planning clients."
>
> —*Steering committee member*

One steering committee member reported that the pilot had built institutional capacity within the IPPF network, which could be leveraged to propagate IPV screening skills in other IPPF member clinics:

> "The project has strengthened the institutional capacity of our [member association]. We want to develop the same skills at other clinics."
>
> —*Steering committee member representing an IPPF member association*

Implementation challenges and suggestions for improvement

Respondents identified challenges and areas of improvement for the pilot; their opinions echoed many of the comments made by the clinic providers. Stakeholders felt that providers need monetary compensation for the added workload that IPV screening and counseling entails, particularly as a motivation to continue the work. Because of the limited uptake of referral services during the pilot, respondents recommended that psychosocial counseling be available on-site. Several stakeholders pointed out a need for more implementation time and a shortened version of the safety plan. Finally, one respondent suggested including a community

outreach component that would reach women beyond the clinic with information about IPV and related services.

Facilitators and barriers to replication and scale-up

When asked about facilitators to pilot replication and scale-up, stakeholders cited the importance of the following factors:

- Involving local authorities and opinion leaders
- Sharing the results of the current pilot
- Providing dedicated staff as facilitators

The integration format (i.e., adding IPV screening and counseling to existing FP services) was also seen as favorable to replication and scale-up.

Perceived barriers to replication and scale-up included inadequate funding, insufficient clinic staff, and lack of political commitment for IPV services on the part of MOHPH.

Lessons Learned

Feasibility of the Approach

This pilot project to integrate IPV screening and counseling into FP services in a low-income setting demonstrated that the approach is feasible. When providers are well-trained and receive facilitative, close supervision, they can gain the skills needed to deliver the services. From the clients' perspective, the integration of IPV screening and counseling into FP services is both needed and appreciated, as it allows women to discuss an issue that is culturally taboo in many settings. Including IPV screening did not negatively impact clients' willingness to use existing FP services. On the contrary, most clients accepted and appreciated the opportunity to speak out about their suffering and discuss ways to deal with it in daily life.

The Capacity-Building Process

Use of the curriculum and posttraining follow-up revealed several important lessons about how to create a successful IPV-FP integration curriculum. The first important lesson is to create a curriculum that is highly practical and adapted to the educational and skill levels of trainees. AGBEF providers reported that the curriculum should balance theoretical concepts with operational aspects of IPV-FP integration (e.g., simulated client interviews, practice using reporting forms). Some theoretical material in the original curriculum was too advanced for the providers' level of knowledge. Participants also reported the need for more time to absorb, review, and practice the curriculum content; the five days allotted to the initial training was not sufficient to cover all the material.

While revising the curriculum is important, the initial training activity was just one of several capacity-building elements; other major components were on-the-job training and supportive supervision. Both providers and trainers in the pilot felt that these two additional elements were successful and essential to operationalizing learning.

Based on experience during the initial training, follow-on training, and follow-up supervision, the following recommendations were made to make the curriculum more relevant and useful in future contexts similar to this one:

- The content of the curriculum should be simplified and adapted to the education and skill levels of participants.
- The section on communication should be reduced and simplified to focus on active listening and skills directly related to IPV screening and counseling.
- More time should be dedicated to role plays and practice with conducting IPV screening and counseling.

These suggestions were taken into consideration and added to the final version of the curriculum.

Other lessons stemmed from the pilot's collaboration with local IPV referral partners. Visits to AGUIAS and CONAG-DCF helped to familiarize FP providers with referral services and led to the development of a linkage coding system to track client referral visits to AGUIAS facilities. Although use of referrals was low in the pilot, this type of visit should occur during the initial training period, so the collaborating organizations can create relevant linkages and FP providers can improve their understanding of referral services.

Posttraining activities before service delivery begins are essential to ensure that providers responsible for IPV screening and counseling (and the facility as a whole) are ready and able to deliver the services. Such activities include:

- Posttraining visits to the clinic to provide facilitative supervision, additional training and support, and TA, as needed
- Monitoring meetings with the staff providing IPV screening in which they practice filling out forms (e.g., screening forms, confidentiality disclosure forms, safety plans)
- Simulated client consultations (in which the provider practices the full IPV screening and counseling process in the clinic, replicating the step-by-step process with a simulated client)
- TA in data management and quality assurance; if needed, this assistance can also address FP data management

Project Implementation

Even after implementation began, the RESPOND team continued to provide TA to the clinic; in particular, staff needed help with completing screening forms and developing safety plans. The ongoing guidance of technical experts led to a close working relationship between providers and the RESPOND team and provided ample support to clinic staff as they absorbed their new responsibilities.

As has been previously mentioned, one of the providers initially trained in screening was not available for the implementation period. As a result, one nurse-midwife was responsible for all IPV screening and counseling, as well as for her regular FP duties; in fact, her workload doubled over the course of the project. This provider understandably reported experiencing stress and fatigue. Ideally, to spread out the burden and to encourage sharing, clinics should have more than one provider conducting IPV screening and counseling. Originally, RESPOND envisioned regular meetings with several staff involved in screening so they could share experiences, challenges, and ways to deal with those challenges, including stress management. Because the nurse-midwife at the Conakry clinic was working by herself, she could not share her experiences with others, and she sometimes felt isolated. Training sessions had discussed secondary trauma (i.e., the stress resulting from treating or helping a person who has directly experienced trauma); however, given the burdens and stress experienced by the sole provider, RESPOND developed a discussion guide about secondary trauma that an AGBEF supervisor could use with her.

The length of the safety planning guide (seven pages) was an additional work burden for both the provider and for some clients. During TA visits, observers noted that the provider would feel overwhelmed by the safety planning guide and would instead conduct oral security

planning with the client. This resulted in a lack of uniformity in the way in which services were being delivered; thus, the RESPOND team asked the provider to use only the applicable sections of the guide (such as home safety planning), as opposed to reviewing the full form.

Both the nurse-midwife and the FP counselor believed that the nurse-midwife should receive monetary compensation for the additional services she provided. No extra incentives were provided to either the provider or clients because RESPOND believed that they would diminish the sustainability of the project; they would have also violated the Tiahrt amendment.[2]

Referrals

Throughout the project, providers were committed to helping clients understand that they do not deserve to be abused, that clients can take steps to help mitigate the situation, and that services that can potentially lessen the suffering associated with IPV are available. Clients who screened positive for IPV received a list of referral agencies available in the community. However, very few women expressed an interest in visiting referral sites; the project is aware of only one client who did so during the project. This situation was demoralizing to the provider, who viewed the lack of referral uptake as a mark on her performance. AGUIAS and AGBEF staff devised a system for tracking referrals, but because of the short project timeline and the low uptake of referral services, staff did not track any referral visits to AGUIAS.

Because of time limitations and the need for IRB clearance, staff were unable to follow-up with clients to investigate reasons for the lack of referral uptake. Project staff and providers together reflected on why clients were reluctant to use referral services. The sociocultural context, which is characterized by normalization of IPV and a taboo about discussing IPV, may stigmatize visiting services that are aimed specifically at IPV survivors. Furthermore, describing personal experiences of IPV can be difficult or traumatic for survivors; the prospect of repeating those experiences at a second location may be a barrier to referral uptake. The additional cost in money and time may also be prohibitively burdensome for some clients, particularly women who are responsible for the care of multiple children.

Furthermore, some women may have reported incidents that occurred a relatively long time ago; they may not have perceived an urgent need to seek additional assistance. At the same time, women who were experiencing recent, acute incidents of IPV (such as rape or a recent beating) might not have sought help from AGBEF but may have chosen instead to go directly to CONAG-DCF, AGUIAS, or even the police. Even though there was only one documented referral visit, 88% of clients who screened positive for IPV (Table 2) completed a safety plan, which provided a basic tool to help protect their personal safety.

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[2] The Tiahrt Amendment, which was enacted by the U.S. Congress in 1999, offers guidelines that USAID and their grantees must follow in FP programming. These prohibit FP providers from setting targets or quotas, providing clients with incentives to clients to accept FP, or withholding care or services if a client declines to use FP services.

Conclusions and Recommendations

The integration of IPV screening and counseling into FP services is a feasible and acceptable approach both for providers and for clients. The findings from this pilot project can be used to sustain and scale up the approach in Guinea and to adapt it for other, similar contexts. Even though the project demonstrated successes, this type of programming would work best as part of a broader multisectoral IPV initiative, with IPV screening and counseling in FP clinics as only one element of the larger approach. During the project, several changes were made to adjust to the different concerns and challenges that providers experienced. The curriculum was revised to simplify it and allow for more practice, and certain areas were given more attention than was initially planned (such as practice filling out forms).

The pilot project implemented many of the recommendations described below but was unable to implement them all. These recommendations should be considered by other programs interested in integrating IPV screening and counseling into FP services.

1. Design a curriculum that is appropriate for the level of the trainees; ensure that there is enough time for practice sessions on receiving clients, screening, counseling, administering and completing forms (e.g., screening, a safety plan), and storing records.
2. Allow for testing of a curriculum in the context and culture where it will be used. This project did not have the time or resources to thoroughly test the curriculum before the initial training, though it did modify the curriculum in response to training results and feedback.
3. Allow sufficient time and practice for the clinic to integrate IPV screening and counseling into their systems and operating protocols.
4. Stipulate that IPV screening and counseling will begin only when the responsible providers are ready to provide these services with skill and confidence.
5. Adapt the IPV screening and counseling process to the procedures already used at the implementing facility, to facilitate the work of providers and to avoid double paperwork.
6. Depending on the performance of providers after initial training, schedule refresher trainings that focus especially on practical skills.
7. Before implementation, allow for sufficient on-the-job practice through simulated client interviews. These exercises help to ensure that providers are well-prepared to follow all of the steps of the screening and counseling process. During implementation, continue simulated client visits as needed, to increase providers' skill and confidence.
8. Be mindful of staffing levels and provider workload at the clinic; sufficient staffing is needed to successfully sustain integration of IPV screening and counseling into an FP clinic. Ideally, several staff should be able to provide IPV screening and counseling so that they can share experiences, challenges, and strategies and help each other cope with stress.
9. Provide close facilitative supervision and TA, to ensure that the implementation process is progressing smoothly and that providers avoid burnout and have the support they need. A sample schedule is three visits per week over the first month, then two visits per week for one month, and then one visit per week until the service is well-established.

10. Provide a guide to help supervisors work with providers to prevent and manage secondary trauma. While this project developed a simple discussion guide toward the end of the project, more time and resources should be dedicated to this effort to ensure adequate support and assistance for staff.
11. Offer additional services to IPV survivors at the clinic, such as psychosocial counseling with experienced mental health or social work professionals, to ensure that survivors have increased access to basic services.
12. Conduct research studies to (a) document access to and utilization of referral services and (b) measure the impact of IPV screening and counseling on FP utilization, RH, IPV incidence, and survivors' well-being. Focus especially on benefits to FP clients and IPV survivors.
13. Implement this type of program as part of a broad multisectoral approach to IPV, which includes IPV prevention (e.g., promoting female empowerment, working with men to prevent IPV, challenging inequitable gender norms, and addressing structural barriers such as income and education), legal measures (e.g., laws against IPV, law enforcement measures), community responses to IPV (e.g., traditional justice, community-based prevention), and IPV response services (e.g., psychosocial counseling, legal aid, safe houses/shelters, medical services, income generation). This project focused solely on the FP clinic, but a wider programming approach would offer a more comprehensive solution and would help to address concerns raised by providers and staff who participated in this pilot project.

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APPENDIX

PROTOCOL FOR THE INTEGRATION OF FAMILY PLANNING AND INTIMATE PARTNER VIOLENCE SERVICES

Protocol for the Integration of Family Planning and Intimate Partner Violence Services

The RESPOND Project
August 21, 2013

Background on the Association of Intimate Partner Violence and Reproductive Health

Gender-based Violence and HIV. Gender-based violence (GBV), including intimate partner violence (IPV), is a risk factor for the transmission of HIV and sexually transmitted infections (STI).[3] A comparison of Demographic Health Survey (DHS) data from nine countries showed that women who experience domestic violence are up to 50% more likely to report an STI compared to women who did not report violence.[4] Surveys have also shown that men who are physically and sexually violent are more likely to engage in behaviors that put them at greater risk for HIV. Women who have experienced physical and sexual violence are also more likely to be vulnerable to HIV. For example, women who have partners who are violent are more likely to report that their partners have multiple sexual partners compared to women who have partners who are not violent.[5]

Gender-based Violence and Family Planning (FP). In terms of family planning, women who experience violence may be less likely to achieve their desired family size. A comparison of DHS data in nine countries showed an association between violence and fertility. Women who experienced violence had higher fertility rates in all nine countries though the direction of causality is not clear. The likelihood of a woman having an unwanted birth was found to be significantly higher if she had experienced violence than if she had not. Also, women who experienced domestic violence were more likely to either use family planning clandestinely or to have an unmet need for family planning. [6]

The Role of Family Planning/Reproductive Health Providers. If family planning and reproductive health providers are unaware of, or are unable to recognize signs and symptoms of IPV, and do not have procedures to respond to IPV, they may fail to meet their client's needs and may even inadvertently contribute to a client's sense of disempowerment. Women often underreport violence to health and legal services providers because they fear they will be doubted or blamed. They also fear that providers will fail to maintain confidentiality and privacy, and/or be unable to provide options for services or support. To meet the reproductive health needs of their clientele, it is important that FP providers be sensitive to the issues associated with IPV and cognizant of survivors' medical, psychosocial, legal, and economic needs.

Benefits Associated with Screening for Intimate Partner Violence. Screening family planning clients for IPV can yield positive outcomes including:

- The ability to respond and treat using a more comprehensive approach.
- Shed light on pre-existing conditions that are a direct result of IPV, including but not limited to: Unplanned pregnancy; sexually transmitted infections; mental health disorders; drug or alcohol dependencies; and untreated traumatic injuries.
- Provide an opportunity to connect survivors with additional care and support services.

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[3] http://www.ghi.gov/resources/guidance/161891.htm
[4] Kishor, Sunita and Kiersten Johnson. 2004. *Profiling Domestic Violence – A Multi-Country Study.* Calverton, Maryland: ORC Macro.
[5] WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses / authors: Claudia García-Moreno, et al; WHO 2005.
[6] Kishor, Sunita and Kiersten Johnson. 2004. *Profiling Domestic Violence – A Multi-Country Study.* Calverton, Maryland: ORC Macro.

- The opportunity to safety plan and identify methods of harm reduction with clients.
- Build mutual trust and confidence with clients.
- Impart knowledge about the prevalence of IPV, and normalize client experiences and reactions.
- Educate clients about their medical and legal rights.
- Assist clients in making informed and voluntary family planning and reproductive health decisions that take into consideration their relationships and IPV they have been experiencing.

Family Planning-Intimate Partner Violence Integration Protocol

The Family Planning-Intimate Partner Violence Integration Protocol presented here includes suggested opportunities for integrating IPV screening into family planning counseling sessions. IPV can be described as physical, sexual, or psychological harm by a current or former partner or spouse. In an effort to provide a seamless transition, this protocol builds upon the GATHER Approach for Family Planning Counseling, while aligning with standard operating procedures[7] for responding to gender-based violence in humanitarian settings. It should be noted that this protocol is specific to environments with little access to low-cost or free specialty referral services for survivors of IPV, including legal assistance, psychosocial support and follow-up medical care. Therefore, the screening suggestions are intended to yield results that generate a more holistic assessment of a client's family planning and sexual and reproductive health needs, including additional health care referrals to treat injuries sustained by IPV, and referrals to community-based resources and services that support survivors of IPV. This protocol incorporates principles of harm reduction[8], and a supplemental tool that clients may choose to complete - with assistance from a provider - and keep in their confidential case file. The tool was created as a means of acknowledging and honoring the need for safety planning, while recognizing the lack of intervention services in under-resourced communities.

The following supplemental materials are referenced throughout the protocol, and provided at the conclusion of the protocol:

- Confidentiality Release Form;
- IPV Questionnaire and Documentation Form;
- Family Planning Methods and IPV-Related Benefits and Risk Guide;
- Personalized Safety Plan;
- Community Resource Map (template only); and,
- Community Resource Guide (template only).

Family Planning Counseling Standards that Integrate Intimate Partner Violence Screening and Support Services. Similar to general health care screenings, screening for IPV should occur each and every time a provider meets with a client. Intimate partner violence evolves over time, and often follows a cyclical pattern of escalation and de-escalation of violence. Some sources argue that ongoing, routine screening can cause clients to shy away from services due to the stigma and shame of having to disclose or discuss IPV. However, effective screening questions are gently worded as not to alienate clients from the provider. When asked routinely, screening questions help to normalize and qualify the

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[7] IASC Sub-Working Group on Gender and Humanitarian Action. *Guidelines for GBV Intervention in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies."* IASC, 2008.

[8] http://harmreduction.org/about-us/principles-of-harm-reduction/

experiences of IPV survivors. Lastly, routine screening supports the fact that reproductive health and family planning can be directly impacted by the cycles of IPV.

The following standards for FP counseling should remain true when screening for and providing basic intervention services for clients experiencing IPV:

- The right to private and confidential counseling services.
- The opportunity to express feelings and opinions, free from judgment on behalf of the provider.
- The right to access information related to reproductive health care treatment and case management plan.
- The autonomy to make the best decision(s) for self and family, based on informed consent, and consistent with cultural, religious, moral or ethical belief systems and taking into consideration client's own conditions and circumstances.
- The opportunity to ask questions, and receive comprehensive answers.
- The right to request a different provider if not satisfied with care and treatment.
- The right to request a provider that is of the same gender.
- The right to decline care and/or referral services.

In addition to general counseling standards, clinics should utilize a client-centered approach to providing care and family planning services.

GATHER Approach for Family Planning Counseling. GATHER is a client-centered approach to providing family planning services, wherein the client's environment and circumstances are taken into consideration, as these factors likely impact the client's family planning needs. GATHER requires two-way communication between a client and a provider, in which both parties are actively engaged in the conversation. It is the provider's responsibility to guide the conversation, while providing the client with the opportunity to ask questions and to express her family planning needs and desires. After presenting the client with her options, the provider is to assist the client in making an informed and voluntary decision regarding her family planning method. Informed and voluntary decisions result in client satisfaction and empowerment. Thus, clients are more likely to use the family planning method and to return to the clinic as needed.

Separated into six fluid steps, GATHER is as follows:

Step 1	G: Greet the client respectfully.
Step 2	A: Ask the client about her family planning needs.
Step 3	T: Tell the client about different contraceptive options and methods.
Step 4	H: Help the client make an informed and voluntary decision regarding family planning.
Step 5	E: Explain and demonstrate.
Step 6	R: Schedule the client for a return visit. Provide the client with a referral if necessary.

Integrating Intimate Partner Violence Services within GATHER. Because of the documented impact IPV can have on a victim's sexual and reproductive health, it behooves clinics to integrate IPV

screening and intervention services into family planning visits. Screening for IPV and responding accordingly, is an aspect of providing client-centered care; the GATHER approach can easily be expanded to accommodate the screening and response. With proper training on the dynamics of IPV, providers have the unique opportunity to strengthen their clinical practice and to provide more comprehensive information to their clients. In turn, a client is even more equipped to make an informed and voluntary decision about her family planning need, and the option to receive additional IPV-related support should she so choose.

Maintaining the original steps of GATHER, IPV services can be integrated as follows.

Step 1	G: Greet the client respectfully. ***IPV Services Integration:*** Demonstrate – visually and verbally – the clinic's commitment to the holistic care of clients. Explain the need to ask private and/or sensitive questions regarding IPV during the counseling session.
Step 2	A: Ask the client about her family planning needs. Assess her risk for HIV/STIs. ***IPV Services Integration:*** Screen for potential incidences of intimate partner violence.
Step 3	T: Tell the client about different family planning methods. ***IPV Services Integration:*** Explain the STI/HIV risks and IPV risks resulting from each option.
Step 4	H: Help the client make an informed and voluntary decision regarding family planning. ***IPV Services Integration:*** Take into consideration the impact of IPV. Help the client develop talking points to be used with her partner.
Step 5	E: Explain and demonstrate how and when to use the method of contraception. ***IPV Services Integration:*** Take into consideration the impact of IPV, and develop strategies for harm reduction.
Step 6	R: Return/refer - schedule a return visit and follow up with the client. ***IPV Services Integration:*** Remind the client that she may return to or call the clinic with any problem or concern regarding her family planning decision. Safety plan with the client, and communicate that the clinic will remain a safe place for her to return to should she need further assistance addressing the IPV. Refer the client to any and all community-based IPV intervention services.

The remainder of this protocol will take an in-depth look at how clinics can expand on each of the six GATHER steps in order to improve clinic culture, strengthen provider-client interactions and empower clients to make voluntary and informed decisions that take into consideration the impact of IPV.

GATHER Step 1 **G: Greet the client respectfully.** ***IPV Services Integration:*** Demonstrate – visually and verbally – the clinic's commitment to the holistic care of clients. Explain the need to ask private and/or sensitive questions regarding IPV during the counseling session.	I. Using visual and print messaging II. Ensuring client confidentiality III. Strengthening provider greeting and introduction

In order to create an environment conducive to inviting disclosures of intimate partner violence, the clinic must focus attention at multiple levels – from how the clinic is organized, to the print and visual messaging available to clients, to the staff members' interactions with clients. The manner in which a clinic expresses its commitment to clients will greatly impact whether or not a client feels safe to express her needs, concerns and fears to a provider.

- **Using Visual and Print Messaging:** Acknowledging the prevalence of IPV must begin the moment a client walks through the clinic doors. In addition to family planning education materials (e.g., pamphlets, posters), the clinic should incorporate materials and messages that raise awareness of what constitutes IPV, rejects IPV and promotes healthy and caring relationships. This type of messaging provides one mechanism for building rapport and trust with clients, in addition to:
    - Affirming that a clinic is not only interested in the family planning aspects of its clients' lives, but also their overall wellbeing;
    - Communicating the clinics policy for screening all clients for IPV;
    - Introducing the concept of IPV to clients who are unfamiliar with the term or concept of IPV;
    - Providing a space to think about the nature of one's personal intimate partner relationship *before* difficult questions are posed during the screening process with the family planning provider;
    - Acknowledging the impact IPV may have on the family planning and reproductive needs of clients;
    - Catering to diverse sensory processing styles – clients with varying degrees of literacy.

- **Ensuring Client Confidentiality.** A client's decision to disclose IPV may be contingent on the clinic's overall commitment to maintaining client confidentiality. The safety of a client experiencing IPV can be directly impacted by the level of confidentiality they are provided. If confidentiality in any area, and particularly in IPV, is broken the client's risk of danger will increase

  Clinics should integrate the following IPV-related confidentiality guidelines into the existing confidentiality policy:
    - *Informing Clients of Their Right to Confidential Family Planning and Reproductive Health Care Services*
        1. The clinic's policy for ensuring client confidentiality should be clearly posted throughout the clinic.
        2. At the beginning of each counseling session, the provider is to assure a client that information shared in a counseling session will remain confidential. If the clinic has any exceptions in its confidentiality policy, providers should articulate as such to the client.
        3. The provider is to ensure that counseling sessions are held in a room that offers visual and audio privacy, and communicate as such to the client.

4. If the provider anticipates the need to release information for referral purposes, the provider must have the client sign a *Confidentiality Release Form* prior to leaving the clinic. This form should be completed for each referral source. As a means of restoring power and control to the client experiencing IPV, it is important to allow the client to articulate the amount and type of information that is released to another provider.

- *Storing and Accessing Client Case Files*
  1. All client files are to be stored in a locked filing cabinet. This filing cabinet is located in [insert location]. The following individuals have keys to the filing cabinet: [insert names]. The following individuals have keys to the office in which the filing cabinet is stored: [insert names].
  2. Client files are to be reviewed during clinic hours, only: [insert clinic hours]. All open client files are to be returned to the locked cabinet prior to the close of business day.
  3. A client's case file may be removed from the cabinet and reviewed only: a.) If the client is currently in the clinic; b.) If the client is in need of follow-up or referral services; or, c.) If the client is requesting a copy of their medical records.
  4. The following job functions have permission to remove and review client files: [insert job function].
  5. Access to client case files shall be denied to any party without the written consent and signature of the client receiving services.

- *Releasing Client Information to External Parties*
  1. Under no circumstances may a clinic release any written or spoken documentation of a client's information without the written consent and signature of the client receiving services. This information includes, but is not limited to: medical records; treatment plan and outcome; dates of service; test results; disclosure of intimate partner violence and subsequent, personalized safety plan.
  2. Under no circumstances may a clinic release the contact information or location of a client without the written consent and signature of the client receiving services.

- *Maintaining Confidentiality Beyond the Clinic*
  1. Under no circumstances will a client, or a client's clinic visit(s), be referenced outside of the clinic.
  2. Under no circumstances will an off-duty clinic employee follow-up with a client regarding their clinic visit, even if there is concern for the safety and wellbeing of a client experiencing IVP.

- **Strengthening Provider Greeting and Introduction.** The perceived interaction between a client and a provider is one of the most important aspects of communicating a clinic's commitment to the holistic care of its clients. All clients, and especially clients who have experienced IPV, are intuitive and receptive beings. Their willingness to disclose their needs, concerns and fears often depends on how they interpret their provider's use of verbal and non-verbal social cues. Providers should incorporate the following verbal and non-verbal elements into their greeting and introduction to the client.
  1. After the provider introduces self and welcomes the client to the clinic, the counselor will invite the client to take a seat. The room in which the provider and client meet should be in

private setting, where there will be little to no interruption from others, including telephone inquiries. The door should remain closed until the session is finished.

2. If the provider's chair is sitting behind a desk, the chair should be moved away from the desk so the provider and client are sitting face to face. The height of the provider's chair is equally important. In health care settings, there is already a power imbalance – the provider, inherently, has more power than the clients. If possible, the provider should lower their chair so that the provider and client's heads are at the same level.
3. The provider should thank the client for coming to the clinic today.
4. The provider should then inform the client of their right to confidential family planning and reproductive health care. (See *Informing Clients of Their Right to Confidential Family Planning and Reproductive Health Care Services* under "Ensuring Client Confidentiality.")
5. The provider should be always mindful of their body language, remaining "open" to giving and receiving the client's information by not crossing their legs, or crossing their arms over their chest. It is important that the provider match the cultural standard for using eye contact.

GATHER Step 2 **A: Ask the client about her family planning needs. Assess her risk for HIV/STIs.** ***IPV Services Integration:*** Screen for potential incidences of intimate partner violence.	I. Pre-screening conversation II. Provider Interview A. Family planning need and desired outcome B. Intimate partner violence screening questionnaire

As indicated in GATHER Step 1, building rapport with a client begins the moment the client walks through the clinic door, and during the provider greeting and introduction. In GATHER Step 2, the provider is charged with the responsibility of deepening the rapport in order to assist the client in making informed and voluntary decisions about her FP needs. During a brief, pre-screening conversation, the provider should communicate to the client that the clinic is committed to addressing her needs from a holistic perspective – one that takes into consideration her personal life and support network. Additionally, the provider should express trust in the client's ability to make healthy and sound decisions about her FP needs. After doing so, the provider may continue to provider interview, asking about the clients FP needs and desired outcome and screening her for IPV.

- **Pre-Screening Conversation.** The provider should inquire about the client's personal life and support network - if someone accompanied her to the clinic and/or if anyone in her life knows of her visit to the clinic, if she is bearing the burden of FP on her own. Survivors of IPV are often isolated from their family, friends and community. The provider should learn more about the client's family, friends, and acquaintances. Talking about reproductive health is often seen as a "private" matter; if the client has someone in her life that is also accessing FP services, perhaps that person could later serve as an ally if need be.

  The provider may transition into the provider interview at any point during the pre-screening conversation.

- **Provider Interview.** In health care settings, the provider interview is the most common place for disclosures of IPV to occur. While it is a provider's job to gather pertinent information, all too often questions about IPV are overlooked, and IPV can go undetected. Some providers are charged with caring for large numbers of clients in a short period of time, and so the thought of adding a set of questions might feel frustrating. However, the more a provider knows about the client's current situation and recent history, the more helpful a provider can be in assisting a client in making an informed and voluntary decision about FP. If the client is presenting with multiple concerns, asking about IPV – and receiving confirmation of IPV – might also help speed up the diagnostic process. Though, if a client seems resistant to disclose information related to IPV, the provider should respect her boundary and cease asking additional IPV-related questions, even if the provider suspects IPV. Because clients experiencing IPV have been conditioned by their partners to remain silent and/or reserved, it is likely that that client will need to form a trust – a bond – with a provider before they feel safe and comfortable disclosing of information. This bond may not form until the second or third visit and, thus, why it is important to screen clients for IPV each and every visit. Ignoring a client's wishes can feel similar to the mistreatment she is experiencing at home – the lack of control she has over her life.

The provider should incorporate the following verbal and non-verbal elements into their provider interview:

1. The provider should explain that the FP questions they will be asking are questions asked of every client. Additionally, the provider should explain that the clinic also routinely screens for IPV, that the information the client shares may have a direct impact on their FP decisions, and how to implement the decisions. The provider should acknowledge the private and sensitive nature of the questions, and reiterate that the information the client shares with the provider will remain confidential.
2. The provider should ask permission to inquire about the personal aspects of the client's life, and state that the client has permission to stop the question process at any point. If the client agrees, the provider should ask open-ended questions, and stress that there are no right or wrong answers to the questions. And, that there will no negative consequence to the client should she opt not to answer a question.
3. If the provider finds that the nature of the questions unintentionally upsets the client, the provider should acknowledge the client's emotions, and ask if there is anything the provider can do to make the client feel more comfortable.
4. The provider should use care and compassion while asking questions, speaking slowly with a tone of voice that is quiet and calming.
5. To demonstrate comprehension and active listening, the provider should paraphrase and reflect back the information the client is sharing in regards to the questions. The provider should allow for moments of silence so the client has time to process the question. The provider should never interrupt the client.
6. The provider should use encouraging statements throughout the interview such as, "The information you are sharing with me is important information," and "Thank you for sharing this information with me."

- *Family Planning Need and Desired Outcome*

  The provider should follow standard clinic protocol for inquiring about a client's family planning needs and desired outcome. While doing so, the provider should keep in mind that an additional technique used to detect IPV without asking pointed questions, is to learn details of the client's family planning decision-making process and desired outcome. Is the client's partner actively engaged in the process? Is there equal participation from both parties on how to proceed? Is there one partner who wants something different from the other partner? If FP decisions are not mutually agreed upon, the counselor should inquire about which partner has more power and control over the situation.

  The following questions may help the provider detect IPV prior to conducting the IPV screening questionnaire:

  1. "Was there a particular reason or experience that encouraged you to come to the clinic today?"
  2. "What are your goals for FP?"
  3. "What are your partner's goals for FP?"
  4. "What does your partner think about your decision to use FP, to have/or not have children anymore?"
  5. "What would happen if you decided upon a different route for FP than your partner?"

The provider should be cognizant of any risk factors that surface during the pre-screening conversation and the family planning discussion with the client. These factors should be further explored during the IPV screening questionnaire.

- Client implies a level of urgency in needing to get to the clinic.
- Client's intimate partner is unaware of visit.
- Client needs to keep her visit a secret from anyone, including family members.
- Client is unable to identify anyone in her life with whom she can speak about FP.
- Client is unable to articulate her own FP goal, but able to articulate her partner's FP goal.
- Client indicates that her partner will be anything other than supportive, if she decides upon a different route for FP than her partner's desired route.
- Client's FP goal differs significantly from her partner's FP goal.

- *Intimate Partner Violence Screening Questionnaire*

The *Intimate Partner Violence Questionnaire and Documentation Form* every client who receives services, and at each of the client's subsequent visits. It can be challenging to ask and to answer questions regarding one's intimate partner relationship. The provider should assure the client that the line of questioning is routine and will help the client make decisions that better suit her circumstances. The provider, again, should remind the client that anything she shares will remain confidential and that she may end the questionnaire process at any point and still receive services.

The following questions appear on the *Intimate Partner Violence Questionnaire and Documentation Form*:

1. "What happens when you and your partner argue about something?"
2. "Can you think of a time when you have ever been fearful of your partner's behavior or actions?"
3. "How does your partner respond when you express your opinions, concerns or desires?"
4. "Can you think of a time when your partner has ever said something to you that has made you feel badly about yourself? How long did the bad feeling last?"
5. "Can you describe a time when your partner has threatened to harm you physically (scratch, slap, hit, bit or pushed)?"
6. "Can you describe a time when your partner has hurt your physically (scratch, slap, hit, bit or pushed)?"
7. "Has your partner ever forced you to participate in or do things you don't want to do sexually?
8. "How do you currently negotiate FP decisions? What would happen if you decided upon an FP method that contradicted your partner's FP outcome?"
9. "Has your partner ever forced you to have sexual intercourse as a means of getting you pregnant or because you didn't want to have sex?"

It is likely that some of the questions on the *IPV Questionnaire and Documentation Form* will upset the client. It is important that the provider try not to minimize the abuse the client is experiencing. IPV is a mechanism that is used to exact power and control over another individual, often leaving the abused individual feeling isolated and without the ability to share her thoughts and opinions. This presents a unique opportunity for the provider to, momentarily, restore power and control to the client. In order to accomplish this, the provider

should proceed with questioning at the client's pace, and regularly check in about whether or not the client would like to continue to answer the questions being presented to them.

If none of the questions resonate with the client, then the health care provider can proceed with the rest of the FP visit. However, if one or more of the questions does, in fact, resonate with the client, the health care provider should proceed with the following two steps:

1. Show empathy to the client.
   "I am sorry to hear your partner has treated you in this way. What you are experiencing are forms of intimate partner violence. This is something that many of my clients have dealt with at some point in their lives. What is happening to you is not okay, and I want you to know that this is not your fault. You are not doing anything wrong to cause your partner to treat you in this manner. While I am not an expert in intimate partner violence, there are other organizations and providers who work – everyday – with women who are experiencing similar things to what you have experienced. Thank you for sharing this important information with me. What I can help you with today, is making certain that we meet your most immediate family planning needs as they may be impacted by the violence you are experiencing. I can also provide you with information about the additional support services that are in our immediate area."
2. Offer the client additional support. If the clinic has additional trained staff members who are free, the provider might present the option of having a staff member serve as a support person. If the client was accompanied by a person other than the abuser, the provider might suggest that person join the session if the client has or would feel comfortable sharing information about her experiences with that person.

GATHER Step 3 **T:** Tell the client about different family planning methods. ***IPV Services Integration:*** Explain the STI/HIV risks and IPV risks resulting from each option.	I. Link between intimate partner violence, family planning and women's reproductive health. II. Family planning methods: considerations for clients experiencing.

Family planning counseling often consists of the provider and client discussing the benefits, risks and side effects of each method. When working with clients experiencing IPV, a provider should also infuse the conversation with information about the dynamics of IPV, the linkages between IPV, FP and RH, as well as IPV-related risks associated with each method. As with any client, the provider must also consider other RH services the client may need; the need will likely increase for clients experiencing IPV.

Before providing the client with facts regarding IPV, the provider should ask the client if they would like information on how their FP and SRH may be impacted by what they are experiencing in their home. If the client so chooses, the provider should use care and compassion when describing the dynamics of IPV, potential health outcomes that result from IPV, increased risk for SITs, and, if applicable, IPV during pregnancy. The provider should create structured space for the client to ask questions, and allow the client a few moments to process the information she has been given. The provider should then ask permission to explore the client's family planning options and the potential need for additional sexual and reproductive health care services, taking IPV into consideration for both.

In order to best assist a client in making an informed and voluntary decision about her FP and RH needs, a provider must be cognizant of the documented linkages between IPV, FP and women's reproductive health.

- **Link between intimate partner violence, family planning and women's reproductive health.** Research indicates that IPV will, undoubtedly, impact a client's family planning and sexual and reproductive health. The following realities are commonly experienced by FP and RH clients experiencing IPV:
  - IPV is more common among women who choose not to disclose of an abortion to their partner.
  - Unplanned pregnancies increase women's risk for violence. Violence increases women's risk for unplanned pregnancies.
  - Clients, who are forced to hide their FP methods from their abuser, often struggle to return to the clinic for follow-up visits.
  - Women experiencing physical and emotional IPV are more likely to report not using their preferred method of contraception.
  - Young mothers who experience physical or sexual IPV within three months of giving birth are nearly twice as likely to get pregnant, again, within 24 months.
  - Physical violence increases the risk of STIs by three times. Psychological abuse increases risk of STIs by 2 times.
  - Women experiencing IPV are more likely to experience: urinary tract and vaginal infections; painful sex and vaginitis; pelvic inflammatory disease; and, chronic pelvic pain.

- Women who have experienced IPV are almost 3 times more likely to be diagnosed with invasive cervical cancer.
- Women experiencing IPV often cancel or miss appointments due to their partner controlling their whereabouts.

Additionally, it is not uncommon for perpetrators of IPV to use the following tactics to control their partners' FP:
- Throw away or destroy methods of contraception;
- Tamper with barrier methods to render them ineffective; and,
- Force pregnancy as a means of increasing a victim's dependency on the perpetrator.

- **Family Planning Methods: Considerations for Clients Experiencing IPV.** The provider must honor the client's desired FP outcome – to have/not to have children – regardless of whether the client is experiencing IPV. However, this does not mean a provider should shy away from informing a client of the potential risks associated with her FP decision as a result of the IPV she is experiencing. This is not an attempt to sway the client from their decision, but rather an opportunity for the provider and client to further explore the client's environment and pertinent circumstances. This process supports the informed and voluntary decision making of the client.

  The FP needs of client's experiencing IPV are often times more complex than the needs of clients not experiencing IPV; implementing the use of a method requires planning on multiple levels, as to avoid escalating the IPV perpetrated by her partner. The following elements should be taken into consideration when discussing FP with a client experiencing IPV:
  - Does the client's desire FP outcome differ from her partner's desired FP outcome?
  - What would happen if the client did not follow the wishes of the partner?
  - Does the client's partner have a history of sabotaging FP methods?
  - Does the client need a method that can be concealed from her partner?
  - Is the client able to negotiate the use of barrier methods?
  - If the client needs a method that can be concealed from her partner, how will she reduce her risk for potential STIs?
  - Does the client have the ability to return to the clinic for regular visits? Will she need a long-term method of birth control?
  - Does the client have the ability to abstain from sexual intercourse?
  - Did IPV increase during her last pregnancy, and/or after the birth of her last child?

  Providers may refer to the *Family Planning Methods and IPV-Related Benefits and Risk*s *Guide* at the end of this protocol for comprehensive information about each FP method, and its respective benefits and risk for clients experiencing IPV.

GATHER Step 4

H: Help the client make an informed and voluntary decision regarding family planning.

IPV Services Integration: Take into consideration the impact of IPV. Help the client develop talking points to be used with her partner.

I. Informed and Voluntary Decision Making (IVDM)
II. Restoring power to a client experiencing IPV
III. Strategies for addressing FP methods with abusive partners
IV. Documenting intimate partner violence

- **Informed and Voluntary Decision Making (IVDM).** The decision making phase of FP counseling is key to supporting a client's autonomy. The role of the provider is to explore whether or not another person is influencing the client's decision, which is likely the case for clients experiencing IPV. The provider must also be aware if/when they may be putting pressure on the client to make the decision that seems medically "correct." While a provider's opinion needs to be considered in the decision making, the client should feel that she has reached her decision for her own reason.

  Research indicates that informed decisions lead to better method use, client compliance with treatment regimens and client satisfaction. IVDM allows clients to have power and control over their bodies and lives. For clients experiencing IPV, IVDM helps to *restore* power and control over their bodies and lives.

- **Restoring power to a client experiencing IPV.** In general, the following five factors influence an FP client's decision:
  1. Their environment (social and culture factors);
  2. Their knowledge and understanding;
  3. The possible outcomes of their decision;
  4. Their access to resources; and,
  5. The laws, policies and service-deliveries of the region.

  An IPV client's decision is further impacted because:
  - Their environment is constantly shifting due to the cycle of violence;
  - They are conditioned to believe that their thoughts and opinions don't matter, and there are often consequences for voicing those thoughts and options;
  - Information is often withheld from them – having information is equated to having power;
  - They can often predict what the outcome will be, and if the process is her idea, the outcome is often not good;
  - Their resources are often limited – having resources is equated to having power; and,
  - Depending on location, social norms and practices, IPV may not be recognized as a crime.

  Using IVDM, the provider has the unique opportunity to directly address the factors that further impact the decisions of clients experiencing IPV. The provider can increase the client's knowledge and understanding of her FP and RH rights. Together, the provider and client can explore the cycle of violence she experiences, and predict the possible behaviors and actions of an abusive partner as it relates to her FP decisions. The provider can validate the client's experience, and acknowledge the impact it has on her FP and RH; thus, the provider and client can explore

options that can help reduce the impact of IPV. The provider can communicate trust in the client's ability to govern her body and her life by empowering her to make the best decision for her.

- **Strategies for Addressing FP Methods with Abusive Partners.** Survivors of IPV are incredibly intuitive individuals and learn to quickly assess their surroundings for danger; they can often predict the onset of a violence incident. Additionally, survivors of IPV have a good sense of what "triggers" their partner's violence; it is not uncommon for survivors to utilize their own tactics to deescalate their partner's violence.

  If a client experiencing IPV chooses an FP method that does not align with her partner's desired outcome, the provider should inquire about the potential downfall of such a decision. If the client feels comfortable doing so, the provider and client can develop strategies for dealing with the downfall, including the following:
  - In an effort to avoid alarming her partner that she is be using an FP method, the client might consider *not* altering her behavior or actions surrounding FP. For example, if the client has consistently negotiated barrier methods with her partner, she might continue to do so.
  - If using a detectable method of FP, the client will need to find a secure location within the home to hide the method from her abusive partner.
  - If the partner suspects the use of hormonal methods, the client might consider using the excuse that the method helps to control her menstrual cycle and stave off monthly sickness or cramping associated with her menstrual cycle.
  - If the partner suspects the use of hormonal methods, the client might consider denying the use by stating her inability to use hormonal methods because of an allergy.
  - The client might consider having the provider give a fictitious report to the abusive partner.
  - If using a method that requires frequent visits to the clinic, the client might consider telling the partner that the visits consist of interventions to *help* her become pregnant.

  The provider should be certain to communicate to the client that these strategies cannot prevent incidences of violence, but they may help to reduce number of incidences and the harm caused by IPV. These strategies should be weaved into the client's *Personalized Safety Plan*.

- **Documenting Intimate Partner Violence.** The provider should ask the client for permission to document the information she has provided during the IPV screening and FP counseling session. Documenting findings of IPV serves a number of purposes, including:
  - Establishes a formal record of a pattern of abusive behavior on behalf of the abuser;
  - Creates awareness for future screenings;
  - Prevents the client from having to repeat their story to each and every provider they encounter in the clinic; and,
  - Supports the fact that the clinic regards intimate partner violence as a serious health matter.

  Documentation, within the realm of FP, should not be confused with documentation that may take place during a forensic medical exam. Rather, FP documentation should consist of a short basic form, accompanied by sections for follow-up and referral recommendations. The provider is to pay close attention to the following items and record any findings on the *IPV Questionnaire and Documentation Form*:

1. Physical Findings: Contusion, abrasion, laceration, bleeding or tenderness to the head, ears, nose, cheeks, mouth, neck, shoulder, arms, hands, chest, back, abdomen, genitals, buttocks, legs and feet.
2. Psychological/Emotional Findings: depression, loss of trust, fear, anxiety, guilt, shame, tension, low self-esteem, high suicide risk, body aches, trouble sleeping or sleeplessness.

It is not uncommon to complete a physical assessment that yields no physical findings; wounds can heal quickly, but the psychological and emotional impact of IPV is long-lasting. Therefore, the provider should record the client's report – using quotations – on the *IPV Questionnaire and Documentation Form*.

Lastly, it is not uncommon for clients experiencing intimate partner violence to feel shameful about the abuse they have experienced. Some clients feel uncomfortable naming the parts of their body where trauma or abuse has occurred. In these instances, the provider may incorporate the use of a "body map" (found on the *IPV Questionnaire and Documentation Form*) to document the area on the body, and the type of injury that occurred.

GATHER Step 5 E: Explain and demonstrate how and when to use the method of contraception. ***IPV Services Integration:*** Take into consideration the impact of IPV, and develop strategies for harm reduction.	I. Intervention II. Personalized safety plan

- **Intervention.** Integrating IPV screening into FP services, and providing tailored IPV-FP care, *are* methods of intervening in IPV. The provider's reaction to a disclosure of IPV can also serve as a point of intervention. How the provider responds to the disclosure of IPV – positively or negatively – will contribute to the client's understanding of their experience, shape their help-seeking behaviors and grow or diminish their self-worth. Following a disclosure of IPV, it is imperative that the provider remain composed and professional, offering services that are within the realm of their expertise, and not promising the client something the provider cannot offer.

  Providing intervention services can be quite challenging. While some providers want to leap into action, clients experiencing IPV often need time between their initial disclosure and their first action step. This can be confusing and frustrating for an outsider, but the client's reaction and behavior is directly linked to the complexities that exist within IPV, including, but not limited to:
  - Client loves their abusive partner, and has built a life with them.
  - Client feels responsible for the abuse that is being perpetrated on them.
  - Abuse escalates and de-escalates; the client believes that the abuse is just a phase in their relationship.
  - Client feels as if they do not have the power to change their situation.
  - Dependence on abuser/Abusive partner is the sole provider of the family.
  - Client has children with their abusive partner.
  - Client is afraid of their abusive partner.
  - Client is in denial about the IPV they are experiencing.
  - Client is without a support network, or feels isolated from their family, friends and community.
  - Social stigma associated with being a victim of IPV.
  - Adherence to a cultural or religious belief system that condones or justifies IPV.

  It is important to communicate to the client that IPV is not a phase. While the abuse may feel less severe at times, it will almost assuredly escalate in subsequent days, months or even years. IPV is a learned behavior that is deeply rooted in a perpetrator's belief system. Behaviors like IPV require tremendous effort, on behalf of the perpetrator, to change. However, there are strategies a client might consider in an attempt to reduce the number of incidences of violence, and the harm it causes. The mechanism used to explore these strategies is the *Personalized Safety Plan.*

- **Personalized Safety Planning.** One of the most important steps of intervention is to provide the client with the opportunity to develop a *Personalized Safety Plan*. Safety plans seek to:
  - Give back a sense of power and control to the client.
  - Help a client compartmentalize the forms of IPV, and develop strategies for coping with each form of IPV.

- Assist clients in identifying and utilizing support services like psychosocial and counseling services, legal assistance and medical treatment.
- Encourage the client to create a network of safe people with whom the client can turn to for assistance or for support.
- Help the client measure the risk of danger, and be better prepared for when the IPV escalates.
- Establish a formal record of the IPV the client is experiencing.

The provider should reiterate that that safety plans are intended to *increase* a sense of safety and *reduce* the harm caused by IPV. The provider should explain that safety plans cannot prevent IPV; the only person who can prevent IPV is the person perpetrating the violence. However, if clients plan what to do before, during or after an incident of IPV, prepare to carry out the plan and rehearse the steps they need to take, they are for more likely to be successful in reducing the harm caused by IPV.

The client should be encouraged to share elements of the safety plan with at least one other person in her network of safe people. Given the dangers of having a paper copy of a *Personalized Safety Plan* in the client's possession, the client may opt for the clinic to store their safety plan within their medical file.

The following items should be incorporated into a general safety plan:
- Safety during a violent incident.
- Safety within the home.
- Safety on the job and/or in public places.
- Safety for emotional wellbeing.
- Safety if preparing to leave an abusive relationship.
- A list of items to take if leaving an abusive relationship.
- A list of important telephone numbers.
- A map of the town that indicates where services are being offered.

The *Personalized Safety Plan* is intended to be a guide, which is tailored to the specific needs of the client experiencing IPV. Not all elements of the safety plan will apply to all clients; however, that should not deter providers or clients from completing at least *some* of the elements of the safety plan. When assisting a client in preparing the *Personalized Safety Plan*, the provider should keep in mind that IPV can impact a victim's ability to concentrate for long periods of time. Additionally, abusers often use psychological abuse as a tactic to alter a victim's ability to create structure or to stabilize her environment. Many of the clients experiencing IPV will likely need assistance with organizing their thoughts, or thinking of examples of harm reduction. This is an opportunity for a provider to incorporate the information they have learned about the dynamics of IPV.

Finally, the provider must always consider the client's reading and comprehension ability, and offer to read-aloud the information for a client and record her responses for her.

GATHER Step 6 R: Return/refer - schedule a return visit and follow up with the client. ***IPV Services Integration:*** Remind the client that she may return to or call the clinic with any problem or concern regarding her family planning decision. Communicate that the clinic will remain a safe place for her to return to should she need further assistance addressing the IPV. Refer the client to any and all community-based IPV intervention services.	I. Providing a referral for a client experiencing IPV

- **Providing a Referral for a Client Experiencing IPV.** A strong intervention plan includes a referral that meets the client's most pressing need at the time of the disclosure. Some clients might feel as if they need legal assistance or medical support before they can address the psychological impact of the IPV. Other clients might feel the exact opposite. When completing the *IPV Questionnaire and Documentation Form*, it is important to ask the client what their most pressing need is, and provide a referral based on that need. It is not uncommon for survivors to be unsure of what they need or how to proceed. If this is the case, the provider should explain the various options for support – legal and financial assistance, psychosocial, counseling and advocacy services, medical and forensic medical services – while referencing the *Community Resource Guide* and *Community Resource Map*.

  The provider should be prepared to have the client decline any and all referral services. The client might need time to process the information, or to reflect on their experience. Simply because a client declines intervention in one visit, does not mean they will decline intervention in future visits. Therefore, not only is it crucial to screen new clients for IPV, it is crucial to follow-up with clients who have disclosed of IPV during previous visits.

  Remind the client that she may return to or call the clinic with any problem or concern regarding her family planning decision. Communicate that the clinic will remain a safe place for her to return to should she need further assistance addressing the IPV.

Intimate Partner Violence Questionnaire and Documentation Form

Date________________ **Client ID#**______________
Patient Name __________________________________

___**yes** ___**no** IPV confirmed by patient
___**yes** ___**no** IPV suspected but not confirmed
State reason: ______________________________

IPV Screening Questions

1. "What happens when you and your partner argue about something?"
2. "Can you think of a time when you have ever been fearful of your partner's behavior or actions?"
3. "How does your partner respond when you express your opinions, concerns or desires?"
4. "Can you think of a time when your partner has ever said something to you that has made you feel badly about yourself? How long did the bad feeling last?"
5. "Can you describe a time when your partner has threatened to harm you physically (scratch, slap, hit, bit or pushed)?"
6. "Can you describe a time when your partner has hurt your physically (scratch, slap, hit, bit or pushed)?"
7. "Has your partner ever forced you to participate in or do things you don't want to do sexually?
8. "How do you currently negotiate FP decisions? What would happen if you decided upon an FP method that contradicted your partner's FP outcome?"
9. "Has your partner ever forced you to have sexual intercourse as a means of getting you pregnant or because you didn't want to have sex?"

Patient Report: With the client's permission, record the client's account.

____
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____
____

FOR CLINIC USE ONLY

Provider Evaluation

____
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____
____
____

Special Considerations for Family Planning

____
____
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____
____
____

Referrals Provided to Client

___**yes** ___**no** Referred to [insert advocacy organization]
___**yes** ___**no** Referred to [insert legal organization]
___**yes** ___**no** Referred to [insert medical facility]
___**yes** ___**no** Referred to [insert internal source]
___**yes** ___**no** Referred to________________________
___**yes** ___**no** Follow-up appointment scheduled for_____

Personalized Safety Plan

___**yes** ___**no** Safety planning was offered to client
___**yes** ___**no** Safety plan was completed by client

Psychological Findings of IPV: Describe the client's demeanor.

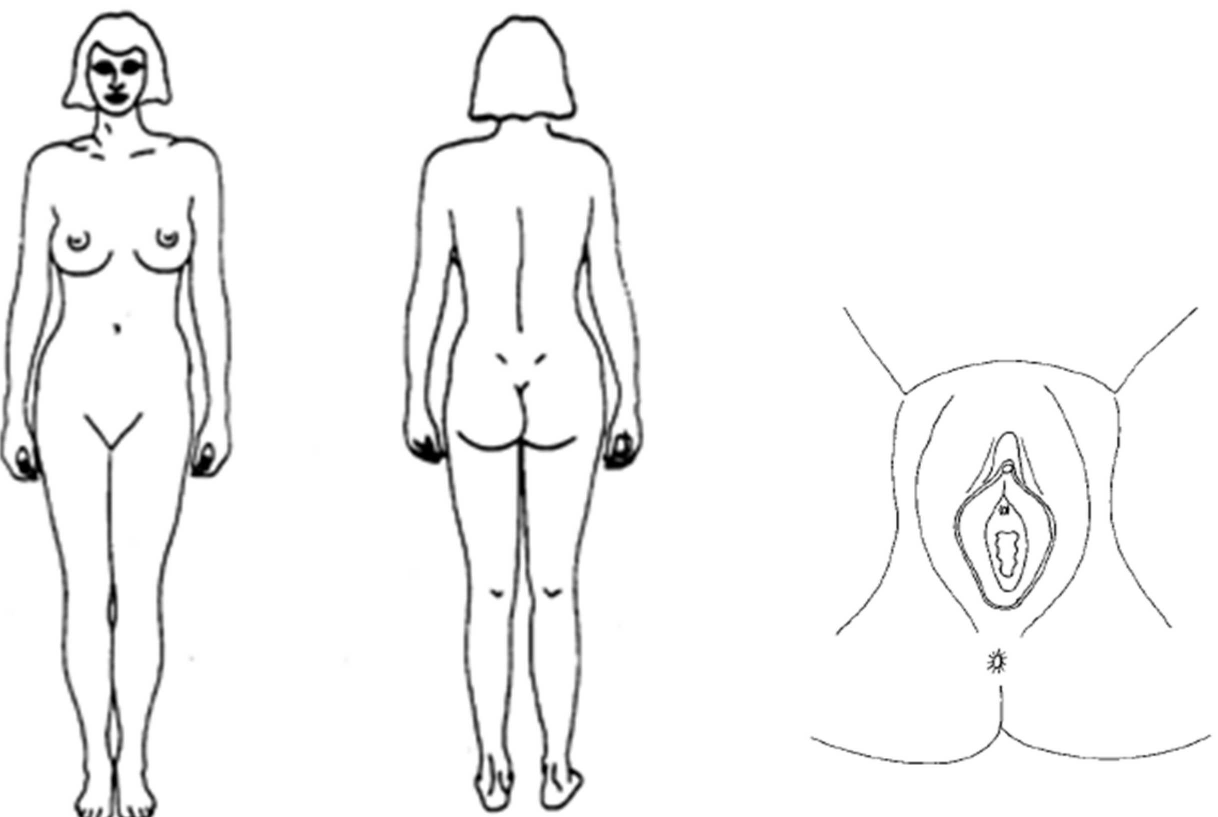
____
____
____

Physical Findings of IPV: Describe the nature of injuries.

____
____
____

See reverse side for additional instructions.

Physical Findings of IPV: Indicate by circling and/or drawing an arrow on the body map, and recording type of injury and region on the chart.



	Tenderness	Contusion	Abrasion	Laceration	Bleeding
Head					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulder					
Arms					
Hands					
Chest					
Breasts					
Back					
Abdomen					
Genitals					
Anus					
Buttocks					
Legs					
Feet					

CONFIDENTIALITY RELEASE FORM
[Insert Clinic Name]
[Insert Clinic Address]
[Insert Clinic Phone]

This form authorizes the release of confidential health information including disclosure of Intimate Partner Violence (IPV)-related information, for the purposes of making a proper referral. This form may be voided at any time, but will remain in effect until the indicated expiration date.

I consent to the release of (please check all that apply):

___ My health information (medical record)

___ My disclosure of intimate partner violence

___ Both, my health information and disclosure of intimate partner violence.

___ I only want to release the following information:

____

____

Name and contact information of agency receiving the client referral:

____
(Name of Agency) (Address of Agency) (Telephone)

If information to be released to this agency is to be limited to specific individuals at the agency, please specify:

____

Name and title of provider making the referral: ____________________________________

Name of client whose information is being released: ______________________________

Reason for release of information: ____

Time period during which release of information is authorized: From________ To _________

Signature of provider: _________________________________ **Date:** _________________________

Signature of client: ____________________________________ **Date:** _________________________

For Office Use Only
Date(s) in which the referral was attempted: _____________________________________
Date in which the referral was completed: _______________________________________

Family Planning Methods and IPV-Related Benefits and Risk Guide

Type of Method	Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Hormonal Methods IPV-Related Benefit: • Can be easily started and stopped by the client • If undetected, does not require negotiation with abusive partner • If used correctly, highly effective in preventing pregnancy IPV-Related Risk: • Does not protect the client from STIs • Requires return visits • Could be damaged or destroyed by partner • Abusive partner could label the client "undesirable" if unable to conceive, and subsequently increase level of violence or leave client entirely	Combined oral contraceptives (COCs) or "the pill"	Contains two hormones (estrogen and progestogen)	Prevents the release of eggs from the ovaries (ovulation)	>99% with correct and consistent use 92% as commonly used	Reduces risk of endometrial and ovarian cancer; should not be taken while breastfeeding
	Progestogen-only pills (POPs) or "the minipill"	Contains only progestogen hormone, not estrogen	Thickens cervical mucus to block sperm and egg from meeting and prevents ovulation	99% with correct and consistent use 90–97% as commonly used	Can be used while breastfeeding; must be taken at the same time each day
	Implants	Small, flexible rods or capsules placed under the skin of the upper arm; contains progestogen hormone only	Same mechanism as POPs	>99%	Health-care provider must insert and remove; can be used for 3–5 years depending on implant; irregular vaginal bleeding common but not harmful
	Progestogen only injectables	Injected into the muscle every 2 or 3 months, depending on product	Same mechanism as POPs	>99% with correct and consistent use 97% as commonly used	Delayed return to fertility (1–4 months) after use; irregular vaginal bleeding common, but not harmful
	Monthly injectables or combined injectable contraceptives (CIC)	Injected monthly into the muscle, contains estrogen and progestogen	Same mechanism as COCs	>99% with correct and consistent use 97% as commonly used	Irregular vaginal bleeding common, but not harmful

Type of Method	Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
	Emergency contraception (levonorgestrel 1.5 mg)	Progestogen-only pills taken to prevent pregnancy up to 5 days after unprotected sex	Prevents ovulation	Reduces risk of pregnancy by 60–90%	Does not disrupt an already existing pregnancy
Intrauterine Device IPV Benefit: • Undetectable/Concealable • Long-term method for clients who are unable to return • Does not require negotiation with abusive partner • Highly effective in preventing pregnancy IPV-Related Risk: • Does not protect client from STIs • Abusive partner could render the client undesirable if unable to conceive, and subsequently increase level of violence or leave client entirely	Intrauterine device (IUD): copper containing	Small flexible plastic device containing copper sleeves or wire that is inserted into the uterus	Copper component damages sperm and prevents it from meeting the egg	>99%	Longer and heavier periods during first months of use are common but not harmful; can also be used as emergency contraception
	Intrauterine device (IUD) levonorgestrel	A T-shaped plastic device inserted into the uterus that steadily releases small amounts of levonorgestrel each day	Suppresses the growth of the lining of uterus (endometrium)	>99%	Reduces menstrual cramps and symptoms of endometriosis; amenorrhea (no menstrual bleeding) in a group of users
Barrier Methods IPV-Related Benefit: • Reduces the risk of contracting STIs and HIV • If used correctly, reduces the risk of pregnancy by 5% IPV-Related Risk: • Detectable method • Requires negotiation with abusive partner	Male condoms	Sheaths or coverings that fit over a man's erect penis	Forms a barrier to prevent sperm and egg from meeting	98% with correct and consistent use 85% as commonly used	Also protects against sexually transmitted infections, including HIV
	Female condoms	Sheaths, or linings, that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film	Forms a barrier to prevent sperm and egg from meeting	90% with correct and consistent use 79% as commonly used	Also protects against sexually transmitted infections, including HIV

Type of Method	Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
• Only effective in preventing pregnancy if used correctly and consistently	Spermicide	Cream, film, foam, gel or suppositories that contains chemical	Stops sperm from moving to egg	85% with correct and consistent use 71% as commonly used	Do not protect against sexually transmitted infections, including HIV
	Sponge with Spermicide	Shallow silicone cup inserted into the vagina to prevent pregnancy	Forms a barrier to prevent sperm and egg from meeting	94% with correct and consistent usage 88% as commonly used	Do not protect against sexually transmitted infections, including HIV
	Cervical cap	A silicone cup inserted into the vagina to prevent pregnancy.	Forms a barrier to prevent sperm and egg from meeting	86 with correct and consistent usage 71 as commonly used	Do not protect against sexually transmitted infections, including HIV
	Diaphragm	Shallow silicone cup inserted into the vagina to prevent pregnancy	Forms a barrier to prevent sperm and egg from meeting	94% with correct and consistent usage 88% as commonly used	Do not protect against sexually transmitted infections, including HIV
Permanent Methods IPV-Related Benefit: • Undetectable/Concealable • Does not require negotiation with partner • Nearly 100% effective in preventing pregnancy	Male sterilization (vasectomy)	Permanent contraception to block or cut the vas deferens tubes that carry sperm from the testicles	Keeps sperm out of ejaculated semen	>99% after 3 months semen evaluation 97–98% with no semen evaluation	3 months delay in taking effect while stored sperm is still present; does not affect male sexual performance; voluntary and informed choice is essential

Type of Method	Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
IPV-Related Risk: • Abusive partner could render the client undesirable if unable to conceive, and subsequently increase level of violence or leave client entirely	Female sterilization (tubal ligation)	Permanent contraception to block or cut the fallopian tubes	Eggs are blocked from meeting sperm	>99%	Voluntary and informed choice is essential
Temporary Methods IPV-Related Benefit: • Undetectable/Concealable • Does not require negotiation with partner • Nearly 100% effective in preventing pregnancy IPV-Related Risk: • Time-limited	Lactational amenorrhea method (LAM)	Temporary contraception for new mothers whose monthly bleeding has not returned; requires exclusive breastfeeding day and night of an infant less than 6 months old	Prevents the release of eggs from the ovaries (ovulation)	99% with correct and consistent use 98% as commonly used	A temporary family planning method based on the natural effect of breastfeeding on fertility
Traditional Methods IPV-Related Benefit: • Fertility awareness is undetectable/concealable • If used correctly and consistently, reduces the risk of pregnancy by 5% IPV-Related Risk: • Requires negotiation with abusive partner • Only effective in preventing pregnancy if used correctly and consistently • Does not protect the client from STIs	Withdrawal (coitus interruptus)	Man withdraws his penis from his partner's vagina, and ejaculates outside the vagina, keeping semen away from her external genitalia	Tries to keep sperm out of the woman's body, preventing fertilization	96% with correct and consistent use 73% as commonly used	One of the least effective methods, because proper timing of withdrawal is often difficult to determine
	Fertility awareness methods (natural family planning or periodic abstinence)	Calendar-based methods: monitoring fertile days in menstrual cycle; symptom-based methods: monitoring cervical mucus and body temperature	The couple prevents pregnancy by avoiding unprotected vaginal sex during most fertile days, usually by abstaining or by using condoms	95-97% with correct and consistent use 75% as commonly used	Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy. Correct, consistent use requires partner cooperation.

Community Service and Resource Map

Example only – map below does not represent the service locations in Conakry, Guinea

Medical Care and Treatment

Police

Services for Pregnant Women and Women with Children

Psychosocial and Counseling Services

Legal Support Services

Financial Services

Community Resource Guide

Type of Service	Name of Organization	Services Offered	Cost of Services	Service Days & Hours	Obtaining Services	Location of Services	Policy on Confidentiality	Contact Person & Telephone
Legal Assistance								
Financial Assistance								
Psychosocial & Counseling Services								
Advocacy Services								
Medical Services								
Forensic Medical Services								