

INTEGRATION OF FAMILY PLANNING AND INTIMATE PARTNER VIOLENCE SERVICES

A PROTOTYPE FOR ADAPTATION

TRAINER'S GUIDE

The RESPOND Project



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USAID
FROM THE AMERICAN PEOPLE



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The RESPOND Project
c/o EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@respondproject.org
www.respondproject.org

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- *Engaging Boys and Men in Gender Transformation: The Group Education Manual (2008)*
- *Counseling for Effective Use of Family Planning: Trainer's Manual (2008)*
- *Engaging Boys and Men in GBV Prevention and Reproductive Health in Conflict and Emergency-Response Settings (2008)*
- *Men As Partners to Reduce Gender-Based Violence (2006)*

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Robert Vizzini formatted this manual; Michael Klitsch provided overall publications management.

For more information contact:

EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@engenderhealth.org

ACRONYMS AND ABBREVIATIONS

DoLI	Date of Last Incident
FP	Family Planning
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
IPV-FP	Intimate Partner Violence-Family Planning
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection

Introduction

Intimate Partner Violence and Family Planning (FP)

Women who experience violence may be less likely to achieve their desired family size. A comparison of Demographic and Health Survey (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 intimate partner violence were more likely to either use family planning clandestinely or to have an unmet need for family planning.¹

Intimate Partner Violence and STIs/HIV

Gender-based violence (GBV), including intimate partner violence (IPV), is a risk factor for the transmission of HIV and sexually transmitted infections (STI).² A comparison of 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.³ Surveys have also shown that men who are physically and sexually violent are more likely to engage in behaviors that put them, and thus their partners, at greater risk for 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.⁴

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.

Integrating Intimate Partner Violence Services and Family Planning Services

By increasing the capacity of family planning and reproductive health providers to better recognize and respond to the impact of intimate partner violence in the lives of their clients, providers are able to accomplish the following:

- Impart knowledge about the prevalence of IPV, and validate the client's experiences and reactions to the IPV they are experiencing;
- Explore family planning options and deliver reproductive health care services that take into consideration the IPV the client is experiencing;
- Assist in identifying safety measures that safe guard the client's family planning decision, increase the client's sense of safety and reduce the harm she is experiencing; and,
- Provide referrals to other medical, psychosocial and legal services that can further assist the client in addressing the IPV that is being perpetrated against her.

¹ Kishor, Sunita and Kiersten Johnson. 2004. *Profiling Domestic Violence—A Multi-Country Study*. Calverton, Maryland: ORC Macro.

² <http://www.ghi.gov/resources/guidance/161891.htm>

³ Kishor, Sunita and Kiersten Johnson. 2004. *Profiling Domestic Violence—A Multi-Country Study*. Calverton, Maryland: ORC Macro.

⁴ 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.

About the Manual

Target Audience for the Manual

This manual is an educational tool for increasing the capacity of family planning and reproductive health care providers to better recognize and respond to the impact of intimate partner violence in the lives of their family planning clients. It is meant as a tool to be utilized by a trained and experienced facilitator. It can also be used to train facilitators who will implement workshop activities with groups of family planning and reproductive health care providers but in that case the training would need to include specific activities to build facilitation skills especially around the materials in this manual and specific sessions need to be included for practicing the facilitation of the sessions in this manual.

How the Manual Was Developed

This manual was developed in conjunction with a clinic protocol to integrate intimate partner violence screening and basic crisis intervention services within a family planning and reproductive health clinic in Conakry, Guinea. Since the pilot training in January 2014, the activities have been modified to better meet the expressed needs of family planning and reproductive health providers.

The results of the educational activities has resulted in positive changes in knowledge, skill and attitudes related to the integration of intimate partner violence and family planning services, as well as increased the numbers of disclosures of intimate partner violence among family planning clients in Conakry, Guinea.

Included in this manual is the protocol for integrating intimate partner violence and family planning services. The protocol is specific to the clinic process in Conakry, but may be adapted for the use of other reproductive health and family planning clinics.

How the Manual Is Organized

This manual is organized in the form of a five-day training, with the possibility to extend the training to include a sixth day of training. Each day focuses on various topics including, but not limited to: root causes and dynamics of intimate partner violence; the process for integrating services; provider attitudes and skills-development; and, action planning. A five-day sequential training is not ideal in terms of having time to reflect on and digest the new information yet it is often the most pragmatic strategy for training of providers. Therefore, if the opportunity exists to spread the training out over a longer period of time (which is ideal), then this manual can be adapted to that opportunity.

The training process comprises a series of activities, or **sessions**. The sessions are numbered, so that they may be completed in sequential order. Each session includes **learning objectives** that participants are expected to accomplish by the completion of the activity. The **materials needed**, suggested **preparatory measures**, and the **time frame** in which it will take to complete the session, are also indicated at the beginning of each session.

Finally, the **procedure** gives the facilitator/trainer detailed, step-by-step instruction on how to conduct the session. It provides the discussion questions for engaging participants in dialogue, tips for the trainer and suggestions for transition from one session to the next.

Using the Manual Effectively

Organizing the Training Workshop

Because the manual includes a number of activities spread over five days, we recommend the use of at least two skilled facilitator/trainers. The room in which the training takes place should be large enough for participants to both sit in a large group, as well as break off into smaller groups, without being disruptive to one another.

Preparing for the Training

The designated facilitator/trainer is to read through the manual thoroughly in order to understand the perspective, flow of activities and the content that will be presented to the participants over the course of the training.

It is suggested that the facilitator/trainers meet prior to the training to decide, in advance, which facilitator/trainer will conduct each session. It is advised that the facilitator/trainers practice with colleagues prior to the training. This way, the facilitator/trainers have the opportunity to refine their technique, practice discussion questions, gain a sense of possible questions asked of them and develop talking points for those questions.

Materials Needed for Each Session

Most of the resource materials needed to successfully implement each training is included in each session. However, the facilitator/trainers will need to photocopy **participant handouts** for most of the sessions. It is suggested that the facilitator/trainer secure the use of an LCD projector and computer in order to present PowerPoint presentations. If unable to do so, the facilitator/trainer may opt to write-out the PowerPoint presentations on flipchart paper.

It is best if the facilitator/trainer is able to prepare the materials at least one day in advance.

Conducting the Five-Day Training

It is the facilitator/trainers' roles to guide the participants through each session with the end goal of achieving the desired learning objective(s). This manual generally utilizes participatory methods of instruction which means that the facilitator/trainers should encourage the participants to express their views and opinions, and to provide as much opportunity as possible for participants to engage with one another.

The facilitator/trainers should always observe the participants closely, as facial expressions and body language will help the facilitator/trainer gauge the participants' comprehension and interest in the material being presented. If looking tired or disengaged, the facilitator/trainer may add additional breaks and/or opportunities for the participants to move about the room.

A time frame for each activity has been indicated at the beginning of each session. The facilitator/trainer may adjust the time frame—moving faster or slower—as per the needs of the participants. It is recommended that the facilitator/trainer complete all of the sessions on the day in which the session is assigned.

The Role of the Facilitator/Trainer

The facilitator/trainer will play a key role in the training workshop. The facilitator/trainer is not only responsible for delivering new information and ideas, but also for creating a space conducive to learning—a space in which participants feel comfortable expressing their attitudes and beliefs, and feel supported in their learning journey.

A facilitator/trainer can create this type of environment by playing close attention to the following aspects:

- **Respect the Participants:** The facilitator/trainer must approach the participants with respect for the personal and professional experiences. The facilitator/trainer is to allow the participants the opportunity to express their opinions, and listen attentively to the participants. It is best if the facilitator/trainer save their own opinions until after all of the participants have shared their opinions. The act of doing so will help the facilitator/trainer build rapport with the participants, and model the behavior the facilitator/trainer would like the participants to use with their family planning clients.
- **Know When to Concede and When to Be Firm:** The facilitator/trainer should expect that the participants will join the training with varying skills, knowledge and opinions. Because of this, facilitation will become challenging, and the facilitator/trainer may feel frustrated by the process. It is important for the facilitator/trainer to know when to stand their ground on a point and when to guide the conversation in a different direction. If the facilitator/trainer allows an argument to go on for too long, the facilitator/trainer begins to ignore the needs of the other participants. The facilitator needs to encourage open and honest sharing of opinions (some of which may be inequitable) while at the same time promoting gender-equitable views. However, justification for the topic at hand—intimate partner violence—should never be condoned. The facilitator/trainer should stand firm in their position of rejecting intimate partner violence, under whatever circumstances it occurs.

SESSION 1.1: WELCOME AND INTRODUCTION

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explain the goals and objectives of the course.
2. List the group agreements.

TIME

1 hour, 15 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or timer
- Handout 1.1A: Training Agenda*
- Handout 1.1B: Learning Objectives of Training*
- Handout 1.1C: Participant Self-Assessment of Knowledge and Skills*

ADVANCE PREPARATION

- Review the training modules to be certain you understand content, methodology and timing.
- Depending on local custom, invite a dignitary, program manager, or other authority to open the workshop. In advance, discuss key points for emphasis and/or prepare remarks, as needed. Be prepared to shift timing for a formal opening, if speakers arrive late or leave quickly.
- Review the course agenda, learning objectives, and all training modules to be certain you understand content, methodology and timing.
- Create a flipchart titled “Parking Lot.”
- Create a flipchart titled “Group Agreements.”
- Print one copy of *Handout 1.1A: Training Learning Objectives* for each participant.
- Print one copy of *Handout 1.1B: Training Agenda* for each participant.
- Print one copy of *Handout 1.1C: Participant Self-Assessment of Knowledge and Skills* for each participant.

TRAINING STEPS

Step 1: Welcome and Introduction (10 minutes)

1. Welcome the participants to the course. Explain that this course will focus on Intimate Partner Violence (IPV). Specifically, the training will focus on ways a clinic can expand its services to include screening clients for IPV during clinic visits, and provide basic IPV-related counseling, safety planning and referral services to clients experiencing IPV.
2. Allow any special guests (dignitaries, funders, etc.) to introduce themselves to the group and share a few words about why this course is essential to the clinic, its staff and clients.
3. Introduce yourself and explain your role in the course. Model the introduction you would like the participants to use. Share your name, where you work, what programs or projects you are responsible for, and one expectation you have for this workshop. If there are other facilitators, have them do the same.

Step 2: Group Introductions (15 minutes)

1. One by one, ask the participants to provide their name, where they work, what role they play at the clinic, and one expectation they have for the course.
2. Record their expectations on a flipchart.

Step 3: Review of the Course and Learning Objectives (10 minutes)

1. Review the workshop learning objectives. Distribute *Handout 1.1A: Training Agenda* and *Handout 1.1B: Learning Objectives of Training*, and review the content with the participants. Link the participants' expectations to the objectives and activities of the course.
2. Write any expectations that do not fall within the scope of the course on the flipchart titled "Parking Lot." Explain that you will try your best to identify ways to meet the participant expectations. Acknowledge that some expectations may not apply to this particular training, of which may shed light on the need for additional training.
3. Ask participants if they have any questions about the training agenda.

Step 4: Group Agreements (5 minutes)

1. Explain to the participants you will now create group agreements for the course. Group agreements create the framework for how participants communicate ideas, how they navigate difficult conversations, and promote equity and inclusion within the group.
2. Provide an example of a group agreement— "Respect others when they are talking"—then ask them to list other group agreements. Record their answers on the flipchart titled, "Group Agreements."
3. Share with the participants that group agreements serve as informal contract, and will exist for the duration of your time together.

4. Ask the participants to commit to the group agreements, and to hold each other—including the trainer—accountable to the group agreements at all times. You might consider asking them to raise their hands to signal their commitment.

TRAINING TIP

- ✓ Additional group agreements may include any of the following:
 - Be respectful of all participants and facilitators. [It may be helpful to layout concrete guidelines here—turn off cell phones, speak one at a time, etc.]
 - Honor confidentiality—do not disclose identifying information about others and do not share personal information discussed during the session with anyone outside of the group.
 - Challenge opinions, not people. [Remind the participants that although they may have different experiences and opinions about sexual violence and that debate is encouraged, they should be careful to not attack or judge one another for having different ideas.]
 - Be kind to yourself—keep yourself emotionally safe. [Let the participants know that some of the material will be heavy and may be triggering. Remind participants that their participation is voluntary and that they can choose not to participate in any activity. Use this time as an opportunity to let them know which facilitators they can speak with if they are uncomfortable or triggered, and where they can go if they need to step out of the session.]

Step 5: Questions and Answers (4 minutes)

1. Ask the participants if they have any questions or comments about the next five days. Answer questions.

Step 6: Closure and Transition (30 minutes)

1. Explain to the participants that, in order to gauge the effectiveness of the training course, you are asking them to complete a self-assessment of the skills and knowledge now and at the end of the course. Explain that it is not a test that they will be graded on. You will be using the results to measure how well you and the training sessions were able to meet the learning objectives.
2. Distribute *Handout 1.1C: Participant Self-Assessment of Knowledge and Skills*.
3. Ask the participants to please put their name at the top of the session. Explain that doing so will allow you to compare the preassessment with the postassessment. Assure the participants that you will keep their answers and scores confidential.
4. Ask the participant to indicate by circling whether the assessment is pretraining or posttraining.
5. Allow the participants 25 minutes to complete the assessment. Keep an eye on the clock and inform the participants when they have 10 minutes left, and five minutes left.

TRAINING DAY 1

HANDOUT 1.1A: TRAINING AGENDA

SUPPORTING SURVIVORS OF INTIMATE PARTNER VIOLENCE: TRAINING AGENDA FOR FAMILY PLANNING SERVICE PROVIDERS IN GUINEA

DAY 1		
Schedule—Session 1	Time	Topic
9:00am–10:15am	1 hour, 15 minutes	1.1: Welcome and Introduction <ul style="list-style-type: none"> • Welcome (10) • Group introductions (15) • Review of course agenda and learning objectives (10) • Group agreements (5) • Question and answer (4) • Participant Self-Assessment (30) • Closure and transition (1)
10:15am–10:50am	35 minutes	1.2: Sex or Gender <ul style="list-style-type: none"> • Definitions of sex and gender (10) • Sex and Gender Game (20) • Closure and transition (5)
10:50am–11:10am	20 minutes	Tea Break
11:10am–11:50am	40 minutes	1.3: Personal Reflection on Sex and Gender <ul style="list-style-type: none"> • Introduction and guided visualization (15) • Large group discussion (20) • Closure and transition (5)
11:50am–1:10pm	1 hour, 20 minutes	1.4: Act Like a Man / Act Like a Woman <ul style="list-style-type: none"> • Brainstorm (10) • “Act Like a Man” activity (20) • “Act Like a Woman” activity (20) • Large group discussion (25) • Closure and transition (5)
1:10pm–2:20pm	1 hour, 10 minutes	Lunch
2:20pm–3:15pm	55 minutes	1.5: Dynamics of Intimate Partner Violence <ul style="list-style-type: none"> • Group brainstorm (5) • Lecture and activity (40) • Closure and transition (10)
3:15pm–4:25pm	1 hour, 10 minutes	1.6: Forms, Effects and Causes of Intimate Partner Violence— Problem Tree <ul style="list-style-type: none"> • Introduction and small group work—identifying effects of IPV (20) • Large group share (10) • Large group brainstorm—root causes (15) • Large group discussion and debrief (20) • Closure and transition (5)
4:25pm–4:45pm	20 minutes	Tea Break
4:45pm–5:30pm	45 minutes	1.7: Intimate Partner Violence Case <ul style="list-style-type: none"> • Case studies and discussion (40) • Closure and transition (5)

HANDOUT 1.1A: TRAINING AGENDA *continued*

**SUPPORTING SURVIVORS OF INTIMATE PARTNER VIOLENCE:
TRAINING AGENDA FOR FAMILY PLANNING SERVICE PROVIDERS IN GUINEA**

DAY 2		
Schedule—Session 2	Time	Topic
9:00am–9:30am	30 minutes	2.1.: Welcome and reflections <ul style="list-style-type: none"> • Welcome and review of Day 2 agenda (5) • Reflections on Day 1 (20) • Closure and transition (5)
9:30am–10:35am	1 hour, 15 minutes	2.2: Myths Related to Intimate Partner Violence <ul style="list-style-type: none"> • Brainstorm (5) • Dispelling the myths of IPV (20) • Large group discussion (25) • Closure and transition (15)
10:35am–11:35am	1 hour, 15 minutes	2.3: Link Between Family Planning and Intimate Partner Violence <ul style="list-style-type: none"> • Family planning and intimate partner violence trivia game (35) • Large group discussion (20) • Closure and transition (10)
11:35am–11:45am	10 minutes	Tea Break
11:45am–1:00 pm	1 hour, 15 minutes	2.4: Provider Values and Attitudes <ul style="list-style-type: none"> • Vote with Your Feet (20) • Values and Attitudes Clarification and Group Discussion (50) • Closure and transition (5)
1:00pm–2:00pm	1 hour	Lunch
2:00pm–3:00pm	1 hour	2.5: The Impact of Intimate Partner Violence and Empathizing with the Survivor <ul style="list-style-type: none"> • Nkirukua’s Story (45) • Closure and transition (15)
3:00pm–3:15pm	15 minutes	Tea Break
3:15pm–4:30pm	1 hour, 15 minutes	2.6: Setting Boundaries and Maintaining Confidentiality <ul style="list-style-type: none"> • Brainstorm (10) • Setting boundaries and maintaining confidentiality (30) • Large group discussion (30) • Closure and transition (5)
4:30pm–5:40pm	1 hour, 10 minutes	2.7: Integrating Intimate Partner Violence Services and Family Planning Services <ul style="list-style-type: none"> • Introduction (5) • Large group discussion (15) • Presentation on Five Key IPV Services (30) • Large group discussion (15) • Closure and transition (5)

TRAINING DAY 1

HANDOUT 1.1A: TRAINING AGENDA *continued*

SUPPORTING SURVIVORS OF INTIMATE PARTNER VIOLENCE: TRAINING AGENDA FOR FAMILY PLANNING SERVICE PROVIDERS IN GUINEA

DAY 3		
Schedule—Session 3	Time	Topic
9:00am–9:30am	30 minutes	3.1: Welcome and Reflections <ul style="list-style-type: none"> • Welcome and review of Day 3 agenda (5) • Reflections on Day 2 (20) • Closure and transition (5)
9:30am–11:15am	1 hour, 45 minutes	3.2: Screening for Intimate Partner Violence—Overview and Demonstration <ul style="list-style-type: none"> • Large group brainstorm (10) • Introduction to “Intimate Partner Violence Screening and Documentation Tool (25) • Screening for IPV with care and compassion—“The Dos and Don’ts (10) • Demonstration of IPV screening (15) • Large group screening debrief (20) • Large group discussion—interpreting answers to screening questions (20) • Closure and transition (5)
11:15am–11:30am	15 minutes	Tea Break
11:30am–12:45pm	1 hour, 15 minutes	3.3: Participant Practice—Screening for Intimate Partner Violence <ul style="list-style-type: none"> • Introduction (2) • Participant practice (45) • Large group discussion (25) • Closure and transition (3)
12:45pm–1:45pm	15 minutes	Lunch
1:45pm–2:55pm	1 hour, 20 minutes	3.4: Providing Counseling to Clients Experiencing IPV— Demonstration <ul style="list-style-type: none"> • Introduction (5) • Large group discussion on informational and emotional needs of clients (15) • Demonstration of counseling skill—“Active Listening and Paraphrasing” (25) • Demonstration of counseling skill—“Validating and Educating” (25) • Closure and transition (10)
2:55pm–3:15pm	20 minutes	Tea Break
3:15pm–5:00pm	1 hour, 45 minutes	3.5: Participant Practice – Intimate Partner Violence Counseling and Education <ul style="list-style-type: none"> • Introduction (3) • Participant practice—counseling and educating (75) • Large group discussion (25) • Closure and transition (2)

HANDOUT 1.1A: TRAINING AGENDA *continued*

**SUPPORTING SURVIVORS OF INTIMATE PARTNER VIOLENCE:
TRAINING AGENDA FOR FAMILY PLANNING SERVICE PROVIDERS IN GUINEA**

DAY 4		
Schedule—Session 2	Time	Topic
9:00am–9:30am	30 minutes	4.1: Welcome and Reflections <ul style="list-style-type: none"> • Welcome and review of Day 4 agenda (5) • Reflections on Day 3 (20) • Closure and transition (5)
9:30am–10:45am	1 hour, 15 minutes	4.2: Exploring Family Planning Options with Clients Experiencing Intimate Partner Violence <ul style="list-style-type: none"> • Introduction (2) • Presentation on considerations for care (8) • Small group work (25) • Debrief and Large group discussion (35) • Closure and transition (5)
10:45am–11:00am	15 minutes	Tea Break
11:00am–12:35pm	1 hour, 35 minutes	4.3: Documenting Intimate Partner Violence <ul style="list-style-type: none"> • Introduction and brainstorm (5) • Documentation 101—how, what and when (10) • Large group practice (60) • Large group discussion (15) • Closure and transition (5)
12:35pm–1:35pm	1 hour	Lunch
1:35pm–2:50pm	1 hour, 15 minutes	4.4: Safety Planning with Clients Experiencing Intimate Partner Violence—Overview and Demonstration <ul style="list-style-type: none"> • Introduction and brainstorm (20) • Introduction of “Provider Tool for Safety Planning with Clients Experiencing IPV” (20) • Large group discussion—safety measures (30) • Large group discussion (5)
2:50pm–3:10pm	15 minutes	Tea Break
3:10pm–5:10pm	2 hours	4.5: Safety Planning—Demonstration and Participant Practice <ul style="list-style-type: none"> • Introduction and demonstration (45) • Small group—preparing role play (30) • Large group role plays (60) • Large group discussion (20) • Closure and transition (10)

TRAINING DAY 1

HANDOUT 1.1A: TRAINING AGENDA *continued*

SUPPORTING SURVIVORS OF INTIMATE PARTNER VIOLENCE: TRAINING AGENDA FOR FAMILY PLANNING SERVICE PROVIDERS IN GUINEA

DAY 5		
Schedule—Session 2	Time	Topic
9:00am–9:30am	30 minutes	5.1: Welcome and Reflections <ul style="list-style-type: none">• Welcome and review of Day 5 agenda (5)• Reflections on Day 4 (20)• Closure and transition (5)
9:30am–10:40am	1 hour, 20 minutes	5.2: Providing Referrals to Clients Experiencing Intimate Partner Violence <ul style="list-style-type: none">• Introduction and brainstorm (30)• IPV related services available to clients in Conakry, Guinea (20)• Matching needs with resources (10)• Clinic protocol—“Confidentiality Release Form (15)• Closure and transition (5)
10:40am–11:00am	20 minutes	Tea Break
11:00am–12:10pm	1 hour, 10 minutes	5.3: Preparing the Clinic Environment <ul style="list-style-type: none">• Introduction and brainstorm (10)• Small group work (40)• Large group debrief (30)• Preparing of case profiles (10)
12:20pm–1:20pm	1 hour	Lunch
1:15pm–3:00pm	1 hour, 45 minutes	5.4: Action Planning <ul style="list-style-type: none">• Introduction (5)• Small group work (60)• Large group share and discussion (45)
3:50pm–4:10pm	20 minutes	Tea Break
4:10pm–5:00pm	50 minutes	5.5: Closing and Post Assessment <ul style="list-style-type: none">• Closing thoughts (10)• Group Reflection (15)• Participant Self-Assessment of Knowledge, Skills and Attitudes (25)

HANDOUT 1.1B: TRAINING AGENDA

At the completion of this four-day training, participants will be able to:

1. Describe the differences between sex and gender.
2. Describe the positive and negative impact of rigid, inequitable gender norms, and how they related to IPV.
3. Explore personal experiences of gender socialization, and how those experiences shape the way they interact with clients who have experienced IPV.
4. Describe the causes and consequences of IPV.
5. Explain why family planning (FP) health centers are good entry points to screen survivors of IPV.
6. Identify challenges that may arise in serving clients who have experienced IPV and how to overcome these challenges.
7. Argue against common myths and misinformation related to IPV.
8. Acquire skills to deliver five key services to FP clients, including:
 - Conduct universal screening for IPV.
 - Counsel and educate on the dynamics of IPV and the impact IPV can have on FP.
 - Explore family planning options and deliver reproductive health care services that take into consideration the IPV the client is experiencing.
 - Assist in identifying safety measures to safe guard the client's family planning decision, increase the client's sense of safety and reduce the harm she is experiencing.
 - Provide referrals to other medical, psychosocial and legal services that can further assist the client in addressing the IPV that is being perpetrated against her.
9. Describe how the five key services listed in Objective #8 can be integrated within FP visits.
10. Explain the importance of maintaining confidentiality, and the minimum components of confidentiality procedures within the context of serving clients who have experienced IPV.
11. Explain the importance of informed consent and voluntary decision making for clients experiencing IPV.
12. Identify concrete ways to support family planning clients who has survived IPV.

TRAINING DAY 1

HANDOUT 1.1C: PARTICIPANT SELF-ASSESSMENT OF KNOWLEDGE AND SKILLS

Participant Pre/Post Self-Assessment Intimate Partner Violence Integration Training

Name: _____ Job Function: _____

Indicate by circling whether assessment is pre training or post training: Pre Post

Decide whether each of the following statement is T (true) or F (false). Write your response for each statement in the space provided below.

1. ___ In health care settings, the interview is the most common place for disclosures of intimate partner violence to occur.

2. ___ Intimate partner violence has no documented impacted on family planning, sexual and reproductive health.

3. ___ Safety planning with a client who is experiencing IPV is a method used to restore power and control to a survivor of IPV.

4. ___ Counselors and providers should talk clients into pregnancy prevention methods if there is intimate partner violence in the home.

5. ___ Integrating intimate partner violence screening in family planning services, and providing tailored IPV-FP care, are considered methods of intervention.

6. ___ It is the clinic's responsibility to ensure the physical and psychological safety of clients experiencing IPV.

7. ___ Gender norms are socially assigned roles and responsibilities for both women and men.

The following are multiple choice questions. Please circle the correct response for each question. Unless otherwise indicated, there is only one correct response for each question.

8. The root causes of intimate partner violence is:
 - a. Stress and frustration
 - b. Substance abuse (drugs or alcohol)
 - c. Power and control
 - d. Mental health problems
9. Intimate partner violence includes the following forms of abuse:
 - a. Physical abuse
 - b. Psychological abuse
 - c. Sexual abuse
 - d. All of the above
10. Which of the following is not required of counselors and providers?
 - a. Screening for intimate partner violence.
 - b. Assisting the client in making an informed and voluntary decision about their family planning.
 - c. Providing shelter to a client experiencing intimate partner violence.
 - d. Making an appropriate referral, as per the request of the client.
11. Which of the following indicates that a counselor and/or provider is effectively listening to a client? (circle all that apply).
 - a. Occasionally paraphrasing or summarizing what the client has said.
 - b. Looking at the client when the client is speaking.
 - c. Thinking about what you will say next to the client.
 - d. Writing or reading notes when the client is speaking.
 - e. Asking specific questions related to what the client has told you.
 - f. Interrupting the client to give her advice.
 - g. Nodding your head or making encouraging sounds when the client is talking.

12. How should a provider respond to a client that discloses of intimate partner violence. (circle all that apply)
- a. Thank her for sharing this information with you.
 - b. Encourage her to leave the situation.
 - c. Explain how her experience might impact her family planning decisions.
 - d. Offer her the option of safety planning.
13. A “safety plan” is best described as:
- a. A step-by-step guide on how to leave an abusive relationship.
 - b. A comprehensive set of steps and suggestions to follow in order to avoid a dangerous situation, or increase an individual’s sense of safety.
 - c. A comprehensive guide to preventing intimate partner violence.
 - d. A document that is shared with an abusive partner so they can understand the impact of the violence they are perpetrating.

Please answer the following question in the space provided.

Define the following terms:

14. Intimate Partner Violence

15. Screening Questions

16. Integrated Services (Intimate partner violence and Family Planning)

17. Confidentiality



18. Name at least three IPV related services a counselor or provider can offer to a client experiencing IPV.

19. Name the three types of behaviors abusers use to wield power and control over their partner.

20. Explain how IPV might impact a client's family planning decision.

21. Explain how a provider can create a safe and inviting environment for a client experiencing IPV.

22. Explain how a provider's personal attitudes and morals might negatively or positively impact a client experiencing IPV.

a. Negatively impact a client:

b. Positively impact a client:

TRAINING DAY 1

SESSION 1.2: SEX AND GENDER¹

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explain the concept of gender
2. Explain the difference between gender and sex.

TIME

30 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors

ADVANCE PREPARATION

- Review the training modules to be certain you understand content, methodology and timing.
- Prepare one flipchart with definition of gender and the definition of sex written on it:
 - Sex:** Sex refers to one's biological characteristics—anatomical (breasts, vagina, penis, testes), physiological (menstrual cycle, spermatogenesis), and genetic (XX, XY)—as male or female.
 - Gender:** *Gender* is the set of qualities and behaviors expected from men and women. Gender is determined by society and culture and can evolve over time.
- Print *Trainers' Tool 1.2: Sex or Gender*.
- Practice reading aloud the gender/sex statements for this activity.

TRAINING STEPS

Step 1: Definitions (10 minutes)

1. Ask participants if they can explain the difference between the terms “gender” and “sex.” Allow the participants to share their answers and to discuss.
2. Post the flipchart with definitions of gender and sex at the front of the classroom, and ask one of the participants to read it aloud.

⁵ Adapted from: The ACQUIRE Project/EngenderHealth and Promundo. 2008. Engaging boys and men in gender transformation: The group education manual. New York and Rio de Janeiro.



Step 2: Sex and Gender Game (20 minutes)

1. Explain to the participants that you are going to read aloud eight statements. Ask them to hold up one finger if they think the statement refers to gender, two fingers if they think the statement refers to sex. Ask them to go with their first instinct, instead of relying on the answers of their peers. If there are differences in opinions, allow them one minute to debate, before you provide them with the correct answer.
2. Ask participants if they have any questions about the activity.
3. Using *Trainers' Tool 1.2: Sex or Gender*, read aloud the statements, pausing to allow the participants time to respond.

Step 3: Closure and Transition (5 minutes)

1. Explain to the participants that you will be addressing sex and gender throughout the remainder of the training, as both are closely linked to the root causes of intimate partner violence.
2. Move immediately into the next activity, “Personal Reflection on Sex and Gender.”

TRAINING DAY 1

TRAINERS' TOOL 1.2: SEX OR GENDER

1. Women give birth to children; men don't. *Answer: Sex*
2. Girls are gentle; boys are tough. *Answer: Gender*
3. Men generally have a higher income than women when performing the same job function. *Answer: Gender*
4. Women are less likely than men to voice their opinions about sexual desire. *Answer: Gender*
5. Men's voices change during puberty. *Answer: Sex*
6. Typically, men have a larger bone structure than women. *Answer: Sex*
7. Women can breastfeed babies; men can bottle-feed babies. *Answer: Sex*
8. Parents sometimes prefer male children. *Answer: Gender*

Key Messages:

- *Sex* and *gender* are to different things.
- *Sex* refers to the biological differences between men and women. Generally these differences cannot be changed without medical, hormonal and surgical interventions.
- *Gender* refers to all the other differences and inequalities created by society. These differences can be changed.

SESSION 1.3: PERSONAL REFLECTION ON SEX AND GENDER²

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explore personal experiences of gender socialization.
2. Describe how personal experience of gender socialization might affect their interaction with clients.

TIME

40 minutes

MATERIALS

- Trainers' Tool: Session 1.3: Personal Reflection on Sex and Gender*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print *Trainers' Tool 1.3: Personal Reflection on Sex and Gender*.
- Practice reading aloud the statements listed on *Trainers' Tool 1.3: Personal Reflection on Sex and Gender*.
- Make sure that the training room can be closed to outsiders during the personal reflection activity.

TRAINING STEPS

Step 1: Introduction and Guided Visualization (15 minutes)

1. Explain that the activity is a guided visualization exercise. You will read a series of questions that will guide them through memories of learning about sex and gender. Explain that, while you will not go into depth at this time, sex and gender can be linked to intimate partner violence.
2. Ask them to consider two things throughout the exercise:
 - How these memories shaped their own sense of self;
 - How these experiences influence the way in which they interact with the opposite gender.
3. Inform the participants that this exercise is only for them, to think and reflect for themselves. They will not be asked to share their personal thoughts or experiences with the larger group. During this time, no one else is allowed in the room, and no one will be watching them.

² Adapted from: The ACQUIRE Project/EngenderHealth. 2008. *Counseling for effective use of family planning: Trainer's manual*. New York

4. Ask if anyone has any questions. Answer questions as needed.
5. Ask the participants to make themselves comfortable. Suggest that they close their eyes and take a few deep breaths. Explain that you will be reading to them for the next 10 minutes.
6. In a slow, reassuring voice, read aloud the script to the participants. Pause between questions to enable them to reflect on memories and images.

TRAINING TIPS

- ✓ No interruptions should be allowed during the personal reflection activity. Maintaining a comfortable, quiet and private environment is critical to this activity. Invite participants to find a spot in the room where they can sit comfortably and still be able to hear your voice.
- ✓ It is possible that the personal reflection activity could ignite a strong emotion among the participants, particularly those with a history of traumatic experiences. Acknowledge this fact to the group before you begin the activity, and allow participants to disengage by covering their ears or putting their head down. If you witness a participant struggling through the activity, talk to them privately during the break to see if there is anything you can do to create an inviting space during the rest of the training.

Step 2: Large Group Discussion Questions (20 minutes)

1. Lead a discussion about the reflection activity. Emphasize that people do not have to share their personal experiences, but rather discuss aspects about the activity.
 - How did it feel to complete this exercise?
 - How might your personal reflection be helpful in the context of working with clients?
 - How is the experience of development and learning different for boys and girls? In what ways might this difference have an impact on family planning clients?
 - Given what we know about the rigid, inequitable gender roles prescribed to girls and women, how might you reassure a client that they have the right to govern their own body?
 - In what ways do you think sex and/or gender might be linked to intimate partner violence?

Step 3: Closure and Transition (5 minutes)

1. Ask if there are any final questions. Answer them to the best of your ability.
2. Share that the next activity will draw from this one, but that you will be focusing on sex and gender from a societal perspective, as opposed to individual experience.
3. Conclude by thanking the group for their participation and willingness to reflect on their personal experiences.

TRAINING DAY 1

TRAINERS' TOOL 1.3: PERSONAL REFLECTION ON SEX AND GENDER

Picture yourself as a child and see what memories come up as I ask you the following questions:

- Reach back into your memories and picture yourself as five years old. What was your life like then? Who were the important people in your life? *Pause.*
- If you're a man, how old were you when realized you were a boy, as opposed to a girl? If you're a woman, how old were you when you realized you were a girl, as opposed to a boy? How did you know that was the case? *Pause.*
- Remember yourself at age 10. Where did you live? Who were the important people in your life? *Pause.*
- As you were growing up as a young child, what types of messages did you receive from other people about your body? *Pause.*
- What messages did you receive about the opposite sex? As you grew older, how did these messages change? *Pause.*
- Who took care of you when you were a child? Who cooked you dinner? Was there anyone in your house that worked outside of the home? *Pause.*
- What kinds of things were you told about getting older? Did someone talk to you about being a parent? Did someone talk to you about getting a job? *Pause.*
- When you were 12, how did you feel about your body? How did people talk about your body? How did people talk about bodies that were like yours? How did people talk about bodies that were different from yours? *Pause.*
- Think back to when you first learned about sex. Where did you hear about it first? Did you talk about it with a parent or an adult, or with a friend? What did you learn? *Pause.*
- Think about the first time you tried to talk to someone about sex. What did you talk about? How did this person respond? How did it make you feel? *Pause.*
- Did you go to school when you were a child? What kinds of things did you learn, formally and informally? *Pause.*
- Think about your first sexual experience. How did you feel beforehand? How did you feel afterward? What was the communication with your partner like? *Pause.*
- How did the messages that other people gave about sex affect your feelings? How did those messages affect how you acted or behaved during your first sexual experience? How do they affect you now? *Pause.*
- Think about yourself now. Do you ever feel nervous when you're around someone of the opposite sex? Do you feel like you can express your feelings, opinions or desires? *Pause.*

- 
- Have you ever been told you couldn't do something simply because of your gender? *Pause*
 - Do you ever feel unsafe in place or situation simply because of your gender? *Pause*
 - Have you ever wondered what it would be like to be the opposite gender or sex? Have you ever wished you were something different than what you are? *Pause*

When you are ready, open your eyes.

SESSION 1.4: ACT LIKE A MAN/ACT LIKE A WOMAN⁷

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Define the terms “gender role,” “gender norm,” and “social norm.”
2. Describe the negative impact of subscribing to rigid, inequitable gender norms.
3. Understand and describe the social norms related to femininity and masculinity.

TIME

1 hour, 20 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Prepare two flipcharts, one with the heading “Act Like a Man” and the other titled “Act Like a Woman.” Draw a large box on each paper, with enough room to write message both on the inside of the box and around the margins of the boxes.

TRAINING STEPS

Step 1: Brainstorm (10 minutes)

1. Ask the participants if they have ever been told to “act like a man” or “act like a woman.” Ask them to share some experiences in which someone has said this or something similar. For example, why did the individual say it? How did it make the person to whom it was directed feel?
2. Ask the participants to look more closely at the two phrases. By taking a deeper look at the meaning behind each phrase, we can begin to see how society creates very different rules for how men and women are supposed to behave. Explain that these rules are sometimes called *gender norms*, or *social norms*, because they define what is “normal” for men and women to think, feel, and act. Explain that these rules restrict the lives of both women and men by keeping men in their “Act like a Man” box and women in their “Act like a Woman” box.

⁷ Adapted from: The ACQUIRE Project/EngenderHealth and Promundo. 2008. *Engaging boys and men in gender transformation: The group education manual*. New York and Rio de Janeiro.

TRAINING TIPS

- ✓ This activity helps to build the foundation in identifying the root causes of intimate partner violence. Rigid, inequitable gender norms are one of the many social norms that promote and permit IPV to occur in the first place. While you want to create comprehensive gender boxes, the most important part of this activity are the discussion questions. The conclusions drawn from the discussion questions will help to set up your next activity, and will be referenced in subsequent training sessions. You will want to help the participants make the following connections throughout this activity:
 - Gender norms are socially assigned roles and responsibilities for women and men.
 - Men are often socialized to be powerful, controlling, unemotional and aggressive. This results in a social acceptance of men being dominant.
 - Women are socialized to be nurturing, passive, submissive and emotional. This reinforces the notion that women are weak, powerless and need to depend on someone else.
 - The socialization of men and women results in an unequal power balance in society and in the home.
- ✓ It is not uncommon for participants to become defensive during this activity. Some participants may try to express concern that they are being categorized—that they do not abide by or agree with the social norms associated with men and women. These are normal and healthy reactions to the activity, and are a sign that your participants are actively engaged with the material. You want participants to think and analysis their own behavior. Explain that they will have an opportunity to do that in subsequent sessions. Analyzing one’s own behavior is welcomed and necessary. However, for this activity, encourage them to think more broadly—at the societal level.
- ✓ Use the term “we” and “society” interchangeably, as a means of reinforcing the above tip. Each person is an individual; individuals make up a society.
- ✓ This activity can sometimes feel as if the trainer is trying to say that women are “weak” and men are “bad.” Remind them that you are talking about the socialization of boys and girls. Be certain to assure the participants that gender norms can be both harmful and beneficial to both men and women.
- ✓ Use the terms gender norms and social norms interchangeably. Gender roles—gender norms—are one of many social norms that promote and permit IPV to occur. Hone in on the fact that social norms are part of a larger “system.” The “system” grants certain individuals—those that “act like men” with more power. Participants might be confused by this as many people think power is something that is earned. Encourage them to reflect on the visioning exercise, particularly the question: “How old were you when you realized you were a boy/girl? How did you know you were a boy/girl?” Boys and girls learn their respective status in society at a very early age, without ever having the opportunity to actual earn power.

TRAINING TIPS *continued*

- ✓ Help the participants to identify that, while society places expectations on both women and men to subscribe to particular gender norms, men and boys may face greater social sanctions when they step out of the box. As such, men and boys may have a greater stake in maintaining their boxes; this often results in extreme displays of dominant masculinity that can result in harmful/violent consequences for women and girls.
- ✓ At the end of the activity, pose a thought to the participants, which will serve as the first link between social norms and IPV: “When we think of something as ‘lesser than’—an object (e.g., a farm tool)—we don’t feel badly about using it. After all, objects are supposed to be used by us. Now, exchange the term ‘object’ for the term ‘women.’ We are socialized to think, feel and act as if being a woman is the *worst* possible thing. We are taught to believe that women are somehow of lesser value than men. We treat women as if they are objects to be used at our disposal. When that is the case, it seems less harmful to perpetrate violence against them.

Step 2: Act Like a Man (20 minutes)

1. Post the flipchart “Act Like a Man” at the front of the room. Ask participants to share their ideas about what this means. If the participants hesitate in replying, explain that these are society’s expectations of who men should be, how men should act, and what men should feel and say. Write their responses inside the box. Some responses might include:

- Be tough.
- Don’t cry.
- Yell at people.
- Show no emotion.
- Take care of other people.
- Don’t back down.

If the participants’ responses do not include references to sex, sexuality, violence, or power and control, use the following questions to help prompt the group:

- What messages are given to men about engaging in sexual activity?
- What messages are given to men about using violence?
- What messages are given to men about obtaining leadership or control?

2. Ask the participants to think about what happens when a man acts in a manner that is *outside* of the “act like a man” box. What behaviors, emotions and actions are associated with men who fall outside of inequitable masculinity? What are some of the names that a person is called when he acts in this way? Write their responses outside the box.

3. Lead a short (5 minute) group discussion about gender norms related to men by asking:

- Can expectations to behave in this manner make men feel limited in their actions? Why?
- Which emotions are men allowed to express? Which emotions are men *not* allowed to express?
- How do you think these limitations affect men's health? Relationships with women? Relationships between male providers and female clients?

Step 3: Act Like a Woman (20 minutes)

1. Post the flipchart "Act Like a Woman" at the front of the room (you might consider using the phrase "Act Like a Lady" if the word "woman" does not carry the same cultural connotation). Ask participants to share their ideas about what this means. If the participants hesitate in replying, explain that these are society's expectations of who women should be, how women should act, and what women should feel and say. Write their responses *inside* the box. Some responses might include:

- Be passive and quiet.
- Be the caretaker and homemaker.
- Follow the man's lead.
- Pleasure men/partner.
- Don't discuss sex.
- Avoid conflict.
- Produce children.
- Get married.

If the participants' responses do not include references to sex, sexuality, violence, or power and control, use the following questions to help prompt the group:

- What messages are given to women about engaging in sexual activity?
- What messages are given to about being assertive?
- What messages are communicated to women about violence?
- What messages are given to women about the importance of beauty/being attractive?

2. Ask the participants to think about what happens when a woman acts in a manner that is outside of the "act like a woman" box. What behaviors, emotions and actions are associated with women who fall outside of inequitable femininity? What are some of the names that a person is called when she acts in this way? Write their responses *outside* the box.

3. Lead a short (5 minute) group discussion about gender norms related to women by asking:

- Can expectations to behave in this manner make women feel limited in their actions? Why?
- Which emotions are women allowed to express? Which emotions are women not allowed to express?
- How do you think these limitations affect men's health? Relationships?

Step 4: Large Group Discussion (25 minutes)

1. Post the boxes side by side on the front wall. Ask the students to take a moment to compare the boxes. Ask them to notice any emotions, words or phrases that are listed under both the man and woman box. Ask them to notice any behaviors or emotions that can be linked to one another (e.g. Men are supposed to provide for their family; women are supposed to be taken care of).
2. Discuss the following discussion questions:
 - Are there any common themes among the behaviors and emotions you linked together?
 - What characteristics do we tend to value about men and women? What characteristics do we tend to devalue as it pertains to men and women?
 - How have norms of masculinity and/femininity influenced your life? Have you ever felt like stepping “outside” of your assigned box? When? What happened as a result of stepping outside of the box?”
 - How do these social norms contribute to the distribution of power and control between men and women?
 - Have you ever met someone who has used their status to control someone else? In what ways can we redistribute power and control, or equalize the balance between the sexes?

Step 5: Closure and Transition (5 minutes)

1. Thank the participants for being actively engaged with the material, and acknowledge that some of the material can be challenging to understand and process.
2. Share one final thought, linking this activity to your next activity “Intimate Partner Violence: Causes and Consequences:”

“Think about something lesser than you. Think about an object—a farm tool, for example. No one taught you that it was an object; you just knew that it was an object that could be used at your disposal. At some point you learned how to use the tool: Maybe someone taught you how to use it; maybe you learned how to use it by watching someone else and/or drawing from previous knowledge and skill. Our society often treats women like objects. We learn how to view and treat women based on what we are told, by watching others and drawing from cultural and social cues. If we are socialized to think, feel and act as if being a woman is the worst possible thing. We are taught to believe that women are somehow of lesser value than men. We treat women as if they are objects to be used at our disposal. When that’s the case, it seems less harmful to perpetrate violence against them.”
(See training tips for additional context)

SESSION 1.5: DYNAMICS OF INTIMATE PARTNER VIOLENCE

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explain the dynamics of intimate partner violence.
2. Describe the different forms of intimate partner violence.
3. Describe at least statistics on the prevalence of intimate partner violence.

TIME

55 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Paper and Pens
- Computer
- LCD projector
- Trainers' Tool 1.5: PowerPoint Presentation—Dynamics of IPV*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Prepare and post 3 flipchart posters, each with one of the following titles: “Tactics and Examples of Physical Abuse,” “Tactics and Examples of Sexual Abuse,” and “Tactics and Examples of Emotional/Psychological Abuse.”
- Set up computer and LCD projector for PowerPoint Presentation. If equipment is not available, develop a flipchart presentation using the *Trainers' Tool 1.5: PowerPoint Presentation—Dynamics of IPV*.

TRAINING STEPS

Step 1: Brainstorm (5 minutes)

1. Ask the participants to share their definition of “violence” with you. What does it look like? What occurs when there is violence? Who is generally involved? What feelings are evoked when you hear the word violence?
2. Then ask participants how they would define the term—“intimate partner violence.” Record their answers on a flipchart.

Step 2: Lecture and Lecture Activity (40 minutes)

1. Using *Trainers’ Tool 1.5: PowerPoint Presentation—Dynamics of IPV*, provide a 40-minute flipchart presentation on the dynamics and prevalence of IPV. Utilize the 15-minute, participant engagement activity that is imbedded within the presentation.

Participant Engagement Activity: Tactics of Intimate Partner Violence (15 minutes)

- a. Divide the group into pairs. Provide each pair with a piece of paper and a pen. Ask them to divide the paper into 3 sections and label each section with one form of IPV—physical abuse, sexual abuse and psychological abuse.
- b. For 10 minutes, allow the participants to brainstorm examples of the types of IPV abusers use to maintain power and control over their victims.
- c. At the conclusion of 10 minutes, provide each group with a flipchart marker, and ask them to record their answers on the flipchart paper at the front of the room. Assure them that their individual answers will not be analyzed but, rather, you are creating a comprehensive list of experiences clients might be facing when they arrive at the clinic. Remind them to write as clearly as possible, but not to be concerned about spelling, articulating things perfectly, or repeating any information that a peer has already written on the flipchart.
- d. For the next five minutes, review the posters one by one, clarifying any misconceptions and filling in any missing information.

Step 3: Closure and Transition (10 minutes)

1. Ask the participants for their gut reactions regarding the information they just heard. If the participants need prompting, ask the following questions:
 - Are you surprised by anything you heard?
 - How does it make you feel to know how prevalent this problem is?

TRAINING TIP

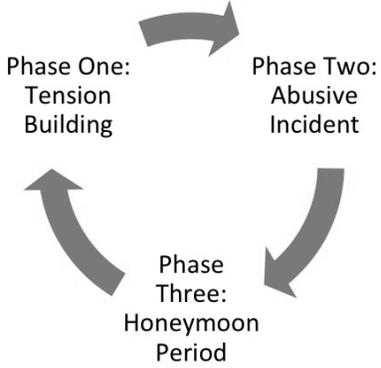
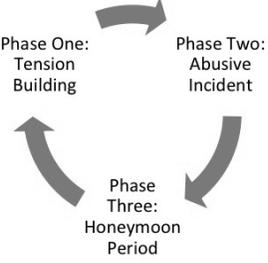
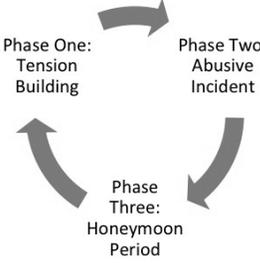
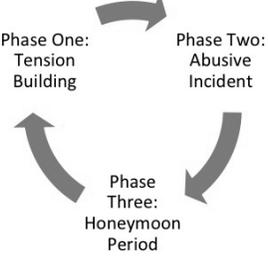
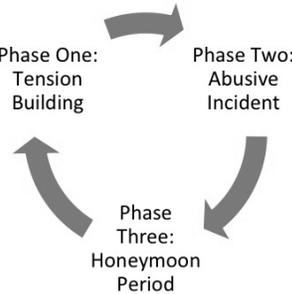
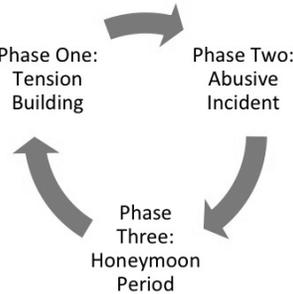
- ✓ Do not allow the conversation to delve too deep. You only want the participants to share their gut reaction. This is not an opportunity for them to contradict the information presented to them.
- ✓ Given that you only have 10 minutes, consider asking the participants to each share just one sentence describing their reaction to the information.

2. Explain that the next activity will tie all of today's activities together. The participants will soon learn how and why intimate partner violence is such a pervasive problem.

TRAINERS' TOOL 1.5:
POWERPOINT PRESENTATION—DYNAMICS OF IPV

<p>What is Intimate Partner Violence?</p> <p>Intimate partner violence (IPV) is a pattern of abusive behaviors and actions perpetrated by one person onto their intimate partner. IPV includes physical, sexual and psychological harm. Each of these three categories include varies methods for controlling an intimate partner.</p>	<p>What is an intimate partner?</p> <p>An intimate partner can be...</p> <ul style="list-style-type: none"> • a <u>current</u> husband, lover, boyfriend, wife* or girlfriend* • a <u>former</u> husband, lover, boyfriend, wife* or girlfriend*
<p>Intimate partner violence can...</p> <ul style="list-style-type: none"> • occur in opposite sex and gender relationships (a man and a woman). • occur in same sex and gender relationships (a man and a man; a woman and a woman). <p>Two people <u>do not</u> need to be living together and/or having sexual relations with someone in order for the relationship to be considered “intimate.”</p>	<p>Fact: IPV is linked to gender roles and gender norms.</p> <p><i>Remember:</i> Gender norms are socially assigned roles and responsibilities for women and men.</p> <ul style="list-style-type: none"> • Men are often socialized to be <u>powerful, controlling, unemotional and aggressive</u>. This results in a social acceptance of men being dominant. • Women are socialized to be <u>nurturing, passive, submissive and emotional</u>. This reinforces the notion that women are weak, powerless and need to depend on someone else. <p>The socialization of men and women results in an unequal power balance in society and in home...</p>
<p>Fact: IPV occurs when one person uses their status or power to control their partner.</p> <p>Most often, perpetrators of IPV are men. Men who perpetrate IPV think and believe they have the right to control their partner, because they see their partner as something less than themselves.</p> <p>This <i>does not mean</i> ALL men are perpetrators.</p>	<p>Fact: Victims of IPV are most often women.</p> <p>Women are socialized at a very early age to ignore and/or silence their opinions and thoughts. They are also taught that their body is not entirely their own.</p> <p>Because of this, it can be hard for women to recognize that what they are experiencing <u>is</u> IPV. Additionally, cultural beliefs about the gender roles of women can “naturalize” or “normalize” the abuse she is experiencing.</p>

TRAINERS' TOOL 1.5: POWERPOINT PRESENTATION—DYNAMICS OF IPV *continued*

<p>Fact: IPV escalates and de-escalates during a relationship.</p> 	<p>Phase One: Tension Building</p> <ul style="list-style-type: none"> • Abuser experiences increased tension • Accuser often increases threats and intimidation. • Accuser does not allow for open communication. • Victim feels uneasy, nervous and scared about upsetting the abuser. • Victim attempts different strategies to help keep things calm. • Tension become unbearable. 
 <p>Phase Two: Abusive Incident</p> <ul style="list-style-type: none"> • Abuser often uses physical strength to control victim. • Abuser's behavior is unpredictable. • Abuser blames the victim for his behavior. • Victim is traumatized and fearful. 	<p>Phase Three: Honeymoon Period</p> <ul style="list-style-type: none"> • Abuser is attentive and apologetic. • Abuser promises abuse will end. • Abuser minimizes the abuse and impact of the abuse. • Victim feels confused about the abuse. 
 <p>Participant Question:</p> <ol style="list-style-type: none"> 1. Who has the most power during each of the phases? 2. How did you make that determination? 	<p>The abuser has power and control in every stage of the cycle.</p> <p><i>The abuse – the power and control dynamic – is harder to “detect” in some phases because the abusers tactics of maintaining power and control over his victim are different.</i></p> 

TRAINERS' TOOL 1.5:
POWERPOINT PRESENTATION—DYNAMICS OF IPV *continued*

<h3 style="text-align: center;">The Cycle of Violence</h3> <ul style="list-style-type: none"> • IPV is present throughout all stages of the cycle of violence, even if the stages appear to vary in severity. • Because abusers can move between stages without warning or explanation, their victim is constantly on-guard. • Moving between stages without warning or explanation can also render a victim feeling confused about what they have done to prompt the shift in their perpetrator's "good" or "bad" behavior. • Moving between stages without warning or explanation is part of an abuser's tactic to cause harm. 	<p>Fact: Abusers use three main types of IPV to maintain power and control over their partner.</p> <p style="text-align: center;">Physical Abuse</p> <p style="text-align: center;">Sexual Abuse</p> <p style="text-align: center;">Emotional/Psychological Abuse</p>
<h3 style="text-align: center;">Participant Activity</h3> <p style="text-align: center;">In pairs, develop a list of examples of the three types of IPV – physical, sexual and psychological – abusers use to maintain power and control over their victims.</p> <p style="text-align: center;"><small>Example: Hitting is an example of physical abuse. Unwanted sexual touch is an example of sexual abuse. Name-calling and shaming are forms of psychological abuse.</small></p> <p style="text-align: center;"><small>(10 Minutes)</small></p>	<h3 style="text-align: center;">Tactics of Abuse</h3> <p>Fact: Sometimes emotional and psychological abuse can be harder to describe and detect than examples of physical and sexual abuse.</p> <p>Fact: All tactics of abuse cause tremendous hurt, pain and damage to victims of IPV.</p> <p>Fact: All tactics of abuse have short-term and long-term impacts on a victim.</p> <p>Fact: All tactics of abuse can have adverse health outcomes on a victim.</p>
<h3 style="text-align: center;">IPV Around the World</h3> <p style="text-align: center;">Intimate partner violence is a world-wide epidemic.</p> <ul style="list-style-type: none"> • The root causes of IPV are quite similar around the world. • The impact IPV has on individuals, families and communities is quite similar around the world. • The tactics of abusers are quite similar, though the examples may vary based on cultural and social norms of a particular region of the world. 	<h3 style="text-align: center;">Global Statistics on IPV</h3> <p>“Overall, 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or nonpartner sexual violence. While there are many other forms of violence that women may be exposed to, this already represents a large proportion of the world’s women.”</p> <p style="text-align: center;"><small>WHO</small></p>

TRAINERS' TOOL 1.5:
POWERPOINT PRESENTATION—DYNAMICS OF IPV *continued*

<p style="text-align: center;">Global Statistics on IPV</p> <p>“Most of this violence is intimate partner violence. Worldwide, almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. In some regions, 38% of women have experienced intimate partner violence.”</p> <p>WHO</p>	<p style="text-align: center;">Global Statistics on IPV</p> <p>Globally, as many as 38% of all murders of women are committed by intimate partners.</p> <p>WHO</p>
<p style="text-align: center;">Global Statistics on IPV</p> <p>“Women who have been physically or sexually abused by their partners report higher rates of a number of important health problems. For example, they are 16% more likely to have a low-birth-weight baby. They are more than twice as likely to have an abortion, almost twice as likely to experience depression, and, in some regions, are 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence.”</p> <p>WHO</p>	<p style="text-align: center;">Global Statistics on IPV</p> <p>“Globally, 7% of women have been sexually assaulted by someone other than a partner. There are fewer data available on the health effects of non-partner sexual violence. However, the evidence that does exist reveals that women who have experienced this form of violence are 2.3 times more likely to have alcohol use disorders and 2.6 times more likely to experience depression or anxiety.”</p> <p>WHO</p>

SESSION 1.6: FORMS, EFFECTS AND CAUSES OF VIOLENCE—PROBLEM TREE⁸

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Identify different forms of intimate partner violence.
2. Identify ways in which intimate partner violence can affect individuals.
3. Identify the root causes of intimate partner violence.

TIME

1 hour, 5 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Pencils/pens
- Watch or timer
- Thick markers—at least six green markers and six black/brown markers
- 10–15 pieces of green construction paper
- Scissors
- Handout 1.6: Intimate Partner Violence Problem Tree*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Cut at least 60 leaf shapes from the green construction paper.
- Print one copy of *Handout 1.6: Intimate Partner Violence Problem Tree* for each participant.
- Draw a tree diagram on the flipchart paper, with the “Effects,” “Forms” and “Root Causes” labeled at the appropriate levels. Provide one example of the type of response expected at each level (see next page).

⁸ Adapted from: The ACQUIRE Project/EngenderHealth. 2008. *Counseling for effective use of family planning: Trainer’s manual*. New York.

LOCATION	PART OF THE TREE	FEATURE	EXAMPLE
Top	Branches/Leaves	Effects	Diminished self-worth
Middle	Trunk	Forms	Physical violence
Bottom	Root	Root Causes	Power is valuable

TRAINING STEPS

Step 1: Introduction (10 minutes)

1. Explain to the participants that IPV grows in the same way a tree grows. In order for a tree to live, stand firm and tall, it needs to be deeply rooted into the ground. The trunk of a tree represents the problem—intimate partner violence. The roots of the tree represent the root causes of IPV. The leaves represent the impact and contributing factors of IPV.

The size of the trunk—the magnitude of the problem—is dependent on the strength of the roots. The leaves of a tree will only grow if they are fed nutrients from the roots.

2. Inform the participants that, together, you will develop a “Problem Tree,” an illustration of the causes and effects of intimate partner violence. Direct the participants’ attention to the tree diagram you have prepared. Provide the participants with the examples you have identified—diminished self-worth as a result of intimate partner violence, physical violence as a form of intimate partner violence, and power is valuable as a root cause of intimate partner violence.
3. Ask the participants if they have any questions about why the examples you have chosen, and where they align in terms of effects, forms or root causes. Answer the participant’s questions.
4. Together, identify the different forms or examples of IPV. Write the forms and examples of IPV on the trunk of the tree with a brown/black marker.

Examples to be included (not an exhaustive list):

PHYSICAL VIOLENCE	EMOTIONAL/ PSYCHOLOGICAL VIOLENCE	SEXUAL VIOLENCE
1. Hitting	1. Intimidations	1. Criticizing sexual performance
2. Kicking	2. Threatening physical harm to self, victim and/or family/friends	2. Forced intercourse (vaginal, oral or anal rape)
3. Slapping	3. Isolation	3. Unwanted touch or sexual advances
4. Punching	4. Undermining/compromising victim's personal relationships	4. Controlling victim's sexual and reproductive health
5. Grabbing	5. Harassment	5. Compromising victim's family planning method
6. Pinching	6. Spreading untruths the victim	6. Forced prostitution
7. Biting	7. Name-calling	7. Attacking sex parts of the body
8. Arm-twisting	8. Shaming/Criticizing	8. Sex outside of the intimate relationship
9. Stabbing	9. Crazy-making (rendering the victim confused about what is actually happening)	9. Accusing the victim of cheating
10. Hitting with objects	10. Instilling fear	10. Withholding sex/affection
11. Withholding or denying basic needs (food, water, medication, shelter, transportation)	11. Guilt-tripping (making the victim feel as if they are responsible for the abuse)	11. Forced pregnancy
12. Forcing the use of drugs or alcohol	12. Invading privacy	

Step 2: Small-Group Work—Identifying Effects of Intimate Partner Violence (10 minutes)

1. Divide the participants into pairs, and distribute at least 10 leaf shapes to each pair.
2. Allow the pairs 10 minutes to identify the effects of IPV, and to write the effects, one by one, on the leaves. Encourage the participants to identify effects at the personal, familial and community level.

Step 3: Large Group Share (10 minutes)

1. After 10 minutes, return the pairs to the large group. Invite each pair to share aloud the effects they identified, and to tape their leaves to the tree diagram. Possible effects may include:

PERSONAL	FAMILY	COMMUNITY
1. Injuries	1. Breakdown in communication	1. Loss of social standing
2. Disfigurement	2. Loss of trust	2. Economic impact—costs associated with “free” medical, legal and psychological assistance
3. Miscarriages	3. Children witness violence	3. Loss of sense of security/safety
4. Exposure to STIs and HIV	4. Constant tension/hyperarousal	4. Neighbors/Friends/Family become secondary care providers of children
5. Shame	5. Financial problems	5. Disruption of community life
6. Fear	6. Community passing judgment on family	
7. Isolation	7. Loss of social standing	
8. Self-blame	8. Divorce	
9. Denial	9. Disruption of everyday life	
10. Loss of sense of control	10. Substance abuse	
11. Stress		
12. Anxiety		
13. Depression		
14. Suicide/suicidal thoughts		
15. Inability to work/care for children		
16. Loss of income		
17. Inability to negotiate sex/use of family planning methods		
18. Substance abuse		

Step 4: Large Group Brainstorm—Root Causes (15 minutes)

1. Explain that intimate partner violence is a result of social conditions that render women with less power than men. For example, rigid and inequitable gender roles are a root cause of intimate partner violence.
2. Explain that our society often confusing root causes of intimate partner violence with behaviors that might “trigger” or “contribute” to the perpetration of IPV. For example, our society often believes that alcohol or drug abuse is a root cause of IPV. While alcohol/drug use may contribute to IPV, perpetrating violence is a choice. Not all individuals who use or overuse alcohol and drugs choose to perpetrate violence on their intimate partner violence; therefore, it is not a valid reason for violence—alcohol use is not a root cause of IPV.
3. Ask the participants to help you identify other root causes of IPV. Record their answers on the flipchart paper, near the roots of the tree. If the participants struggle with identifying root causes and, instead, identify contributing factors for IPV (i.e. alcohol use, etc.), encourage them to think on the societal level, versus the individual level. You may still record their answers on the tree diagram; however, record those responses at the top of the tree (in the leaves).

Definitions of Contributing Factor and Root Cause:

Contributing Factor: The individual experiences and choices we make that may influence whether something will happen.

Root Cause: The underlying conditions (social norms) in our society, which are the origin of the problem.

ROOT CAUSES	CONTRIBUTING FACTORS—DO NOT CAUSE IPV, THOUGH MAY TRIGGER IPV
<ul style="list-style-type: none">• Gender inequality—unequal power relations between husbands and wives• Men want to dominate women and use force to maintain their control• Inequality allows men to treat their wives with contempt—leads to violence• Women are not respected and recognized by society—they are stigmatized• Men think it is acceptable to express anger through physical & emotional violence• Women treated as inferior/subservient to men—makes them vulnerable to abuse• Women are taught to be submissive to their fathers, husbands and sons• Common view that husbands beating wives is acceptable—a form of “discipline”• Women lack decision making and financial power and do not control property	<ul style="list-style-type: none">• Hormones• Stress and frustration• Jealousy• Drugs or alcohol use• Mental health problem• Having a bad temper• Poverty• Weak laws and enforcement of laws related to IPV• Women’s limited access to education, employment and income

TRAINING TIP

- It is not uncommon for participants to misunderstand the difference between contributing factors and root causes of intimate partner violence. If this happens, push the participants to think deeper and broader than their own personal experiences. Rather, encourage them to think about the big picture—about society, as a whole.
- Factors that *contribute* to IPV and/or put an individual at risk for victimization or perpetration of IPV tend to involve an individual choice or revolve around an individual’s behavior. That individual choice or behavior rarely impacts an entire society.
- Root causes are systems of oppression that impact large groups of individuals at one time. In order to change a system, large groups of individuals are required to change their perception, values and ideals.

Step 5: Large Group Discussion and Debrief (20 minutes)

1. Lead a large group discussion with the questions listed below.

- Why is it important for family planning providers to know to be able to understand the causes and consequences of IPV?
- In what ways does our clinic environment currently reinforce harmful social gender norms? What are some of the consequences of such an environment for a female patient?

TRAINING TIP

- Take the participants back to the gender and sex activities you did at the beginning of the day and reinforce the following points:
 - Gender norms are socially assigned roles and responsibilities for women and men.
 - How we are raised—how we are “socialized” has a tremendous impact on how we understand our roles and responsibilities.
 - Men are socialized at an early age to be powerful, controlling, unemotional and aggressive. This results in a social acceptance of men being dominant, and exercising violence as means of demonstrating and maintaining dominance.
 - Women are socialized at an early age to be nurturing, passive, submissive and emotional. This reinforces the notion that women are weak, powerless and need to depend on someone else.
 - The socialization of men and women results in an unequal power balance in society and in the home.

- In what ways can we challenge gender and social norms and modify our clinic environment and the way we provide care and treatment to better serve all of our clients?

TRAINING TIP

- The information you are sharing with participants may be new and challenging information to hear and process. Additionally, it can feel impossible to change something that is so engrained in the way that we live as individuals and within society. Help participants think about the here and now—what they can do to create a clinic environment that supports gender equality and seeks to redistribute power and control evenly. Examples of this include:
 - Modeling healthy behavior among staff and with clients;
 - Allowing clients to exact power and control over their own lives by providing clients with all of their options, and trusting them to make the best decisions for their lives;
 - Reinforcing that intimate partner violence is unacceptable behavior should a client disclose of their experience;
 - Creating mechanisms for clients to access services should they need support that is beyond the scope of care and treatment of the clinic.
- As indicated in the discussion questions, this activity provides the opportunity for you to reinforce the action planning component of this training. At the conclusion of each day, participants will have the opportunity to develop a recommendation for how the clinic can better meet the needs of clients.

Step 6: Closure and Transition (5 minutes)

1. Reiterate the following points to the participants:

- Providing this information to a client experiencing IPV can help to validate their experience.
- Survivors of IPV often focus on changing their circumstances in order to address contributing factors. When they are able to change the circumstances but the violence continues to occur, survivors often times feel as if they have failed in some way.
- The main cause of gender violence is that men use violence to exert control over their wives or partners.
- Women have been socialized to be submissive to their husbands and not to question the husbands' behavior. They have been taught to bottle up the problems of the family and protect the family secrets at all costs. This is why they remain silent after being beaten.
- Men have been socialized to be domineering—to be “laws unto themselves” and to treat women with contempt, rather than respect. They treat their wives as their property: they feel they own their wives, so they have a right to do anything to them without being questioned.
- Men feel that it is acceptable to express their anger through intimidating, verbally abusing or beating their wives. They think this is their right.
- All forms of IPV—physical, emotional, economic or sexual—are wrong and need to be stopped, rather than hidden or condoned. The impact of this violence is far reaching at the individual, familial and community level.

TRAINING DAY 1

HANDOUT 1.6: INTIMATE PARTNER VIOLENCE PROBLEM TREE

Tree Analogy

In order for a tree to live, stand firm and tall, it needs to be deeply rooted into the ground. The size of the trunk is dependent on the strength of the roots. Roots soak up nutrients, which travel through the trunk of the tree and to the branches. As a result, of this nutrient system, leaves begin to grow.

Intimate Partner Violence (IPV) is fed by gender inequality and unequal distribution of power and control. IPV is rooted in the underlying conditions—social and cultural norms—of our society. While there are many contributing factors that may increase the risk for IPV, these factors reinforce the underlying conditions, allowing IPV to occur. The impact of IPV is far reaching and can have lasting effects on a survivors overall health and wellbeing.

- The trunk of the tree presents the problem of Intimate Partner Violence.
- The nutrients represent the essential components of IPV—gender inequity and unequal distribution of power and control.
- The oldest and deepest roots of the tree represent the root causes of IPV:
 - “Act like a man”
 - “Act like a woman”
 - Accustomed to violence
 - Acceptance of violence and/or aggressive behavior
 - Power is valuable
 - Shame or secrecy about sexuality
 - How we were raised
 - Desire for control
 - Lack of awareness of human rights
- The leaves of the tree represents the contributing factors of IPV (excuses for why IPV occurs) and the consequences of IPV, respectively (not exhaustive lists):
 - Hormones
 - Stress and frustration
 - Jealousy
 - Drugs or alcohol use
 - Mental health problem
 - Having a bad temper
 - Poverty
 - Weak laws and enforcement of laws related to IPV
 - Women’s limited access to education, employment and income

HEALTH CONDITIONS	REPRODUCTIVE HEALTH CONDITIONS	PSYCHOLOGICAL	SOCIAL
<ul style="list-style-type: none"> • Asthma • Bladder/kidney infections • Circulatory conditions • Cardiovascular disease • Fibromyalgia • Irritable bowel syndrome • Chronic pain • Central nervous system disorders • Gastrointestinal disorder • Joint disease • Migraines/Headaches 	<ul style="list-style-type: none"> • Gynecological disorders • Pelvic inflammatory disease • Sexual dysfunction • STIs & HIV/AIDS • Delayed prenatal care, if any • Unintended pregnancy • Complicated birth 	<ul style="list-style-type: none"> • Anxiety • Depression • Posttraumatic Stress Disorder • Suicidal thoughts • Low self-esteem • Inability to trust others • Fear of intimacy • Emotional detachment • Sleep disturbances • Flashbacks • Nightmares 	<ul style="list-style-type: none"> • Restricted access to services • Strained relationship with health providers and employers • Isolation from support networks • Homelessness

SESSION 1.7: INTIMATE PARTNER VIOLENCE CASE STUDIES⁹

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Identify different types of violence that may occur in intimate relationships.

TIME

45 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Watch or timer
- Thick markers—various colors
- Pencils/pens
- Watch or timer
- Handout 1.7: Intimate Partner Violence Case Studies*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print one copy of *Handout 1.7: Intimate Partner Violence Case Studies* for each participant, as well as one copy for yourself.

TRAINING STEPS

Part 1: IPV Case Studies and Discussion (40 minutes)

1. In a large group discussion format, ask the participants to volunteer to read aloud each of the case studies on IPV. After each case study is presented, lead a large group discussion using the discussion questions listed under the case study.

⁹ Adapted from: The ACQUIRE Project/EngenderHealth and Promundo. 2008. *Engaging boys and men in gender transformation: The group education manual*. New York and Rio de Janeiro.

TRAINING TIP

- ✓ Establish a mechanism for ensuring that each group member has the opportunity to share their thoughts. Consider using a “talking stick” that is passed from person to person; only the person with the stick can be speaking. This will help cut down on people talking over one another.
- ✓ Some of the case studies are intended to be vague as a means of sparking dialogue. However, all of the case studies include explicit forms of IPV and/or implied forms of IPV. Allow the group to grapple with the information before you interject your opinion. Before moving to the next case study, do take a stance and share your expertise. It is important for the group to understand that IPV isn’t always physical and it isn’t as blatant as we think it might be.
- ✓ Take mental notes of problematic statements that might be made. You may need to address the statements in the moment; however, you may also consider using those problematic statements as teaching moments in subsequent training sessions. For example, some of the information included in the case studies will appear in the Myths and Facts activity. Problematic statements might include:
 - If she didn’t make him so angry he wouldn’t have to hit her.
 - This type of behavior is a private matter.
 - She would leave if it was that bad.
 - He must have a mental disorder.

Part 2: Closure and Transition (5 minutes)

1. Make the following key points with the group:

- Violence can be defined as the use of force, manipulation, intimidation or coercion, by one individual against another, and is used as a way to control another person or to have power over them.
- Violence happens all around the world and often stems from the way individuals, especially men, are raised to deal with power, anger and conflict.
- It is commonly assumed that violence is a “natural” or “normal” part of being a man; however, violence is a learned behavior. Men are often socialized to repress their emotions, and anger is sometimes one of the few socially acceptable ways for men to express their feelings.
- Moreover, men are sometimes raised to believe that they have the “right” to expect certain things from women (domestic tasks or sex, for example), and the right to use physical or verbal abuse if women do not provide these things. Men may also resort to violence to assert their views or decisions, thereby making communication nearly impossible.

- 
- Women are raised to believe that their opinions, beliefs and suggestions are of lesser value than the opinions, beliefs and suggestions of men. Additionally, women are taught that if they express their concerns, they are simply “complaining.”
 - It is important to think about how these rigid gender roles related to how men should express their emotions and how they should interact with women are harmful both to men and their relationships. Additionally, it is important to take into consideration the ways in which women are socialized to understand the proper and improper ways of communicating. In your daily lives, it is essential that you, as providers, can think about ways to restore power back to clients experiencing IPV

TRAINING DAY 1

HANDOUT 1.7: IPV CASE STUDIES

Case Study #1: Family Dinner

Chidike and Abena are married. Chidike's family is coming over to their home for dinner. He is very anxious that they all have a good time and he wants to show them that his wife is a great cook. When he gets home that night, nothing is prepared. Abena has not been feeling well, and she has not started making dinner yet. Chidike is very upset. He does not want his family to think that he cannot control his wife. They begin to argue and yell at each other. The fight quickly escalates, and Chidike hits her.

Discussion Questions

1. Do you think that Chidike was right to hit Abena?
2. How should Abena react?
3. Could Chidike have done anything differently in this situation?
4. How do you think norms about gender contributed to this situation?
5. If Abena was your client and she told you this story, what might you say to her?

Case Study #2: Partners Arguing

As you are leaving the clinic, you notice your client arguing with her partner near the next building. You hear him call her a “bitch” and then ask her why she was flirting with the other man in the waiting area. She looks very upset and says, “I was not looking at him...I'm with you...I love you!” He sees you coming and quiets his voice. You are unable to hear the next thing he says to her, but you see her lower her head and begin to cry. As you walk past them, you hear her say, “I'm sorry.”

Discussion Questions

1. Is this IPV? How do you make this determination?
2. How do you think norms about gender contributed to this situation?
3. What would you do? Would you approach the client? Would you say anything? Why or why not?
4. What can you do in situations like this one? What are your options?
5. Would your determination or actions change if you saw the man hit your client?
6. What might you say to your client?

Case Study #3: You Owe Me Sex

Kayode is an older boy who comes from a wealthy family. He met Monifa one day on her way home from school and they have been dating for one month. One afternoon he tells Monifa how much he likes her. They start to kiss, and Kayode starts touching Monifa under her blouse. But then Monifa stops and says that she doesn't want to go any further. Kayode is furious. He tells her, "I've spent the last month with you and you owe this to me." He pressures her to change her mind. First, he tries to be seductive, then he yells at her in frustration. He begins pulling at her forcefully, pushing her down. He then forces her to have sex, even though she keeps saying, "No, stop!"

Discussion Questions

1. Does Monifa owe Kayode sex?
2. Is this IPV? Why or why not?
3. How do you think norms about gender contributed to this situation?
4. What do you think Kayode should have done?
5. What do you think Monifa should have done?
6. Would the situation be different if Kayode and Pila were married?

Case Study #4: Spending Time with Friends and Family

Nneka used to have a lot of friends in her community, and her children would play with her friends' children. Nneka has not been attending social events recently because Olabode, her partner, wants her to devote her free time to caring for their home. Olabode has also told Nneka that her friends aren't actually her friends, but rather they like her because she shares household goods and food with them. This confuses Nneka because Olabode is very nice to her friends when he sees them. Recently, Olabode started criticizing the amount of time Nneka spends with her mother, father and sister because they he feels as if they don't like him. Nneka has to beg Olabode to spend time with her friends and family. Sometimes he says yes, but most of the time he says no.

Discussion Questions

1. Is this IPV? Why or why not?
2. Do you think either Olabode or Nneka are being unreasonable to one another?
3. How do you think norms about gender contributed to this situation?
4. What might Nneka do in this situation?
5. What might you say to Nneka if she were to tell you this story?

Case Study #5: Expectation to Have Sex No Matter What

Seble and Tamrat have been married for only a year. They were very happy and loving in the beginning of their relationship, but after 6 months things started to change. Tamrat stopped coming home after work, and sometimes disappears for days at a time. Seble tried to confront Tamrat about this and he quickly become angry, telling her it's none of her business since he is the person providing for both of them. Also, Seble has been suffering from chronic urinary tract infections that cause her to feel feverish and have pain when she engages in any sexual activity. Tamrat call Seble's symptoms "excuses" for not to have sex with him. Even though she doesn't want to, Seble will sometimes engage in sexual activity to keep Tamrat from becoming angry with her. Last night, Seble said "no" to having sex. Tamrat said fine, but then told Seble she at least needed to provide him with oral sex.

Discussion Questions

1. Is this IPV? Why or why not?
2. How do you think social norms about gender contributed to this situation?
3. Does Seble have the right to know where Tamrat is even if he is providing for them?
4. Can Tamrat demand sex from Seble?
5. Would this situation be different if Tamrat and Seble were dating and not married?
6. What might you say to Seble if she were your client?

SESSION 2.1: WELCOME AND REFLECTION

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Reflect on the previous day's accomplishments.
2. Articulate at least two new points of knowledge.
3. Describe the agenda for the day.

TIME

30 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or cell phone that can tell time
- Handout 1.1: Training Agenda*

ADVANCE PREPARATION

- Create and post two flipcharts, one titled “Reflections from Day 1,” the other “New Knowledge.”

TRAINING STEPS

Step 1: Welcome and Reflection (5 minutes)

1. Welcome the participants back to the training. Thank the participants for the attention the previous day and for the insight they brought to the training. Encourage the participants to continue to challenge themselves throughout the day, engage with the material and ask questions of each other and of themselves.
2. Direct their attention to *Handout 1.1: Training Agenda* and review the material they will be addressing throughout the day. Ask the participants if they have anything they would like you to be certain to cover in the agenda.



Step 2: Training Reflections (20 minutes)

1. Ask the participants to take a moment to think about two things: What they learned in the previous day's training, and how the previous day's training made them feel. Specifically, you would like them to do the following:
 - a. Identify at least two new points of knowledge they acquired in the previous day's training.
 - b. Identify at least two reflections from the previous day's training—how the training made them feel, what continues to circulate in their mind, or something they need additional clarification on.
2. Ask the participants to jot down their answers on a piece of paper. One by one, ask the participants to share their answers.
3. Record the participant's answers on the flipcharts titled, "Reflections from Day 1" and "New Knowledge."

Step 3: Closure and Transition (5 minutes)

1. Ask the participants if there is anything they would like to add before you begin the training modules.
2. Provide encouraging words for what they might gain from today's material.

SESSION 2.2: MYTHS RELATED TO IPV

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Argue against common myths surrounding intimate partner violence.

TIME

1 hour, 5 minutes

MATERIALS

- Flipchart paper
- Markers—various colors
- Paper and pens
- Flipchart poster of The IPV Problem Tree from Session 1.4
- Flipchart posters of Act Like a Man / Act Like a Woman from Session 1.3
- Flipchart poster of The Cycle of Violence from Session 1.4
- Trainers' Tool 2.2A: Myths Related to IPV*
- Trainers' Tool 2.2B: Dispelling the Myths of IPV*
- Handout 2.2: Dispelling the Myths of IPV*
- Scissors
- Container of some sort (e.g., dish, bowl, hat or small box)

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print one copy of *Trainers' Tool 2.2A: Myths Related to IPV*. Cut the myths into individual slips of paper. Fold the slips of paper in half and place them inside a container. Keep the other copy for your use.
- Print one copy of *Trainers' Tool 2.2B: Dispelling the Myths of IPV*.
- Print a copy of *Handout 2.2: Dispelling the Myths of IPV* for each participant.
- Post flipcharts of the IPV Problem Tree, Act Like a Man / Act Like a Woman and the Cycle of Violence on the front wall.

TRAINING STEPS

Step 1: Brainstorm (5 minutes)

1. Ask participants to define the word *myth*. Example definitions of the term myth include:
 - Something that is untrue.
 - Misinformation that is created to explain something.
 - A widely held belief that resulted from the passage of time.
2. Inquire about where myths come from? Why do they exist? What purpose do myths serve in our society? Example responses may include:
 - Myths exist because we don't otherwise know what is true.
 - Myths become part of our culture and/or traditions.
 - Myths result from misinformation or misunderstanding.
 - Myths can provide explanation for ideas or thoughts that have to be explored.

Step 2: Dispelling the Myths of IPV (20 minutes)

1. Explain to the participants that they will spend 20 minutes in pairs taking an in-depth look at myths related to IPV. Explain that myths related to IPV originate from the root causes of IPV (refer to the IPV Problem Tree exercise).
2. Divide the group into pairs. Allow each group to draw 2–3 statements about myths related to IPV from the container (you will have cut the slips of paper from *Trainers' Tool 2.2A: Myths Related to IPV*).
3. Explain that each group is to discuss the following aspects as it pertains to the myth with which they have drawn:
 - Why the statement is untrue.
 - With which root cause or causes the myth is associated:
 - i. Social acceptance of violence and/or aggressive behavior;
 - ii. Power is value;
 - iii. Shame and secrecy about sexuality;
 - iv. How we were raised;
 - v. Desire for control;
 - vi. Lack of awareness of human rights; or
 - vii. Rigid and inequitable gender roles.

4. Provide them with *Handout 2.2: Dispelling the Myths of IPV* in which to record their answers.
5. Allow small groups 20 minutes to complete the exercise. It is okay if the participants do not finish the exercise within the 20-minute timeframe. You will have time to complete the exercise in the large group discussion.

Step 3: Large Group Discussion (25 minutes)

1. After the conclusion of the 20 minutes, return to a large group.
2. Allow each pair five minutes to share their statements and a summary of their discussion. After each myth is presented, ask the remaining pairs if they have anything they would like to add. If necessary, expand on the answers by using the information providing in the *Trainers' Tool 2.2B: Dispelling the Myths of IPV*.
3. If you have remaining time left, work through any statements that are left in the container.

TRAINING TIP

- This activity can be challenging for both the group and for the facilitator. While some myths seem obvious in nature, others may not. This activity will likely challenge ideas and notions that are deeply imbedded in personal histories. They challenge the social norms we live by every day. For some participants, it can be a painful, frustrated, and disheartening experience to learn that the values and ideals we were raised by are sometimes harmful. For other participants, this activity may feel liberating or validating to finally know the truth behind these statements. Model the behavior you want the clinic staff to embrace by facilitating a discussion that honors the experiences of *all* of your participants.
- Depending on the skill level of the participants, you may consider adding a step to be completed during the small group activity. In addition to asking the participants to identify why the statement is untrue and with which root cause the statement is associated, also ask them to identify the following: a.) The impact the statement could have on a family planning client experiencing IPV; and/or b.) A 1–2 sentence explanation a provider might give to a client whom believes the statement to be true. Please see *Trainers' Tool 2.2: Dispelling the Myths of IPV (alternate exercise)* and *Handout 2.2: Dispelling the Myths of IPV (alternate exercise)*.

Step 4: Closure and Transition (15 minutes)

Reflect back on previous training sessions and express the following sentiments about each activity:

1. Act Like a Man / Act Like a Woman exercise:
 - Many of the myths related to IPV reinforce the notion that men are *supposed* to be strong and dominant, and women are *supposed* to be weak and submissive.
 - Myths about sex and sexuality suggest that women have no sexual desire and that their bodies are objects to be used at men's disposal.

2. The IPV Problem Tree exercise:

- Myths manifest from the root causes of IPV. Like contributing factors, they make excuses for why IPV occurs, rather than addressing the underlying social norms that allow IPV to continue.
- Remind participants that the essential components of IPV are gender inequity and an unequal distribution of power and control. Myths help the tree to grow stronger—they give the tree power. Therefore, myths add to the power and control abusers have over their victims. Myths serve to further disempower victims, and often contribute significantly to a victim's decision to disclose of IPV.
- Men who perpetrate IPV do so because of the way they *think*—they believe they have the right to have power and control over their partner. Their behavior and actions (the abuse) are a result of the way they think. Therefore, myths associated with abusive men's behavior (e.g., "Sometimes men get so angry they lose control.") fail to acknowledge what lies *beneath* the behavior—the root cause of the way they think.

3. Refer to the Cycle of Violence presented during the IPV lecture:

- Remind participants that IPV escalates and deescalates, repeatedly, over the course of a relationship. IPV can be hard to detect in Phases One and Three. Victims often feel confused about what is happening; they begin to think the violence is a result of something they are doing wrong. The only person who can stop the violence is the person who is perpetrating the violence.
- The cycle is powerful, and violence is present in every phase of the cycle. Abusers often move between stages without warning or explanation, leaving their victim constantly on guard. Victims often stay in relationships because of the deescalation—there are times when the relationship feels loving and healthy. Myths associated with leaving an IPV relationship fail to take into account the Cycle of Violence.

TRAINING DAY 2

TRAINERS' TOOL 2.2A: MYTHS RELATED TO IPV

1. Intimate partner violence is just an occasional slap, push or verbal or argument.
2. Women should learn how not to make their partners so angry.
3. Children who witness intimate partner violence are not affected by the abuse.
4. Men who abuse their partners have serious mental health issues.
5. Sometimes men get so angry they lose control.
6. Intimate partner violence only happens in poor communities, and abusers are generally uneducated.
7. A man can do what he wants to a woman once they are married.
8. Women need to learn how to stand up for themselves more.
9. A man is allowed to force his wife to have sex.
10. Mediation between a two people can resolve IPV.
11. Intimate partner violence is extremely rare.
12. Sometimes women deserve to be hit, slapped, kicked or punched.
13. Intimate partner violence is a problem between a husband and a wife.
14. Women stay in abusive relationships because they are weak.

TRAINING DAY 2

TRAINERS' TOOL 2.2B: DISPELLING THE MYTHS OF IPV

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.
Intimate partner violence is just an occasional slap, push or verbal or argument.	Once violence begins in a relationship, it escalates and becomes more frequent and severe over the course of time. IPV is not just one physical attack. Abusive men use a series of tactics to cause harm, including: intimidation, threats, economic deprivation, physical, psychological and sexual abuse. Most survivors have been assaulted by their partner multiple times.	1. Social acceptance of violence and/or aggressive behavior
Women should learn how not to make their partners so angry.	IPV is rooted in power and control. There is nothing a victim can do to stop the violence. The only person who can stop the violence is the abusive partner.	1. Rigid and inequitable gender norms 2. How we were raised
Children who witness intimate partner violence are not affected by the abuse.	While some children may not be the target of physical or sexual abuse, witnessing IPV is absolutely a form of psychological abuse. Many of these children develop cognitive and psychological problems after being exposed to violence. How we are raised is a root cause of IPV; therefore, children who witness violence are at higher risk for becoming a victim or perpetrator of IPV.	1. Social acceptance of violence and/or aggressive behavior 2. How we were raised 3. Rigid and inequitable gender norms
Men who abuse their partners have serious mental health issues.	An extremely small percentage of abusive men have diagnosable mental health disorders. Mental illness may be a contributing factor, but it is not a root cause.	1. Lack of awareness of human rights
Sometimes men get so angry they lose control.	Men who perpetrate IPV do not generally perpetrate violence against other people with whom they associate. If violence was a matter of losing control, then there would not be one single target of the abuse. Abusive men target their partner, and exert their power and control to cause harm.	1. Rigid and inequitable gender norms 2. How we were raised
Intimate partner violence only happens in poor communities, and abusers are generally uneducated.	IPV is a global health problem. It impacts all social groups, regardless of gender, sexuality, religion, marital status, race, economic class or education status.	1. Lack of awareness of human rights.
A man can do what he wants to a woman once they are married.	In general, social norms allow men to have more social standing and power than woman. IPV is an exploitation of power.	1. Power and control are valuable 2. Lack of awareness about human rights 3. Rigid an inequitable gender roles
Women need to learn how to stand up for themselves more.	Abusers feel the need to maintain power and control over their victim. Women who confront their abusive partners are taking back some of the power and control. This is seen as a threat to the abuser's control. As a result, IPV often escalates and the danger increases for women experiencing violence.	1. Power and control are valuable (dominant masculinity is desirable) 2. Rigid and inequitable gender roles.

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.
A man is allowed to force his wife to have sex.	Forcing an intimate partner to have sex is a form of sexual abuse; it is rape. It is a crime. Sexual abuse encompasses a range of actions, including unwanted touch, harassment and exploitation.	<ol style="list-style-type: none"> 1. Rigid and inequitable gender norms. 2. Shame and secrecy about sex and sexuality
Mediation between two people can resolve IPV.	At the root of intimate partner violence is power and control. An abusive partner feels entitled to use their power to control their partner. Mediation can be an effective method if the distribution of power is the same between two people, as the intention of couples counseling is to hold both parties accountable for the health of the relationship. In the case of intimate partner violence, the only person accountable for causing harm is the perpetrator; the only person who can solve the relationship problem is the perpetrator. Using mediation in instances of intimate partner violence is a form of victim blaming—holding a survivor equally accountable for the health of the relationship, when there is virtually nothing she can do to stop the violence being perpetrated on her.	<ol style="list-style-type: none"> 1. Lack of awareness about human rights. 2. Rigid and inequitable gender roles.
Intimate partner violence is extremely rare.	IPV is extremely common. Thirty-five percent of women worldwide have experienced either physical and/or sexual intimate partner violence. Globally, as many as 38% of all murders of women are committed by intimate partners.	<ol style="list-style-type: none"> 1. Lack of awareness about human rights 2. Rigid and inequitable gender roles 3. How we were raised
Sometimes women deserve to be hit, slapped, kicked or punched.	<p>No one deserves to be abused. The only person responsible for the abuse is the abuser. While Guinean law does not recognize domestic violence (intimate partner violence) as a crime, assault of another person is a crime. Intimate partner violence is a form of assault.</p> <p>Secondly, this myth reduces intimate partner violence to isolated instances of violence, rather than recognizing the abuse as a systematic effort to render a victim powerless.</p>	<ol style="list-style-type: none"> 1. Rigid and inequitable gender norms 2. Lack of awareness about human rights 3. Social acceptance of violence and/or aggressive behavior 4. How we were raised
Intimate partner violence is a problem between a husband and a wife.	IPV not only affects families, it affects communities and society. IPV exists because of social norms that are harmful to all individuals. It is an epidemic that will continue until society addresses the social norms that permute and permit intimate partner violence to continue.	<ol style="list-style-type: none"> 1. Lack of awareness about human rights 2. Rigid and inequitable gender norms 3. Social acceptance of violence and/or aggressive behavior
Women stay in abusive relationships because they are weak.	<p>There are number of reasons why women stay in abusive relationships—none of which are because they are weak. The following contribute to why women stay in abusive relationships: lack of a support system; children; economic reasons; diminished sense of self-worth; and, the cycle of violence—waiting for the calm to return.</p> <p>Additionally, this myth sends mixed messages about how women are supposed to act. Gender norms around desired femininity support the notion that women are supposed to be dependent on a partner.</p>	<ol style="list-style-type: none"> 1. Rigid in equitable gender norms 2. How we were raised

TRAINING DAY 2

HANDOUT 2.2: DISPELLING THE MYTHS OF IPV

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.
Intimate partner violence is just an occasional slap, push or verbal or argument.		
Women should learn how not to make their partners so angry.		
Children who witness intimate partner violence are not affected by the abuse.		
Men who abuse their partners have serious mental health issues.		
Sometimes men get so angry they lose control.		
Intimate partner violence only happens in poor communities, and abusers are generally uneducated.		
A man can do what he wants to a woman once they are married.		



MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.
Women need to learn how to stand up for themselves more.		
A man is allowed to force his wife to have sex.		
Mediation between two people can resolve IPV.		
Intimate partner violence is extremely rare.		
Sometimes women deserve to be hit, slapped, kicked or punched.		
Intimate partner violence is a problem between a husband and a wife.		
Women stay in abusive relationships because they are weak.		

TRAINING DAY 2

TRAINERS' TOOL 2.2: DISPELLING THE MYTHS OF IPV (ALTERNATE EXERCISE)

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.	THE IMPACT SUCH A STATEMENT COULD HAVE ON A CLIENT EXPERIENCING IPV.	A 1–2 SENTENCE RESPONSE YOU MIGHT GIVE IF YOU HEARD SOMEONE USING THIS STATEMENT.
Children who witness intimate partner violence are not affected by the abuse.	While some children may not be the target of physical or sexual abuse, witnessing IPV is absolutely a form of psychological abuse. Many of these children develop cognitive and psychological problems after being exposed to violence. How we are raised is a root cause of IPV; therefore, children who witness violence are at higher risk for becoming a victim or perpetrator of IPV.	<ul style="list-style-type: none"> • Social acceptance of violence and/or aggressive behavior • How we were raised • Rigid and inequitable gender norms 	Because of the power and control associated with IPV, most victims will prioritize the needs and desires of those around them, before addressing their own. For some survivors of IPV, knowing the impact the violence is having on the children is the only thing that will motivate her to acknowledge or address the violence she is experiencing.	Generally, those closest to the survivor—physically, emotionally and mentally—are also impacted by the violence a survivor is experiencing. Children often learn how to act and behave based on how those around them act and behave. Because how we are raised—socialized—is a root cause of IPV, children who are exposed to IPV have an increased risk of later becoming perpetrators of violence or victims of violence.
Men who abuse their partners have serious mental health issues.	An extremely small percentage of abusive men have diagnosable mental health disorders. Mental illness may be a contributing factor, but it is not a root cause.	Lack of awareness of human rights	A client may not understand that what they are experiencing is actually IPV. They may feel as if the IPV will end once their partner is well again.	Perpetrating IPV is a choice. There are many people who suffer from mental health disorders who choose not to perpetrate IPV. Mental health disorders cannot be used as an excuse to cause harm.
Sometimes men get so angry they lose control.	Men who perpetrate IPV do not generally perpetrate violence against other people with whom they associate. If violence was a matter of losing control, then there would not be one single target of the abuse. Abusive men target their partner, and exert their power and control to cause harm.	<ul style="list-style-type: none"> • Rigid and inequitable gender norms • How we were raised 	Clients may feel as if they are the cause of their partner's anger and, thus, responsible for the violence they are experiencing. They may not disclose if they feel as if they are to blame for the violence.	This notion is harmful for both men and women. Anger is a normal feeling to experience and there are many ways in which a person can express their anger without causing harm to their partner. Physical abuse against a partner is never justifiable.

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.	THE IMPACT SUCH A STATEMENT COULD HAVE ON A CLIENT EXPERIENCING IPV.	A 1-2 SENTENCE RESPONSE YOU MIGHT GIVE IF YOU HEARD SOMEONE USING THIS STATEMENT.
Intimate partner violence only happens in poor communities, and abusers are generally uneducated.	IPV is a global health problem. It impacts all social groups, regardless of gender, sexuality, religion, marital status, race, economic class or education status.	<ul style="list-style-type: none"> Lack of awareness of human rights. 	A client will likely not disclose if they feel you are making an assumption about them based on their class status or level of education.	IPV is a common experience for women all around the world, regardless of gender, race, class or education status.
A man can do what he wants to a woman once they are married.	In general, social norms allow men to have more social standing and power than woman. IPV is an exploitation of power.	<ul style="list-style-type: none"> Power and control are valuable Lack of awareness about human rights Rigid and inequitable gender roles 	A client may feel as if she needs to follow the wishes of her partner, instead of expressing her own opinions and desires. A client may choose a FP method that suits her partner, rather than a FP method that suits her needs. A client may decide to abandon a contraceptive method because her partner wants her to have more children, even though she may not desire any more children.	Women have their own needs, desires and opinions regardless of whether or not she is married. When we think of women as objects to be used our disposal, it justifies the violence their partner is using against them.
Women need to learn how to stand up for themselves more.	Abusers feel the need to maintain power and control over their victim. Women who confront their abusive partners are taking back some of the power and control. This is seen as a threat to the abuser's control. As a result, IPV often escalates and the danger increases for women experiencing violence.	<ul style="list-style-type: none"> Power and control are valuable (dominant masculinity is desirable) Rigid and inequitable gender roles. 	A client, who has experienced an increase of violence as a result of standing up for herself, will likely be concerned about confidentiality. Disclosing of the abuse and getting help because of it, is a threat to his power. A client who has not resisted her partner's abuse may feel embarrassed and worried that you will think she is allowing the abuse to happen.	<p>Women are receiving mixed information about how they are supposed to act. Women are taught to be nurturing of others, and to be passive or submissive. Standing up for one's self aligns with how men are supposed to act. Acting outside of one's assigned gender role is considered undesirable.</p> <p>Additionally, it may be that she is unaware of how to stand up for herself because she was never been taught to do so. Instead, she was taught that a man—her husband—was supposed to protect her from harm. This is another mixed message women are receiving about how they are supposed to act.</p>

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.	THE IMPACT SUCH A STATEMENT COULD HAVE ON A CLIENT EXPERIENCING IPV.	A 1–2 SENTENCE RESPONSE YOU MIGHT GIVE IF YOU HEARD SOMEONE USING THIS STATEMENT.
<p>A man is allowed to force his wife to have sex.</p>	<p>Forcing an intimate partner to have sex is a form of sexual abuse; it is rape. It is a crime. Sexual abuse encompasses a range of actions, including unwanted touch, harassment and exploitation.</p>	<ul style="list-style-type: none"> • Rigid and inequitable gender norms. • Shame and secrecy about sex and sexuality 	<p>The consequences of rape and sexual assault can be long-lasting and devastating for survivors, especially when the perpetrator is someone that is supposed to love and care for the survivor. Additionally, the risk of developing posttraumatic stress disorder is significantly higher for individuals who lack a strong support network, which can be true of survivors of intimate partner violence, as their partner has likely isolated from their family and friends.</p>	<p>Every person has the right to govern their body, including women. Simply because a man and woman are married, it does not give permission to the husband to force sex at any point in time.</p>
<p>Mediation between two people can resolve IPV.</p>	<p>At the root of intimate partner violence is power and control. An abusive partner feels entitled to use their power to control their partner. Mediation can be an effective method if the distribution of power is the same between two people, as the intention of couples counseling is to hold both parties accountable for the health of the relationship. In the case of intimate partner violence, the only person accountable for causing harm is the perpetrator; the only person who can solve the relationship problem is the perpetrator. Using mediation in instances of intimate partner violence is a form of victim blaming—holding a survivor equally accountable for the health of the relationship, when there is virtually nothing she can do to stop the violence being perpetrated on her.</p>	<ul style="list-style-type: none"> • Lack of awareness about human rights. • Rigid and inequitable gender roles. 	<p>Instead of holding the perpetrator solely accountable for his behavior, couples counseling related to IPV seek to address both the partners' behavior. The majority of survivors of intimate partner violence feel as if they are doing something wrong to cause their partner's behavior. Couples counseling reinforces this notion when in reality, the only person who can stop the violence is the abusive partner. Perpetrating violence is a choice; being victimized by violence is never a choice. If a client is interested in couples counseling, the provider should strongly encourage separate counseling sessions, first, followed by couples sessions, later.</p>	<p>Mediation does not solve the problem of intimate partner violence. Instead of holding the person responsible the abuse accountable for their actions, couples counseling focuses on both parties behavior. A survivor's behavior is not the cause of her partner's violence. Violence is a choice; being victimized by violence is never a choice.</p>

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.	THE IMPACT SUCH A STATEMENT COULD HAVE ON A CLIENT EXPERIENCING IPV.	A 1-2 SENTENCE RESPONSE YOU MIGHT GIVE IF YOU HEARD SOMEONE USING THIS STATEMENT.
Intimate partner violence is extremely rare.	IPV is extremely common. Thirty-five percent of women worldwide have experienced either physical and/or sexual intimate partner violence. Globally, as many as 38% of all murders of women are committed by intimate partners.	<ul style="list-style-type: none"> • Lack of awareness about human rights • Rigid and inequitable gender roles • How we were raised 	Survivors of intimate partner violence often feel alone in their experience. If survivors understand this myth to be a truth, they feel further isolated in their experience, and often do not reach out for help.	Intimate partner violence is all too common around the world. One victim of intimate partner violence is enough. The high prevalence of intimate partner violence makes this issue a worldwide public health crisis.
Sometimes women deserve to be hit, slapped, kicked or punched.	<p>No one deserves to be abused. The only person responsible for the abuse is the abuser. While Guinean law does not recognize domestic violence (intimate partner violence) as a crime, assault of another person is a crime. Intimate partner violence is a form of assault.</p> <p>Secondly, this myth reduces intimate partner violence to isolated instances of violence, rather than recognizing the abuse as a systematic effort to render a victim powerless.</p>	<ul style="list-style-type: none"> • Rigid and inequitable gender norms • Lack of awareness about human rights <ul style="list-style-type: none"> • Social acceptance of violence and/or aggressive behavior • How we were raised 	Survivors of intimate partner violence often feel as if they are doing something to deserve the violence being inflicted on them. Survivors internalize the notion that they “deserve” to be hit, and often do not seek help for the abuse they are experiencing. Secondly, this myth trivializes the experiences of survivors, and fails to recognize the serious health consequences associated with this type of violence.	Every person deserves to live free from violence. Being a woman should never be the root cause of violence.

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.	THE IMPACT SUCH A STATEMENT COULD HAVE ON A CLIENT EXPERIENCING IPV.	A 1–2 SENTENCE RESPONSE YOU MIGHT GIVE IF YOU HEARD SOMEONE USING THIS STATEMENT.
Intimate partner violence is a problem between a husband and a wife.	IPV not only affects families, it affects communities and society. IPV exists because of social norms that are harmful to all individuals. It is an epidemic that will continue until society addresses the social norms that permit and permit intimate partner violence to continue.	<ul style="list-style-type: none"> • Lack of awareness about human rights • Rigid and inequitable gender norms • Social acceptance of violence and/or aggressive behavior 	It is not uncommon for survivors to feel guilty about disclosing of the abuse they are experiencing. Some feel as if they are shaming their family, or shaming their partner, by talking opening about their experience. However, survivors deserve support in order to endure the abuse they are experiencing.	This statement increases a survivor's risk emotional pain and suffering. Without an outlet to express the hurt a survivor is experiencing, the survivor will continue to internalize the consequences. The long-term consequences of intimate partner violence lessen when a survivor is surrounded by a positive support network.
Women stay in abusive relationships because they are weak.	<p>There are number of reasons why women stay in abusive relationships—none of which are because they are weak. The following contribute to why women stay in abusive relationships: lack of a support system; children; economic reasons; diminished sense of self-worth; and, the cycle of violence—waiting for the calm to return.</p> <p>Additionally, this myth sends mixed messages about how women are supposed to act. Gender norms around desired femininity support the notion that women are supposed to be dependent on a partner.</p>	<ul style="list-style-type: none"> • Rigid in equitable gender norms • How we were raised 	Survivors of intimate partner violence often regard themselves as weak and inferior. An abusive partner's goal is to diminish their partner's self-worth. This myth further victimizes a survivor.	There are number of reasons why women stay in abusive relationships—none of which are because she is weak. In fact, survivors of violence are quite often strong, resourceful and resilient individuals.

**TRAINERS' TOOL 2.2: DISPELLING THE MYTHS OF IPV
(ALTERNATIVE EXERCISE)**

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.	THE IMPACT SUCH A STATEMENT COULD HAVE ON A CLIENT EXPERIENCING IPV.	A 1-2 SENTENCE RESPONSE YOU MIGHT GIVE IF YOU HEARD SOMEONE USING THIS STATEMENT.
Intimate partner violence is just an occasional slap, push or verbal or argument.				
Women should learn how not to make their partners so angry.				
Children who witness intimate partner violence are not affected by the abuse.				
Men who abuse their partners have serious mental health issues.				
Sometimes men get so angry they lose control.				
Intimate partner violence only happens in poor communities, and abusers are generally uneducated.				
A man can do what he wants to a woman once they are married.				

MYTHS RELATED TO IPV	WHY THE STATEMENT IS UNTRUE.	ROOT CAUSE THE MYTH IS ASSOCIATED WITH.	THE IMPACT SUCH A STATEMENT COULD HAVE ON A CLIENT EXPERIENCING IPV.	A 1-2 SENTENCE RESPONSE YOU MIGHT GIVE IF YOU HEARD SOMEONE USING THIS STATEMENT.
Women need to learn how to stand up for themselves more.				
A man is allowed to force his wife to have sex.				
Mediation between two people can resolve IPV.				
Intimate partner violence is extremely rare.				
Sometimes women deserve to be hit, slapped, kicked or punched.				
Intimate partner violence is a problem between a husband and a wife.				
Intimate partner violence is just an occasional slap, push or verbal or argument.				
Women should learn how not to make their partners so angry.				

SESSION 2.3: LINK BETWEEN FAMILY PLANNING AND INTIMATE PARTNER VIOLENCE

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explain why family planning health clinics are a good entry point for disclosures of intimate partner violence.

TIME

1 hour, 5 minutes

MATERIALS

- Flipchart paper
- Markers
- Scissors
- Stop watch or clock to manage the time
- Trainers' Tool 2.3A: Trivia Instruction and Resource Guide*
- Trainers' Tool 2.3B: Family Planning and Intimate Partner Violence Trivia*
- Masking Tape

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print 1 copy of the *Trainers' Tool 2.3A: Trivia Instruction and Resource Guide*.
- Print 1 copy of the *Trainers' Tool 2.3B: Family Planning and Intimate Partner Violence Trivia*.
- Cut the trivia pieces from *Trainers' Tool 2.3B: Family Planning and Intimate Partner Violence Trivia*.
- Arrange and tape the trivia pieces to the wall (see *Trainers' Tool 2.3A: Trivia Instruction and Resource Guide* for detailed instructions).
- Prepare and post a flipchart titled "Scoring Sheet."

TRAINING STEPS

Step 1: Family Planning and Intimate Partner Violence Trivia Game (35 minutes)

1. Take five minutes to divide the participants into three even-sized teams and to explain the rules of the trivia game (refer to *Trainers' Tool 2.3A: Trivia Instruction and Resource Guide*). Inform the participants that the game will last 30 minutes.
2. Ask one of the participants if they would be willing to help you keep score for each of the teams.
3. For the next 30 minutes, facilitate the playing of the trivia game.
4. Use the *Trainers' Tool 2.3A: Trivia Instruction and Resource Guide*, to clarify any incorrect answers the participants give. Provide any additional information included in the Trainers' Tool after each question has been answered.

TRAINING TIP

- Some of the information presented in the trivia game will be new information; this is not an attempt to intimidate the participants. Instead, this is an opportunity for participants to draw from the information they have already learned, assess the question and make their best guess.

Step 2: Group Discussion (20 minutes)

Lead a group discussion using the following key discussion questions:

- Was this activity challenging? Why or why not? In what categories did you excel? What categories do you need to focus more energy on learning the information?
- What information from the trivia game was surprising to you? How do you feel about the information that is being presented to you?
- Why do you think family planning health clinics a good entry point for disclosures of intimate partner violence?
- What do you anticipate being the most challenging aspects of working with FP clients who are experiencing IPV?
- What do you anticipate being the most rewarding aspect of working with FP clients who are experiencing IPV?

Assure the participants that subsequent training sessions will address any gaps in the information they were provided in the trivia game.

Step 3: Closure and Transition / 10 minute

1. Praise the participants for answering the difficult trivia questions. Reflect back on the questions they answered correctly, even though they may not have already learned the information. Encourage their continued growth by reflecting on questions that were particularly challenging or surprising, and assure them by that they will be FP/IPV trivia experts by the end of this training.
2. Ask the participants to think of at least one thing they learned from this activity. Allow the participants to use the remaining time to discuss with their neighbor what they learned from this activity, and how it might change the way they perform their job skill.

TRAINERS’ TOOL 2.3A: TRIVIA INSTRUCTION AND RESOURCE GUIDE

Setting up the Trivia Game

1. Cut the category and point value cards from *Trainers’ Tool 2.3B: Family Planning and Intimate Partner Violence Trivia*.
2. Arrange and tape the cards to the wall in the following manner:

INTIMATE PARTNER VIOLENCE AND HEALTH OUTCOMES	FAMILY PLANNING	CARE AND TREATMENT	PREGNANCY
100 Points	100 Points	100 Points	100 Points
200 Points	200 Points	200 Points	200 Points
300 Points	300 Points	300 Points	300 Points
400 Points	400 Points	400 Points	400 Points

Trivia Game Instructions:

1. Divide the group into three teams. Decide which team will go first, second and third.
2. Explain the rules of the trivia game to the participants:
 - Step 1:** One at a time, teams will pick a category and point value card.
 - Step 2:** The trainer will remove and discard the point value card from the wall.
 - Step 3:** Using the information provided below, the trainer will read the selected question and answer choices, twice.
 - Step 4:** The team has 20 seconds to decide the answer to the question, as well as to provide a rationale for their answer.
 - Step 5:** The trainer will provide the group with the correct answer, and share additional information.
 - Step 6:** If the team correctly answers the question, add the appropriate value to the “Scoring Sheet.”
 - Step 7:** Move to the next team.

(Repeat Steps 2–6 until all of the questions have been answered)
3. Facilitate the playing of the Trivia Game.

INTIMATE PARTNER VIOLENCE AND HEALTH OUTCOMES

100 Points

Question—Multiple Choice:

What percentage of women exposed to intimate partner violence have experienced injuries as a result of the abuse?

- a. 19%
- b. 27%
- c. 35%
- d. 42%

Answer:

D—42%

Source:

WHO

http://www.who.int/reproductivehealth/publications/violence/VAW_health_impact.jpeg

200 Points

Question—True or False:

Women exposed to intimate partner violence are twice as likely to acquire alcohol use disorders.

Answer:

True—According to a global study by WHO, women exposed to intimate partner violence are twice as likely to alcohol use disorders. Alcohol may be used as a coping mechanism.

Source:

WHO

http://www.who.int/reproductivehealth/publications/violence/VAW_health_impact.jpeg

300 Points

Question—Multiple Choice:

What percentage of all murders of women globally were reported as being committed by their intimate partner?

- a. 3%
- b. 15%
- c. 38%
- d. 50%

Answer:

D—38%

Source:

WHO

http://www.who.int/reproductivehealth/publications/violence/VAW_health_impact.jpeg

400 Points

Question—True or False:

Roughly 50% of Guinean women have experienced severe IPV including, punching kicking, threats or attacks with firearms, or knives, strangling, forced sex and unwanted sex acts.

Answer:

False: Nearly 62% of Guinean women have experienced IPV.

Source:

Ministère des Affaires Sociales, de la Promotion Féminine et de l'Enfance, Direction Nationale de la Promotion Féminine, La violence à l'égard des femmes et des hommes, October 2009.

FAMILY PLANNING AND STIS

100 Points

Question—Multiple Choice:

Physical and sexual violence can limit a woman's ability to negotiate the use of condoms or other contraception.

Answer:

True

Source:

Garcia-Moreno C et al. *Preliminary Results From the WHO Multi-Country Study on Women's Health and Domestic Violence*. Presentation at the World Conference on Injury. Montreal, Canada, May 2002.

200 Points

Question—True or False:

Women experiencing IPV in Sub-Saharan Africa are 1.5 times more likely to acquire HIV.

Answer:

True—Open wounds (possible outcome of physical and sexual violence), creates a passageway for HIV infection. Additionally, intimate partner violence inhibits open and honest conversation, thus conversations about sexuality, safe sex and condom negation.

Source:

http://www.who.int/mediacentre/news/releases/2013/violence_against_women_20130620/en/

300 Points

Question—Multiple Choice:

A comparison of Department of Health Surveys in Sub-Saharan African counties showed that women who experience IPV are at what percentage more likely to report an STI than women who did not report violence?

- a. 10%
- b. 25 %
- c. 43%
- d. 50%

Answer:

50%

Source:

<http://www.ghi.gov/resources/guidance/161891.htm>

400 Points

Question—Short Answer:

List at 3 tactics abusers use to control their partner's reproductive autonomy.

Answer:

- hiding, withholding, or destroying a partner's birth control pills
- intentionally breaking condoms or removing a condom during sex
- not withdrawing during intercourse when that was the agreed upon method of contraception

Source:

(Chamberlain & Levenson, 2012; Silverman et al., 2010)

PROVIDER CARE AND TREATMENT

100 Points

Question—Short Answer:

List three things a FP provider can do to support a client experiencing IPV.

Answer:

1. discuss IPV with the client in a safe and supportive space;
 2. explore their FP options in the context of IPV;
 3. learn about medical, legal, psychosocial, and other services available to survivors;
 4. discuss and/or plan for their future safety;
- receive relevant medical services offered on site and/or referrals to other services.

200 Points

Question—Multiple Choice:

Which of the following symptoms can be directly linked to IPV?

- a. Unexplained chronic gastrointestinal symptoms.
- b. Chronic pain.
- c. Reproductive symptoms including pelvic pain and sexual dysfunction.
- d. Repeated vaginal bleeding and STIs.
- e. All the above.

Answer:

E

Source:

Adapted from Black MC. Intimate partner violence and adverse health consequences: implications for clinicians. *American Journal of Lifestyle Medicine*, 2011, 5:428–439.

300 Points

Question—Multiple Choice:

Health care professionals may inadvertently put women at risk if they are uninformed or unprepared by doing which of the following:

- a. Expressing negative attitudes to clients about women who are beaten or raped.
- b. Discussing a woman's injuries in a consultation room that can be overheard by an abusive spouse.
- c. Breaching confidentiality by sharing information about pregnancy, STIs, HIV or sexual abuse with another family member without the woman's consent.
- d. All the above.

Answer:

D. Health professionals who breach patient confidentiality, who respond poorly to a disclosure of violence, who blame victims, or who fail to offer crisis intervention can put women's safety, wellbeing and even their lives at risk.

Source:

International Planned Parenthood Federation, Western Hemisphere Region

400 Points

Question—Short Answer:

List at least five negative health outcomes associated with IPV.

Answer:

Chronic pain, STIs, emotional detachment, low birth weight, depression, anxiety, eating and sleeping disorders unexplained vaginal bleeding, unintended pregnancy, pelvic inflammatory disease, delayed prenatal care, preterm delivery, sexual dysfunction, alcohol abuse, unprotected sex...etc.

PREGNANCY	
<p>100 Points</p> <p>Question—Multiple Choice: What percentage of African women experiencing intimate partner violence will be victimized during pregnancy, including being punched or kicked in the abdomen?</p> <p>Answer: C—20–40%</p> <p>Source: http://whqlibdoc.who.int/hq/2011/WHO_RHR_11.35_eng.pdf</p>	<p>200 Points</p> <p>Question—Multiple Choice: Sub-Saharan women who are exposed to intimate partner violence are 50% more likely to experience at least one episode of pregnancy loss compared with women not exposed to abuse.</p> <p>Answer: True—The most common reason for pregnancy loss is physical trauma. Close behind is women’s stress levels associated with the psychological impact of the violence. Higher stress levels caused hypertension and infections during pregnancy.</p> <p>Source: http://www.biomedcentral.com/1471-2393/12/12</p>
<p>300 Points</p> <p>Question—Multiple Choice: Women who experience IPV have _____ % greater chance of having a low birth weight baby?</p> <p>a. 3% greater chance. b. 5% greater chance. c. 10% greater chance. d. 16% greater chance.</p> <p>Answer: D—16%</p> <p>Source: http://reliefweb.int/report/world/global-and-regional-estimates-violence-against-women-prevalence-and-health-effects.</p>	<p>400 Points</p> <p>True or False: There is no direct link between lower rates of breastfeeding and IPV.</p> <p>Answer: False. Physical, sexual and psychological intimate partner violence during pregnancy are associated with higher levels of depression, anxiety and stress, as well as suicide attempts, lack of attachment to the child and lower rates of breastfeeding</p> <p>Source: Zeitlin D, Dhanjal T, Colmsee M. Maternal-foetal bonding: The impact of domestic violence on the bonding process between a mother and child. Archives of Women’s Mental Health, 1999, 2(4):183–189. Bergman KBA, Sarkar PMD, O’Connor TG, Modi NMD, Glover V. Maternal stress during pregnancy predicts cognitive ability and fearfulness in infancy. Journal of the American Academy of Child and Adolescent Psychiatry, 2007, 46(11):1454–1463.</p>

TRAINING DAY 2

TRAINERS' TOOL 2.3B: FAMILY PLANNING AND
INTIMATE PARTNER VIOLENCE TRIVIA

Intimate Partner Violence and Health Outcomes	Family Planning and STIs
Provider Care and Treatment	Pregnancy

100 Points

100 Points

100 Points

100 Points

200 Points

200 Points

200 Points

200 Points

300 Points

300 Points

300 Points

300 Points

400 Points

400 Points

400 Points

400 Points

SESSION 2.4: PROVIDER VALUES AND ATTITUDES¹⁰

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explore personal values regarding gender norms, family planning and intimate partner violence.
2. Identify how values shape attitudes about family planning clients.
3. Identify challenges that may arise in serving clients who have experienced intimate partner violence and how to overcome these challenges.

TIME

1 hour, 15 minutes

MATERIALS

- Trainers' Tool 2.4: Vote With Your Feet*
- 4 pieces of blank paper
- Marker
- Masking tape

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Make four signs with one of the following value statements on each: “Strongly Agree,” “Agree”, “Disagree,” “Strongly Disagree”
- Hang one sign on each of the 4 corners of the room (or at least 10 feet apart from one another).
- If need be, arrange the table and chairs so participants can move about freely.
- Print *Trainers' Tool 2.4: Vote With Your Feet*.
- Choose 5–7 value statements from each of the categories based on the information you have learned about your participants from previous sessions.

¹⁰ Adapted from: The ACQUIRE Project/EngenderHealth and Promundo. 2008. *Engaging boys and men in gender transformation: The group education manual*. New York and Rio de Janeiro

TRAINING STEPS

Step 1: Vote with Your Feet (20 minutes)

1. Explain that this exercise is an opportunity to explore their values. Ask participants to describe what the word value means to them. Then ask how our values form.
 - Example definition of the word “value”: Values are what we consider important or of great worth (e.g., health, respecting others, achieving goals, etc.). Values can serve as guidelines to help us make decisions about life choices and individual behaviors. As a general rule, when we act in accordance with our values, we tend to feel good about ourselves and our actions.
 - Example responses to how values are formed: We form our values based on what we want or desire out of life. Values can be shaped based on our personal experiencing or how we interpret other persons’ experiences. While our values can change over time, we often feel as if our values are engrained in our being.
2. Ask the participants to stand and move to the middle of the room. Explain that you will be reading a series of value statements, and you would like them to move to the sign that best describes their opinion of the value statement—if they strongly agree, agree, disagree or strongly disagree.
3. Encourage them to be open and honest about their opinions even if they are standing alone by an opinion sign. Remind them that this is a silent activity, and that they will have the opportunity to discuss the value statements after the activity is complete.
4. Select 4–6 statements (or as many as you can get through in the stipulated time) from Tool 2.4.
5. Begin to read the statements one by one, allowing enough time for participants to move around the room and for them to observe where their peers are standing.
6. Ask participants to return to their seats after you are done reading the statements.

Step 2: Values Clarification and Group Discussion (50 minutes)

Lead a discussion using the following questions:

- What does the word attitude mean to you? How do our values shape our attitudes?
Example response. Attitudes are positive or negative evaluations that people have toward other people, objects, activities, concepts, etc. Attitudes have two components: 1) a cognitive component, which includes one’s beliefs about something, and 2) an affective component, which includes one’s evaluation of the same thing implying a liking or a disliking or a favorable or an unfavorable view. People who have a positive attitude toward some behavior (e.g., abstinence or condom use) are more likely to engage in that behavior.
- Which statements revealed the widest range of values and attitudes? What could explain these differences in values and attitudes?
- How might values and attitudes be linked to power? Which values might give us more power? Which values might render us with less powerful?

- Why is it important for us, as providers, to be aware of our own personal values and attitudes, and the power we have as providers?
- How can our values and attitudes impact the way we view our clients or the way we provide care to our clients?
- Is it possible to expand our values and attitudes? In what ways? How might this benefit the care and treatment of our clients?
- What do we do when our values don't align with our client's values? What can we do if our client's values make us feel uncomfortable?

Step 3: Closure and Transition (5 minutes)

1. Remind the participants that the provider's job is to provide the best care and treatment based on the client's needs, rather than providing care and treatment based on the provider's personal values and attitudes. With that said, it is important for a provider to articulate that violence is never okay, and that the clinic does not condone such behavior.
2. Remind participants that it is part of the human existence to like certain people more than other people. Encourage the participants to seek the support of a peer if they are feeling frustrated by working with a client of differing values and attitudes. Peers can often help one another develop a solution for effectively working with the client.

TRAINING TIPS

- This activity can feel deeply personal, and can result in participants feeling isolated if their values don't align with the other group participants. Additionally, some participants might feel negatively surprised by their peers' values, leaving them with a range of emotions. If you find this to be happening, intersperse the activity with statements from the fourth category. These statements are intended to be fun, and nonthreatening. Using these statements may help participants regain common ground and stabilize the group dynamic.
- A participant will likely ask you if they can stand between signs or stand in the middle if they are unsure of their value. This is often a reaction to a statement that feels too personal to respond to (i.e. They feel their personal value is too controversial or they feel triggered by the statement). Encourage them to take a stance on the statement. If they continue to resist, use your discretion as to whether you allow them to take an "unsure" stance.
- Participants may become defensive about their values and attitudes, and think that your goal is to change the way they think. While that may be the case in some instances, frame it within the context of how their value and attitude might make a client feel and how it could impact the quality and outcome of the services they deliver. Would the client feel embarrassed, shamed, hurt? Would a client feel comfortable telling you all of their needs, or would the client need to sensor what they were saying as to not offend you? If the answer is "yes," then the care and treatment of the client is being impacted by your personal values and attitude. Finally, the satisfaction of one client can greatly impact how that client will advertise—positively or negatively—the services you offer. Allowing your personal values and attitudes to interfere with the care and treatment you provide will, undoubtedly, impact how often clients are willing to seek out the clinics services.

TRAINING TIPS *continued*

- Help participants make the connection that personal values are often shaped by social norms. We, as a society, are conditioned to think and believe certain things to be true. Remind them that their clients are also conditioned by the same social norms. Because men are socially conditioned to be dominant, they inherently have more power. This is the opposite for women. Therefore, the values and attitudes of men tend to be more highly regarded than the values and attitudes of women.
- Remind them that because they are providing a service that is needed by their clients, that they inherently have more power than their clients. Because of the power imbalance, clients' decisions about FP can be affected by a provider's value and attitudes. A client may decide to do what they think the provider wants them to do, rather than making the best decision for their own life. Remind them that this is a basic principal of FP counseling—to provide clients with all of their options. The options presented should be free of the provider's values and attitudes.
- Victims of IPV are highly affected by others' values and attitudes. They are also acutely aware of their surroundings at all times, and can often sense when someone has a negative thought or opinion about them. That instinct is formed as a means of protection from their abusive partner—if they can predict what is going to happen, they may feel as if they can prevent a violence incident from erupting. Clients experiencing IPV will be particularly observant of a provider, and will often verbally express what they think the provider wants them to say because they have learned that is the best way to avoid conflict. With all clients, and especially clients experiencing IPV, it is important to remind them that they guide their own care. They should do what is best for them, and not to be concerned about what they think you want them to do. Practicing in this manner is one way to restore power and control to a client experiencing IPV.

TRAINERS' TOOL 2.4: VOTE WITH YOUR FEET

*****DO NOT DISTRIBUTE THIS LIST TO PARTICIPANTS*****

Definitions.

- **Value:** Values are what we consider important or of great worth (e.g., health, respecting others, achieving goals, etc.). Values can serve as guidelines to help us make decisions about life choices and individual behaviors. As a general rule, when we act in accordance with our values, we tend to feel good about ourselves and our actions.
- **Attitude:** Attitudes are positive or negative evaluations that people have toward other people, objects, activities, concepts, etc. Attitudes have two components: 1) a cognitive component, which includes one's beliefs about something, and 2) an affective component, which includes one's evaluation of the same thing implying a liking or a disliking or a favorable or an unfavorable view. People who have a positive attitude toward some behavior (e.g., abstinence or condom use) are more likely to engage in that behavior.

Value Statements.**Category 1: Gender and Sexuality**

1. It is more acceptable for men to have multiple sexual partners than for women to have multiple sexual partners.
2. Women who have sex before marriage are putting themselves at risk for being raped.
3. It okay for a man to have an extramarital sexual partner.
4. Men and boys sometimes cannot control their anger.
5. Women enjoy sex just as much as men do.
6. Men deserve to have more power than women.
7. Men have a right to extramarital sex if their wives are not sexually available.
8. Men are supposed to financially support the family and woman are supposed to take care of the home.

Category 2: Intimate Partner Violence

1. There is no such thing as rape in marriage.
2. Sometimes women deserve to be punished for speaking out against their husband's wishes.
3. Intimate partner violence is a family matter and should not be discussed openly.
4. It is easier to believe the existence of IPV if there are bruises on a women's body.

- 
5. It is okay for a woman to say “no” to her husband if she doesn’t want to have sex with him.
 6. Men abuse their partners because they have anger issues.

Category 3: Judgments about Clients

1. Women lie about IPV to get attention from other people.
2. Victims of IPV need to learn how to stand up for themselves in order to stop the abuse.
3. The abuse can’t be that bad if she’s not willing to leave.
4. Women should try to make their relationship work even if their husband is abusing them.
Family should always remain together.

Category 4: Miscellaneous Questions (to be used if group becomes agitated with one another)

1. Chocolate is the best kind of candy.
2. I hate cooking meals.
3. I think I’m a good dancer.

SESSION 2.5: THE IMPACT OF INTIMATE PARTNER VIOLENCE & EMPATHIZING WITH THE SURVIVOR¹¹

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explain how the cycle of violence, power and control impact a survivor of IPV.

TIME

1 hour

MATERIALS

- Flipchart paper
- Markers
- Flipchart of the Cycle of Violence from Session 1.4

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print *Trainers' Tool 2.5: Nkirukua's Story and Discussion Questions*.
- If need be, create a flipchart with the Cycle of Violence (see Session 1.4).

TRAINING STEPS

Step 1: Nkirukua's Story (45 minutes)

1. Explain that the impact of IPV is long lasting due to the physical, mental and emotional trauma caused by an abusive partner. Abusers use tactics to diminish their partner's confidence and self-esteem. This accounts for one reason why leaving an abusive partner can be incredibly challenging for a victim. Survivors often find themselves trapped by the cycles of violence, and often describe the relationship "really good sometimes" and "really bad other times."
2. Share that this activity involves telling a long story that is split up into several segments. Each segment of the story includes a series of questions in which you will ask the group to discuss. In each case, the last question is answered in the segment that follows.
3. Using the *Trainers' Tool 2.5: Nkirukua's Story and Discussion Questions*, begin to read Nkirukua's story (you may opt to have a participant or several participants read the story). Pause the narration when indicated and facilitate a group discussion.

¹¹ Adapted from the "Men as Partners to Reduce Gender Based Violence". 2006. EngenderHealth.

Step 2: Closure and Transition (15 minutes)

1. Share the following sentiments with the participants:

- As Nkirukua's story shows us, one important reason why a woman finds it difficult to get out of a situation of intimate partner violence is that she has little to no support. Her own family may not support her. They may consider her leaving the marriage as a disgrace. They may insist that all this is part of marriage and that she should just try harder to please her husband and not to make him angry.
- Since intimate partner violence happens within the home, neighbors and friends tend to think that it is a private and personal matter between husband and wife; therefore, they do not interfere.
- Children are another reason why a woman finds it difficult to leave a situation of intimate partner violence. She is afraid that she may lose her children. She also worries about the children's future—for example, would leaving the husband affect their education or marriage prospects?
- There are also economic reasons why women find it difficult to leave a situation of intimate partner violence. The woman may not have any money of her own, or skills to earn a living to support herself.
- The constant abuse also destroys the woman's self-confidence. She feels that she is useless, capable of nothing, worthy of nothing. When she has been diminished to such an extent, the very thought of leaving could terrify her.
- One more reason why women continue to remain in situations of intimate partner violence is because of the cycle of violence. The tension builds and builds, and erupts into violence. After the violence has taken place, the man may apologize and promise that he will never behave in such a manner again. For some time he may behave very pleasantly and try to make amends. The woman convinces herself that the man will really keep his word. But sooner or later, the tension starts building again and erupts once again in violence.
- Finally, a woman is at the highest risk of danger at the hands of her partner if/when she decides to leave or leaves the relationship. IPV is rooted in power and control. Leaving an abusive relationship is an act of reclaiming power and control. The majority of women, who are murdered by their intimate partner, are murdered during an attempt to leave, or shortly after they have left. The ultimate form of power and control is to end a person's life.

TRAINERS' TOOL 2.5: NKIRUKUA'S STORY AND DISCUSSION QUESTIONS

Section 1

When I first met my husband I thought he was very kind and warm. We were married not long after we met. The first two years of marriage passed quickly. I was happy, even though my husband suddenly stopped me from going to work. When I was pregnant with Amara, my husband started treating me differently. He said I was focusing too much on the pregnancy and not focusing enough on him. This confused me since this was our first child and I thought he would be excited like me. Instead, he almost seemed jealous of Amara. When Amara was born she became my life. Once when Amara was cranky and feverish all day, I just could not concentrate on the housework or on anything else. The vegetables for the night meal got burnt and the rice was undercooked. I did not even realize this until my husband started shouting. I asked what was wrong, and he pushed the plate on the floor and told me to clean up my mess. While I was on my hands and knees he pushed my head down into the food. I was so shocked by his behavior that I didn't fight back. The next thing I knew was that my face was hurting like hell. He had hit me hard across my face. I still remember the first time he hurt me and what it did to me. My hands were shaking and I could hardly speak. My mind went blank. Amara started to cry and he said, "Shut your kid up, or I will." I swallowed my tears and anger and somehow attended to her. The next day he said he was sorry, and promised that it would never happen again. He seemed genuinely upset. I was mad at him and asked him why he got so angry with me. He told me it was because I wasn't treating him well enough. I was so confused, and I wanted to believe him because I loved him. He had never behaved like this before.

Pause...

Facilitate a discussion using the following questions:

1. Why did Nkirukua's husband push the food onto the floor and slap her?
2. Do you think he was justified?
3. How do you think it made her feel?
4. The husband promised not to do it again. Do you think he kept his promise?
5. Why do you think she believed him?
6. Why do you think Nkirukua stays in the relationship? Or is it too early to ask this question?
7. What is an alternative way that Nkirukua's husband could have behaved?

Section 2

I didn't even think about leaving him after the first incident because I didn't think it would happen ever again. I loved him and believed that he would go back to treating me lovingly. He started calling me names every day, and would hit me occasionally. I do remember a few weeks that went by when he seemed normal, but then I could sense him getting upset with me. I felt like I couldn't do anything right and I knew it was only a matter of time before he would lose it again. I felt like I was going crazy. After a year of treating me badly, I got fed up with it. I felt like I had had enough of this and told my parents what was happening. I cried and asked them to help me leave him so I would have some peace. Then my father said that I must stay with him, that he is my husband and husbands and wives are supposed to stay together. He said I should behave better so he would not have to resort to violence.

This was 5 years ago. The physical abuse has only gotten worse. Now he punches and kicks me. He tells me I'm a bad mother and a horrible wife. He said he treats me how I deserve to be treated. I feel more like his servant than his wife. I want so badly for things to go back to the way they were. He wants to have another baby, but I'm afraid to have another child if things stay the way they are. He refuses to wear a condom so I push him away when he wants to have sex. Sometimes he accuses me of having an extramarital sexual partner as the reason for me not wanting to have sex with him. I tell him I only want to be with him. Sometimes he forces me to have sex and sometimes I just give in to his demands because it helps to keep him from getting worse. I live in fear and uncertainty every day. I'm worried about how this is affecting Amara and if she thinks this is how relationships are supposed to be. I wonder what she thinks of me. I try my best to not let her see what is happening but I know she can hear him when he is in one of his rages.

Pause...

Facilitate a discussion using the following questions:

1. Why do you think Nkirukua's husband has been able to continue the violence on his wife?
2. Over the years, what do you think has been the impact of the violence on Nkirukua?
3. Do you think Amara understands what is happening? What is the impact of the violence on Amara?

Section 3

You may wonder why I am still with this man. Don't think I have not thought of leaving him. I have, and one time I even tried. It was hard for me to find a job after being out of work for so long. I would take odd jobs here and there but finding someone to help care for Amara while I worked was nearly impossible. We were sleeping on the floor at my parents' house and Amara would cry every day for her things. After 2 months, I had to return to him. I'm not going to lie; a small part of me missed him. I thought he would have missed me too, and may have learned a lesson not to hurt me anymore. When we walked through the door, he smashed me up against the wall and wrapped his hands around my neck. Everything went black and the next thing I remember was waking up to him on top of me. He had ripped my shirt and pushed my underwear to the side in order to have sex with me. That was the last thing I wanted, and I cried when he forced me to kiss him. There was blood everywhere. He told me I would never see Amara again if I tried to leave. He told me he'd kill me next time.

There was another time I thought about leaving but I was so embarrassed about going back to him after the first time. Where would I go anyway? My husband has gotten my parents to turn on me because he told them I was a bad mother for keeping his child away from him. What can I do at this point?

Pause...

Facilitate a discussion using the following questions:

1. Now thinking about Nkirukua's story, why did she remain with her husband? What things may keep her with her husband?
2. Have you heard or do you know women in similar situations? Is there enough support here for women in this situation?
3. If she goes for help what will it be like for her? Will she find persons who refuse to help? What kinds of support will she get?
4. What will happen to the Amara if she chooses to leave?

TRAINING DAY 2

SESSION 2.6: SETTING BOUNDARIES AND MAINTAINING CONFIDENTIALITY

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Articulate the importance of setting boundaries and maintaining confidentiality when serving clients experiencing IPV.
2. Problem-solve scenarios that may present when serving clients experiencing IPV.

TIME

1 hour, 15 minutes

MATERIALS

- Flipchart paper
- Markers
- Handout 2.6: Setting Boundaries and Maintaining Confidentiality*
- Trainers' Tool 2.6: Setting Boundaries and Maintaining Confidentiality*
- Pens or pencils for participants

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print a copy of *Handout 2.6: Setting Boundaries and Maintaining Confidentiality* for each participant.
- Print *Trainers' Tool 2.6: Setting Boundaries and Maintaining Confidentiality*.
- Prepare and post 2 flipcharts, one titled “Boundaries,” the other titled “Confidentiality.”

TRAINING STEPS

Step 1: Brainstorm (10 minutes)

1. Ask the participants to share their definition of a *boundary* with you. What does a boundary look like? Do you currently have boundaries with your clients? What are some examples of the boundaries you have with your FP clients. Record their answers on the appropriate flipchart.

Example responses:

- **Boundary:** An imaginary or physical line that marks the outline of an area.
 - **Boundaries within a clinic setting.** Boundaries help define what clinic staff can and cannot do, will or will not do, should or should not do, for a client. Boundaries help shape a client's expectations of a clinic staff. Boundaries help clinic staff understand and define their role and responsibility as it pertains to policy and procedure. When enforced properly, boundaries are intended to protect the wellbeing of both clients and clinic staff.
 - **Importance of boundaries in cases of IPV.** Because of the Cycle of Violence, a victim's environment is constantly changing. When a provider sets boundaries with a client experiencing IPV, the client knows what to expect from the very beginning and does not have to fear being surprised by your actions. Boundaries help to restore power and control to a victim.
2. Ask the participants to share their definition of *confidentiality* with you. Why is maintaining confidentiality important to FP clients? What are you currently doing to maintain the confidentiality of your clients?

Example responses:

- **Confidentiality:** A strict set of written, spoken or implied rules that limit access to certain types of information.
 - **Boundaries within a clinic setting.** Confidentiality ensures that a client's personal information and medical history not be disclosed to anyone without signed consent (permission) from the client. Ensuring confidentiality is a practice that encourages patients to be open and honest about their needs and desires.
 - **Importance of confidentiality in cases of IPV.** Maintaining confidentiality is crucial to the safety of clients experiencing IPV. Breaching confidentiality can put a victim in further danger if their abusive partner were to find out that their victim disclosed of the abuse.
3. Ask participants what might happen when a provider crosses a boundary with a client. What might happen if a provider breached a client's confidentiality?

Example responses:

- The violence could escalate.
 - The client may not return for services and/or tell other women not to come to your clinic.
 - A provider could get into trouble with the clinic and/or jeopardize their license.
4. Explain that participants will be spending the next 30 minutes reviewing case studies that pertain to setting boundaries with clients and maintaining client confidentiality. Boundaries and confidentiality are especially important when working with clients experiencing IPV. Overstepping a boundary or breaching confidentiality can directly impact the physical safety and emotional wellbeing of a client experiencing IPV, as well as the physical safety and emotional wellbeing of clinic staff.

Step 2: Setting Boundaries and Maintaining Confidentiality (30 minutes)

1. Divide the group into pairs or groups of three.
2. Provide each pair with *Handout 2.6: Setting Boundaries and Maintaining Confidentiality* and a pen or pencil. Ask them to work through the case studies with their partner, and to answer the supplemental questions that follow. Explain to the participants that they are to address the case study from the standpoint of a provider.
3. Briefly direct their attention to the content of the case studies, each of which contains elements of FP and IPV. Encourage them to focus solely on the questions provided, rather than the care and treatment they would provide to the client.
4. At the conclusion of 30 minutes, they will return to a large group and report back their answers.

Step 3: Large Group Discussion (30 minutes)

1. Read the case studies aloud, one by one. Ask each of the groups to report back their answers. It is okay if their answers are similar. If the activity feels too simple for the group, consider asking questions that challenge their answers. This will help to deepen their analysis of the case study.

Examples of questions that challenge their answers:

- What if the survivor was a relative or close friend of yours?
 - What if the perpetrator was someone you knew well?
 - What if you feared this person might cause physical harm to them self if you didn't respond in the way they wanted you to?
2. Following the completions OF the last case study, ask the following questions:
 - Was this activity challenging? Why or why not?
 - Have you ever found yourself in a situation similar to any of the case studies? What did you do at the time? Would you do anything differently now that you have completed this exercise?
 - Can you think of an example when you would find it difficult to maintain a boundary and/or confidentiality? What would you do?

Step 4: Closure and Transition (5 minutes)

1. Reinforce the fact that maintaining confidentiality is crucial to the safety of clients experiencing IPV. Breaching confidentiality can put a victim in further danger if their abusive partner were to find out that their victim disclosed of the abuse.
2. Reinforce that fact that setting boundaries helps to protect the well-being of the client. Because of the Cycle of Violence, a victim's environment is constantly changing. When a provider sets boundaries with a client experiencing IPV, the client knows what to expect from the very beginning and does not have to fear being surprised by your actions.

HANDOUT 2.6: SETTING BOUNDARIES AND MAINTAINING CONFIDENTIALITY

Definitions

- **Boundary:** An imaginary or physical line that marks the outline of an area.
 - **Boundaries within a clinic setting.** Boundaries help define what clinic staff can and cannot do, will or will not do, should or should not do, for a client. Boundaries help shape a client's expectations of a clinic staff. Boundaries help clinic staff understand and define their role and responsibility as it pertains to policy and procedure. When enforced properly, boundaries are intended to protect the wellbeing of both clients and clinic staff.
 - **Importance of boundaries in cases of IPV.** Because of the Cycle of Violence, a victim's environment is constantly changing. When a provider sets boundaries with a client experiencing IPV, the client knows what to expect from the very beginning and does not have to fear being surprised by your actions. Boundaries help to restore power and control to a victim.
- **Confidentiality:** A strict set of written, spoken or implied rules that limit access to certain types of information.
 - **Boundaries within a clinic setting.** Confidentiality ensures that a client's personal information and medical history not be disclosed to anyone without signed consent (permission) from the client. Ensuring confidentiality is a practice that encourages patients to be open and honest about their needs and desires.
 - **Importance of confidentiality in cases of IPV.** Maintaining confidentiality is crucial to the safety of clients experiencing IPV. Breaching confidentiality can put a victim in further danger if their abusive partner were to find out that their victim disclosed of the abuse.

Case Studies

Case Study #1:

Fatoumata has been receiving FP services for the last two years at the clinic. She also happens to be your neighbor, though you do not talk about her FP visits outside of the clinic. Fatoumata's husband, Mohamed, has mentioned to you on a number of occasions that they are trying to have another baby. He seems very excited about the idea of another child. Today, Fatoumata is in the clinic for her regular appointment. She just disclosed to you that Mohamed has been verbally and physically abusing her for the last 7 months. She cries to you, saying that she absolutely does not want to have another baby with Mohamed but he refuses to wear a condom and sometimes he forces her to have sex. There is a strong likelihood that Mohamed will ask you about Fatoumata's visit.

- Is Mohamed asking you about his wife a confidentiality or boundary issue?
- What would you want to do in this situation?
- What are you required to do in this situation?
- What do you think Fatoumata's biggest concern is at the moment?
- What do you do if Mohamed asks you about Fatoumata's visit?

Case Study #2:

Saran is 18 years old and recently moved from Kindia to Conakry to marry her husband. Her husband promised her a better life from where she was living. She has been in Conakry for one month and her husband has already physically attacked her three times. As she cries to you and tells you about the verbal and physical violence she is experiencing, she begs you to help her get back to her family. She has no money to make the 131 km trip. You have a friend who has access to a car.

- Is acting on Saran's request a confidentiality or boundary issue?
- What would you want to do in this situation?
- What are you required to do in this situation?
- How would it make you feel if a client begged you for help?
- How might you explain your duty as a clinic staff member?

Case Study #3:

A man you don't recognize barges into the clinic, demanding to see the person who gave his wife the "morning after pill." You did, in fact, prescribe emergency contraception to two women within a three-day time span. One of those women disclosed that her husband had forced her to have sex, and that she was afraid she may become pregnant from the assault.

- Is the information you have about the two clients a confidentiality or boundary issue?

- What would you want to do in this situation?
- What are you required to do in this situation?
- What would you do if the man continued to pressure you for information?
- Do you attempt to contact the two women to whom you prescribed Plan B?

Case Study #4:

Aminata arrives at the clinic badly beaten. Her husband physically and sexually abused her the night before. She said this isn't the first time, but that if she leaves for a night he tends to calm down. She seems very sweet and she reminds you of your own daughter. You have an extra room available in your house.

- Is the resource you have available to you (the extra room) a confidentiality or boundary issue?
- What would you want to do in this situation?
- What are you required to do in this situation?
- What services are you able to provide for her in the moment?
- How might you address feelings of personal connection to a client?

Case Study #5:

A colleague's sister—Aissata—just left the clinic after returning for the result of her HIV test. The test result came back positive. Aissata shared with the provider that her boyfriend is the only person she has ever slept with. She also shared that her boyfriend would kill her if he found out about her test result. You are not sure if her boyfriend is perpetrating IPV or not. Your colleague asks you if everything went okay during the appointment.

- Is answering your colleague's question a confidentiality or boundary issue?
- What would you want to do in this situation?

- What are you required to do in this situation?
- How might this situation affect you personally?
- Are you aware of a similar situation that has happened in real life? How did you handle the situation?

Case Study #6:

An older man and woman arrive at the clinic. You assume they are there for family planning services until you begin to converse with them. Both are visibly upset, and the woman's hands are shaking. They are looking for their daughter. Someone told the man and woman that they saw the daughter at the clinic about a week ago. They describe the daughter to you and say they believe her husband may have done something bad to her. You immediately recognize the story, and remember that you helped her create a safety plan that included the possibility of her leaving her husband. The man and woman beg you to tell them any information you may have about their daughter. You can see they are scared and worried about her wellbeing.

- Is sharing the information you have about the client a confidentiality or boundary issue?
- What would you want to do in this situation?
- What are you required to do in this situation?
- What information, if any, can you provide them?
- How might it affect you to know that a client of yours has disappeared?

SESSION 2.7: INTEGRATING IPV AND FAMILY PLANNING SERVICES

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Describe the five key intimate partner violence services in which family planning clients may benefit.
2. Explore ways in which intimate partner violence services can be integrated into existing family planning services.

TIME

50 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or timer
- Handout 2.7: PowerPoint Presentation—5 Key Intimate Partner Violence Services*

ADVANCE PREPARATION

- Review the training modules to be certain you understand content, methodology and timing.
- Set up computer and LCD projector for PowerPoint Presentation. If equipment is not available, develop a flipchart presentation using *Handout 2.7: PowerPoint Presentation—5 Key Intimate Partner Violence Services*.
- Print one copy of *Handout 2.7: PowerPoint Presentation—5 Key Intimate Partner Violence Services* for each participant.

TRAINING STEPS

Step 1: Introduction (5 minutes)

1. Acknowledge that intimate partner violence is a complex issue, and identifying ways to support clients experiencing IPV may feel overwhelming at times. Make clear to the participants that it is not expected of providers to be able to resolve IPV, or prevent IPV from happening, in the lives of clients. Additionally, providers should never seek to confront an aggressor or pressure the client to make a specific decision (such as go to the police). Instead, by integrating basic, IPV support services into existing clinic services, providers can help demonstrate that violence is not natural and never the client's fault.
2. Explain that this session will introduce five key IPV services that are designed to assist clients who are experiencing IPV. Explain that these services can be adapted to fit within the clinic's existing service delivery model.
3. Share with the participants that you will now explore the ways in which they are currently providing family planning services to clients. This exploration will help lay the groundwork for introducing and integrating the five key IPV services.

Step 2: Large Group Discussion (15 minutes)

1. Post flipchart paper on the wall. Ask the participants to walk you through a typical client visit—from the moment the client walks through the door, to the moment the client leaves the clinic. Encourage participants to be as detailed as possible. Record their answers on the flipchart paper. If there are additional steps taken for new clients as opposed to existing clients, mark the additional step with a symbol (or consider using a different colored marker).
2. Once you have an accurate picture of a client visit depicted on the flipchart paper, ask the participants to help you organize the steps into the following categories:
 - Welcoming, Building Rapport, and Learning about the Client's Needs
 - Informing the Client of Available FP Options and Exploring FP Options
 - Assisting with Decision Making Process
 - Referring and Follow-Up
3. Share with the participants that service delivery models vary from clinic to clinic—some processes are more formal, other processes less formal. Regardless, the process can often be organized into the four categories above. Explain that the five key IPV services are designed to coincide with the categories, as a means for smoother integration for both clients and providers.

TRAINING TIP

- While service delivery models may vary from clinic to clinic, the purpose of each category listed above is crucial. For example, some providers skip the welcoming of a client and immediately begin providing medical care and treatment. Welcoming a client is an essential step to building rapport between a client and a provider. Similarly, a provider that fails to learn about the client's needs and desires will be unable to fully assist with the decision making process, and the provider will make assumptions about the clients needs rather than asking the client to articulate her own needs and desires.
- If you find that it difficult to organize the participants' articulated family planning visit into the categories listed above, you may want to pause to address the importance of each category. Now is not the time to restructure their entire clinical process, but you can still encourage them to think critically about their process and how they might strengthen the process to better serve their clients.

4. Inform the participants that you will now introduce the five key family planning services and how those services can be integrated with the family planning visit.

Step 3: PowerPoint Presentation—Service Integration (30 minutes)

1. Explain to the participants that you will provide them with a presentation on the five key IPV services they will be integrating into their family planning visit. Share that the presentation includes definitions of each service, how and when to integrate IPV and FP services and the IPV-related forms that the providers will be using throughout the clinic visit.
2. Using *Handout 2.7: PowerPoint Presentation—5 Key Intimate Partner Violence Services*, present the information to the participants. Consider printing a copy of the presentation so the participants can follow along and take notes.

Step 4: Large Group Discussion (15 minutes)

1. Start the discussion by asking the following questions:
 - What are your first impressions regarding the 5 key intimate partner violence services?
 - Which of the services do you feel the most concerned about? Which of the services excite you the most?
2. Inquire about the integration process. Ask the participants if they feel as if the proposed integration (from the presentation) will work within their clinic setting. Why or why not?
3. If the participants do not feel as if the proposed integration steps will work for their clinic setting, post the five signs of key IPV services on the wall, next to the flipchart detailing the family planning visit. Ask the participants to arrange the IPV services next to the family planning step they feel it fits best. Engage the participants in a conversation about their



thoughts and ideas. Push back on the participants if necessary. For example, if you think an IPV service will be given short shrift (not completely properly or in its entirety), express that concern. Otherwise, adopt their suggestions. The end goal is to have solid integration process that the participants will want to carry out.

Step 5: Closure and Transition (5 minutes)

1. Remind the participants that they will have plenty of time to learn more about each of the services in the upcoming training modules, and discuss measures to overcome any barriers they might be anticipating.
2. Provide encouraging words about the process for expanding their services to include IPV-related services. This is an exciting time for the clinic and is a reflection of a commitment to provide more holistic care and treatment. Share that the lessons learned from this training will benefit all of their family planning clients, and it will push the participants to think critically about how they carry out all of their services.

**HANDOUT 2.7: POWERPOINT PRESENTATION—
5 KEY INTIMATE PARTNER VIOLENCE SERVICES**

<p style="text-align: center;">Five Key Intimate Partner Violence Services</p> <p style="text-align: center;">Session 2.7: Integrating IPV and Family Planning Services</p>	<p>Presentation Goals:</p> <ol style="list-style-type: none"> 1. Introduce the 5 key IPV services that will be integrated into FP visit. 2. Define each service 3. Describe how and when the service can be integrated 4. Introduce the IPV-related forms that providers will be using to carry out the services
<p>Reminder:</p> <p>This is an introduction, only. Each service described has a training module associated with it. You will be given additional information about the service, an opportunity to practice the service and training on how to use the forms throughout the remainder of the training.</p>	<p>Introduction: Tailored Care</p> <p>Counselors and providers often tailor their approach and family planning services based on the following aspects:</p> <ul style="list-style-type: none"> • Reason for client’s visit • Whether the client is a new client or an existing client • The client’s desired fertility plan • Timing of the client’s last pregnancy • The client’s demographic information (ie. age, health status, socioeconomic status, education status, etc.) • The client’s health
<p>Clients experiencing IPV also require tailored services and care, as IPV can greatly impact their reproductive and sexual health.</p>	<p style="text-align: center;">We suggest integrating 5 key IPV services that will help you to identify and support FP clients who are experiencing IPV.</p> <p style="text-align: center;">These IPV services may be adapted in order to best integrate the service into your clinic’s current FP service delivery model.</p>

TRAINING DAY 2

HANDOUT 2.7: POWERPOINT PRESENTATION— 5 KEY INTIMATE PARTNER VIOLENCE SERVICES *continued*

The 5 Key IPV Services Are:

1. Conduct universal screening for IPV.
2. Counsel and educate on the dynamics of IPV and the impact IPV can have on FP.
3. Explore family planning options and deliver reproductive health care services that take into consideration the IPV the client is experiencing.
4. Assist in identifying safety measures to safe guard the client's family planning decision, increase the client's sense of safety and reduce the harm she is experiencing.
5. Provide referrals to other medical, psychosocial and legal services that can further assist the client in addressing the IPV that is being perpetrated against her.

Benefits of integrating IPV services and FP

- The self-worth of an IPV survivor is often diminished, and she may feel as if she is incapable of doing anything right. Completing the counseling process, and reaching a FP decision, can help to empower an IPV survivor – a reminder that she is capable of achieving great things.
- Provides an IPV survivor with a structured environment in which to operate, something that is often lacking in her personal life due to the violence she is enduring.
- Restores an IPV survivors' control over their sexual and reproductive health, which may be lacking due to IPV.
- Creates positive interaction in which two consenting adults are treating each other with mutual respect and trust.

1. Conduct universal screening for IPV.

“Screening”: Using a series of questions to investigate, evaluate or identify an unrecognized ailment or symptom.

How it applies to the clinic setting:

Providers will ask the client 5 specific questions about the presence of intimate partner violence in the client's life. The client may choose or may not choose to disclose of violence.

INTEGRATE: Learning about the Client's Needs and IPV Screening (only after you have welcomed the client and attempted to build rapport)

The provider should always welcome the client to the clinic, and ask her questions about herself, how her day is going, about her family, etc. This helps to build rapport between the provider and the client. This is also the time for the provider to inform the client about the provider-client confidentiality, as well as how the provider will conduct the FP visit (screening, exploring options, decision making and referrals, if necessary).

Next, the provider will have a conversation with the client regarding her medical history (if necessary) and her family planning needs and desires. **This is an opportune time for the provider to conduct the IPV screening.** Based on the results of the screening, the provider will know if they need to tailor the rest of the FP visit to further address the IPV (if the client so chooses).

IPV Screening Tool

SCREENING QUESTION	TYPE OF VIOLENCE	CLIENT RESPONSE		OFFERING OF SAFETY PLANNING MEASURES
		NO	YES	
Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?	Psychological Abuse			DoLI: At the provider's discretion.
Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?	Psychological Abuse			DoLI: At the provider's discretion.
Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?	Sexual Abuse, emphasis on Sexual and Reproductive			DoLI: Yes, always.
Has your partner ever made you to participate in or do things you don't want to do sexually?	Sexual Abuse			DoLI: Yes, if incident occurred in the last 12 months.
Has your partner ever used a part of his body or another object to hurt you physically? (Examples may include: scratch, hit, slap, kick, punch, squeeze, pin down, strike with object etc.)	Physical and Psychological Abuse			DoLI: Yes, if incident occurred in the last 12 months.

The screening tool is a section on the “IPV Screening and Documentation Form.” The form are for documentation purposes.

Page 1:

INTIMATE PARTNER VIOLENCE SCREENING AND DOCUMENTATION TOOL

Name: _____ Client ID#: _____
 Patient Name: _____ Date of Birth: _____
 Provider Name: _____ Date of Visit: _____

SCREENING QUESTION	TYPE OF VIOLENCE	CLIENT RESPONSE	OFFERING OF SAFETY PLANNING MEASURES
Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?	Psychological Abuse		
Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?	Psychological Abuse		
Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?	Sexual Abuse, emphasis on Sexual and Reproductive		
Has your partner ever made you to participate in or do things you don't want to do sexually?	Sexual Abuse		
Has your partner ever used a part of his body or another object to hurt you physically? (Examples may include: scratch, hit, slap, kick, punch, squeeze, pin down, strike with object etc.)	Physical and Psychological Abuse		

Specialty of consultation for Reproductive Health Services (Indicate specialty or specialty area): _____
 Date of last visit: _____
 Reason for visit: _____

Specialty of consultation for Family Planning (Indicate specialty or specialty area): _____
 Date of last visit: _____
 Reason for visit: _____

Psychological History of IPV: Describe the client's behavior: _____
 Date: _____

Physical History of IPV: Describe any sexual injuries: _____
 Date: _____

Consent: _____
 Date: _____

SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS

Page 2:

Visual Exam - Physical History of IPV: Ask the client if they have physical injuries that they would like the provider to record on the body map. Note: This is to get a baseline exam, rather, a check-out of the body, instead of the entire medical history of the client response and sign for a baseline exam history.





	Head/Neck	Chest	Abdomen	Genitalia	Rectum
Examined					
Findings					
Diagnosis					
Plan					
Signature					
Date					

**HANDOUT 2.7: POWERPOINT PRESENTATION—
5 KEY INTIMATE PARTNER VIOLENCE SERVICES** *continued*

<p>2. Counsel and educate on dynamics of IPV and the impact IPV can have on FP</p> <p>“Counseling and educating”: To meet the emotional and information needs of an individual.</p> <p>How it applies to the clinic setting:</p> <p>Should a client disclose of IPV during the screening process, the provider is to acknowledge the harm caused to the client by offering supportive statements and informing the client how IPV may impact their family planning needs and/or desires. This is to be done <u>only</u> if the client so chooses.</p>	<p>3. Explore FP options and deliver reproductive health services that take into consideration the IPV the client is experiencing.</p> <p>“Exploring options and delivering services”: To <u>engage</u> in a conversation about the FP needs and desires, to <u>offer</u> information about the available resources that <u>address</u> the expressed need and desire and providing care to <u>meet</u> the expressed need and desire.</p> <p>How it applies to the clinic setting:</p> <p>Depending on the client’s expressed need and desire, a provider will <u>offer additional information</u> about how IPV can impact her need and desire. The <u>resources available to her will remain the same, but in order to address and meet her need, the resources may have to be tailored to take into consideration the IPV she is experiencing.</u></p>
<p>Informing a client of her options, exploring those options and counseling and educating go hand-in-hand.</p> <p>These steps do not need to be separated from one another, as each step impacts one another.</p>	<p>INTEGRATE: Informing the Client of Available Services, Exploring FP Options and IPV Counseling and Educating</p> <p>Because of the documented impact IPV can have on the sexual and reproductive health care of a client, it is important that a provider take into consideration the IPV a client may be experiencing when exploring FP options. <u>When informing the client about her FP options options, the provider can infuse the conversation with information about the dynamics of IPV and inquire about the client’s ability to negotiate FP methods with her partner.</u> While doing this, the provider can also share with the client that she is not to blame for the abuse, that many other clients experience this same thing.</p>
<p>4. Assist in developing a “Safety Plan” to safe guard the client’s family planning decision, increase the client’s sense of safety and reduce the harm she is experiencing.</p> <p>“Safety Plan”: Steps and/or suggestions to follow in order to avoid a dangerous situation, reduce the harm experienced and increase an individual’s sense of safety.</p> <p>How it applies to the clinic setting:</p> <p>Providers will engage in a conversation with the client about measures she might take should be experiencing physical or sexual violence, or in the even that the her partner is attempting to control her reproductive health.</p>	<p>INTEGRATE: Assisting the client in making a decision about her family planning and safety planning (as it pertains to her family planning decision).</p> <p>A client <u>may feel obligated to base her family planning decision on the violence she is experiencing.</u> Exploring family planning options and counseling and educating can be effective in helping a client to understand that <u>she does not need to base her FP decision on the IPV she is experiencing.</u></p> <p>When assisting the client in the decision making process, a provider can help the client identify safety measures she may take in order to protect her family planning decision as best as she can.</p>

TRAINING DAY 2

HANDOUT 2.7: POWERPOINT PRESENTATION— 5 KEY INTIMATE PARTNER VIOLENCE SERVICES *continued*

Job Aid: “Provider Tool for Safety Planning With Clients Experiencing IPV”

Provider Tool for Safety Planning with Clients Experiencing Intimate Partner Violence

Safety planning is a tool that can be used with clients experiencing intimate partner violence. While safety planning will not prevent the violence that is being perpetrated against the client, safety planning can increase the sense of control a client has over her life by helping her to identify ways to potentially avoid harm and/or what to do during an act of violence.

Understanding the level of danger in which the client is living, will help the provider and client think through what her options may be. The danger measures listed below align with the screening questions pertaining to sexual and physical violence, and tactics used to control a client's sexual and reproductive health. If the client has confirmed her experience with the indicated danger measures, the provider can offer to safety plan with the client using the suggested talking points.

DANGER MEASURE	NO	YES	If yes, then offer to safety plan.
1. Has the violence perpetrated against the client increased over the last 12 months?			
2. Does the abusive partner deny the client her right to control her sexual and reproductive health (i.e. deny or sabotage family planning methods, deny her access to care and treatment, force pregnancy and/or termination, etc.)?			
3. Does the abusive partner force the client to perform sexual acts against her will?			
4. Does the abusive partner use physical force to cause pain and/or injury?			
7. Each measure indicates a high risk for danger. The more measures the client confirms, the higher her risk of danger.			

TALKING POINTS FOR PROVIDERS

- Would you like to discuss how you might safely guard your family planning device? (Examples: Choosing a method that is not easily detectable, hiding the chosen method, etc.)
- Should your partner threaten your physical safety, might you be able to move the argument to an area in your home that may be safer than other areas? (Avoid: hallways, small spaces, standing next to a window, the kitchen or other areas with potential weapons, attempt to put a large object between abuser and self.)
- If you are concerned that you are pregnant and don't want to be, you can come here for assistance. We can help you assess what your options are.
- Have you confided in anyone about what you have been experiencing? Is there anyone you would feel comfortable speaking to about this? You deserve the support.
- If you need to leave your home, can you identify at least two locations where you might go?
- If you do leave your home, what important items will you need to take with you?
- You may always come to the clinic if you need assistance dealing with this. We will help you to the best of our ability and/or find a referral for someone who can assist you.

5. Provide referrals to other medical, psychosocial and legal services that can further assist the client in addressing the IPV that is being perpetrated against her.

“Referral”: To direct someone to an outside resource for further evaluation, consultation or assistance.

How it applies to the clinic setting:

Should the client so choose, a provider may refer a client to an outside agency with expertise in addressing IPV.

INTEGRATE:
Referrals, Follow-up and Safety Planning for Sexual and Physical Violence

Referrals generally happen at the end of a clinic visit, as does safety planning. However, a provider can introduce the idea of safety planning at any point during the visit and return to it later. It is particularly helpful to introduce safety planning during counseling and education.

It would behoove the provider to address safety measures needed to protect the FP decision, while assisting the client in the decision making process.

Because safety planning is considered an additional support services, it goes hand-in-hand with also suggesting outside services that may be available to assist the client in addressing the IPV she is experiencing.

Job Aid: “Provider Tool for Safety Planning With Clients Experiencing IPV”

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Making Referrals: Internal and External Confidentiality Release Form

Page 1:

Internal and External Confidentiality Release Form

This form defines the release provisions for which a client's confidential health information, including a disclosure of intimate partner violence, may be shared internally within the clinic and externally with other agencies. This form may be utilized if any client has not signed an external agency's required release form. This form must be signed by the client receiving services (additional signatures required if client is under 18).

Complete the following sections if making a client referral to an external agency.

Name and contact information of agency receiving the client referral:

Agency Name: _____
 Agency Address: _____
 Agency Phone: _____
 Agency Fax: _____

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

Individuals: _____

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: _____

Date of client: _____
 Date of provider: _____
 Date of release of information: _____
 Date of provider: _____
 Date of client: _____

(COMPLETE BACK FOR REFERRAL TO EXTERNAL AGENCY)

Page 2:

Internal and External Confidentiality Release Form

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SESSION 3.1: WELCOME AND INTRODUCTION

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Reflect on the previous day's accomplishments.
2. Articulate at least two new points of knowledge.
3. Describe the agenda for the day.

TIME

30 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or cell phone that can tell time
- Handout 1.1: Training Agenda*

ADVANCE PREPARATION

- Create and post two flipcharts, one titled “Reflections from Day 2,” the other “New Knowledge.”

TRAINING STEPS

Step 1: Welcome and Introduction (5 minutes)

1. Welcome the participants back to the training. Thank the participants for the attention the previous day and for the insight they brought to the training. Encourage the participants to continue to challenge themselves throughout the day, engage with the material and ask questions of each other and of themselves.
2. Direct their attention to *Handout 1.1: Training Agenda* and review the material they will be addressing throughout the day. Ask the participants if they have anything they would like you to be certain to cover in the agenda.



Step 2: Training Reflections (20 minutes)

1. Ask the participants to take a moment to think about two things: What they learned in the previous day's training, and how the previous day's training made them feel. Specifically, you would like them to do the following:
 - a. Identify at least 2 new points of knowledge they acquired in the previous day's training.
 - b. Identify at least 2 reflections from the previous day's training—how the training made them feel, what continues to circulate in their mind, or something they need additional clarification on.
2. Ask the participants to jot down their answers on a piece of paper. One by one, ask the participants to share their answers.
3. Record the participant's answers on the flipcharts titled, "Reflections from Day 2" and "New Knowledge."

Step 3: Closure and Transition (5 minutes)

1. Ask the participants if there is anything they would like to add before you begin the training modules.
2. Provide encouraging words for what they might gain from today's material.

SESSION 3.2: SCREENING FOR IPV— OVERVIEW AND DEMONSTRATION

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explain how screening for intimate partner violence can be integrated within the family planning visit.
2. Identify at least two positive outcomes of screening family planning clients for intimate partner violence.

TIME

1 hour, 45 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or timer
- Flipchart titled, “Positive Outcomes of Screening for Intimate Partner Violence”
- Handout 3.2A: Screening for IPV with Care and Compassion*
- Trainers’ Tool 3.2A: Screening Demonstration*
- Handout 3.2B: Intimate Partner Violence Screening and Documentation Tool*
- Handout 3.2C: Screening Basics*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Create a flipchart titled, “Positive Outcomes of Screening for Intimate Partner Violence.” List the following outcomes:
 - The ability to respond and treat using a more comprehensive approach.
 - Shed light on preexisting 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. This will allow the provider to either provide a referral to the client and/or tailor their FP need to account for the preexisting condition.

- Provide an opportunity to connect survivors with additional care and support services.
 - The opportunity to create a safety plan with the client, reducing the potential harm that is caused by the IPV she is experiencing.
 - Build mutual trust and confidence between clients and providers.
 - Impart knowledge about the prevalence of IPV, and validate the client's experiences and reactions.
 - Educate clients about their medical and legal rights.
- Print one copy of *Handout 3.2A: Screening for IPV with Care and Compassion* for each participant.
 - Print one copy of *Handout 3.2B: Intimate Partner Violence Screening and Documentation Tool* for each participant.
 - Print one copy of *Handout 3.2C: Screening Basics* for each participant.
 - Print two copies of *Trainers' Tool 3.2A: Screening Demonstration*—one for you, one for the person assisting you.

TRAINING STEPS

Step 1: Introduction and Large Group Brainstorm (10 minutes)

1. Ask the participants to think back to the family planning and intimate partner violence trivia game. Ask them to list at least 3 to 5 links between IPV and FP.
2. Explain that because IPV can greatly impact a client's FP practice, and sexual and reproductive health (SRH), and given how prevalent the problem is, it is important for providers to screen all clients for IPV.
3. Ask participants to help you define the term "screen." What does it entail? Is it a formal process or an informal process? Do they currently screen clients for other concerns during family planning counseling? Use the example of screening clients for sexually transmitted infections and HIV.

Definition of the term "screening": Using a series of questions to investigate, evaluate or identify an unrecognized ailment or symptom. In this instance, providers will be using a series of questions to identify the presence of IPV in FP clients.

4. Share that in health care settings, the provider interview (when the provider is learning about the client's needs) is the most common place for disclosures of IPV. Also, share that the benefits of screening for IPV are similar to the benefits of screening clients for STIs and HIV. Refer to the flipchart, "Positive Outcomes for Screening for Intimate Partner Violence."

5. Ask the participants to think about any challenges that might be associated with screening for IPV.

Example responses may include:

- IPV is often considered a “private” matter between a husband and a wife.
 - The fear of alienating a client from seeking FP services if they have to disclose personal information about their relationship.
 - The provider feeling uncomfortable with the nature of the subject matter.
 - The fear or uncertainty of what to do or say after a disclosure of IPV.
6. Inform the participants that this session will include a demonstration of how to screen a client for IPV. The following session will allow the participants to practice the skill of screening for IPV.

Step 2: Introduction to Intimate Partner Violence Screening and Documentation Tool (25 minutes)

1. Distribute *Handout 3.2: Intimate Partner Violence Screening and Documentation Tool*. Explain that providers will use this form to record information about the client’s experience with IPV. Allow participants to quickly scan the document for 30 seconds.
2. Explain that the remaining modules of the training—screening, counseling, exploring FP options, and documentation—will incorporate the use of this tool. For the purpose of this session, participants will only use the top section of the form—the IPV screening questions.
3. Ask the participants to take turns reading the five IPV screening questions aloud. Then, ask the participants for their initial reaction to the screening questions. Validate their reactions, whatever they may be. Remind the participants that this is an exciting opportunity for the clinic to be a leader in the field of reproductive health care. Screening for, and responding to, IPV is an example of providing excellent client-centered care, and a demonstration of the clinic’s commitment to the holistic wellbeing of their clientele.

Example reactions to the screening questions may include:

- Feeling as if the questions are too personal.
- Concern that the questions are worded too harshly.
- Thinking that clients will be untruthful when responding to the questions.
- Concern for the number of questions and the time it will take to ask, then address the response, to each question.
- Curiosity about the origin of the questions or why these particular questions are being asked of FP clients.

4. Explain that the questions do not have to be asked word-for-word, as they are printed on the documentation form. However, the questions were developed to detect particular elements of IPV. Ask the participants if they can identify the purpose of each screening question. The purposes are as follows:

SCREENING QUESTION	ALTERNATIVE WAY OF ASKING SCREENING QUESTION
1. Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?	<ul style="list-style-type: none"> • Identify if the client is experiencing psychological abuse. • To obtain a general sense of where the client is currently in the cycle of violence. • Gauge whether the client might benefit from safety planning.
2. Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?	<ul style="list-style-type: none"> • Identify if the client is experiencing psychological abuse. • Identify if the client's partner uses physical force, manipulation, threats or coercion to control the client. • Identify if the client is able to freely express her opinions, thoughts and desires. • Identify if the client's partner uses IPV as a mechanism to silence the client. • Gauge whether the client might benefit from safety planning.
3. Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?	<ul style="list-style-type: none"> • Identify whether the client has control over her sexual and reproductive health, and family planning desires. • Identify the potential for sexual abuse. • Identify if the client is in need of a FP method that takes into consideration the IPV she is experiencing. • Gauge whether the client might benefit from safety planning.
4. Has your partner ever made you to participate in or do things you don't want to do sexually?	<ul style="list-style-type: none"> • Identify if the client is experiencing sexual abuse. • Identify if the client is at risk for STIs, including HIV. • Identify if the client is in need of other reproductive health care services. • Detect elements of IPV in which the provider may help the client to safety plan in order to reduce the harm caused by IPV (discussed on Day 4)
5. Has your partner ever used a part of his body or another object to hurt you physically? (Examples may include: scratch, hit, slap, kick, punch, squeeze, pin down, strike with object etc.)	<ul style="list-style-type: none"> • Identify whether the client is experiencing physical abuse. • Identify if the client is at risk for serious injury. • Identify if the client is in need of a referral for the treatment of injury. • Gauge whether the client might benefit from safety planning.

5. Now, ask the participants to develop alternative ways to ask the question without changing the meaning of question. The participants answers may include:

SCREENING QUESTION	ALTERNATIVE WAY OF ASKING SCREENING QUESTION
1. Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?	<ul style="list-style-type: none"> • Can you think of a time when your partner has degraded or demeaned you in any way? • Can you think of a time when your partner has ever criticized you in any way?
2. Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?	<ul style="list-style-type: none"> • Does your partner ever do or say things that make you feel scared or embarrassed? • Do you ever feel unsafe at home or avoid your home because you are afraid of what your partner might say or do?
3. Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?	<ul style="list-style-type: none"> • Are you and your partner able to come to an agreement about your family planning desires? • Would you partner be angry with you if you went against his family planning desires?
4. Has your partner ever pushed you to participate in or do things you don't want to do sexually? (Examples may include:	<ul style="list-style-type: none"> • Do you feel free to say "no" if your partner wants to have sexual relations with you and you don't? • Do you ever feel like you have to perform sexual acts that you don't want to?
5. Has your partner ever used a part of his body or another object to hurt you physically? (Examples may include: scratch, hit, slap, kick, punch, squeeze, pin down, strike with object etc.)	<ul style="list-style-type: none"> • In what ways has your partner ever used physical force against you? • Can you describe a time in which your partner has used his physical strength to harm or scare you?

Step 3: Screening for IPV with Care and Compassion—“The Dos and Don’ts” (10 minutes)

1. Acknowledge the difficulty in discussing private matters, such as intimate relationships, with a stranger. Having such a conversation becomes even more difficult when the relationship strays from what is socially considered as “healthy” or in regions where IPV is considered to be “normal” and/or “natural.” Assure the participants that they already have practice engaging in conversations with clients that are sensitive and difficult—family planning and sexual and reproductive health.

2. Ask participants:

- How do you explain the need for asking difficult questions about FP needs with clients?
- How do you build trust with a client to create safety and comfort for discussion about private and sensitive information?

Explain that this module, and subsequent modules, will help providers to answer these two questions.

3. Remind the participants that building rapport with a client is a crucial step IPV screening, just as it is in FP counseling. One of the opportunities to build rapport with a client happens when a provider welcomes a client to the clinic, and takes a brief moment to get to know the client, prior to any mention of family planning and/or her sexual and reproductive health. Rapport between a provider and client grows when a provider can clearly articulate the following points to the client, in a way that a client can understand:

- **Client-centered care or holistic care:** A health care approach that honors the client's circumstances and environment, and how each may impact the client's FP decisions. This type of care involves the provider asking personal information about the client in order to understand their needs, equipping the client with relevant information that speaks to their needs, and helping the client in making a FP decision that adequately addresses those needs. This process is a routine process that all FP clients go through.
 - **The client's right to confidential family planning and reproductive health care:** The information the client shares with the provider will remain confidential.
 - **The provider's professionalism:** The provider is invested in helping the client as best they can, and the provider has experience working with clients who have diverse needs and circumstances. Nothing a client shares with the provider will make them feel uncomfortable. If the client's needs fall outside of the provider's expertise, the provider will assist the client in finding someone who can address the client's needs.
4. Explain to the participants that, while screening involves the provider asking a list of questions and receiving the answers, the manner in which the questions are asked, and the answers received, is part of building trust and rapport with a client. The more a provider displays care and compassion, the more likely the client will express their needs, concerns or fears.
 5. Distribute *Handout 3.2A: Screening for IPV with Care and Compassion*. Explain that the document provides examples of things to do during the screening process, and things to avoid during the screening process.
 6. Ask the participants to volunteer to read the examples aloud, one by one. Engage the participants in the material by asking the following questions:
 - Things to do: "In what ways do these examples positively impact the rapport between a client and provider?"
 - Things to avoid: "In what ways do these examples negatively impact the rapport between a client and provider?"
 7. Acknowledge that providers sometimes make mistakes, and say or do things that impact the rapport between the client and provider—sometimes the provider accidentally makes the client feel uncomfortable. Remind the participants that this is part of being human, and how the provider handles her mistake presents an opportunity to gain back the trust of the client. Ask the participants if they can think of at least two examples of when this happened with a client, and how they gained the client's trust back.

Step 4: Demonstration of IPV Screening (15 minutes)

1. Explain to the participants that you will demonstrate screening a FP client for IPV, using the screening questions from the *Intimate Partner Violence Screening and Documentation Tool*. You will begin the demonstration with rapport building—greeting the client.
2. Ask if one of the participants would be willing to assist you with the demonstration, and play the role of the client. Take one minute to quietly brief the participant on the script.

3. Conduct the demonstration using *Trainers' Tool 3.2: Screening Demonstration*. When completed, thank the participant for playing the role of the client.

Step 5: Large Group Screening Debrief (20 minutes)

1. Lead a large group discussion by asking participants the following questions:
 - What did you like about how the provider handled the overall screening process?
 - Is there anything you would have done differently?
 - What did you notice about the provider's body language?
 - In what ways did the provider continue to build rapport with the client throughout the screening process?

Step 6: Large Group Discussion—Interpreting Answers to Screening Questions (20 minutes)

1. Acknowledge to the participants that interpreting the clients' answers to the screening questions can be a challenging thing to do. There is no "one way" to answer the questions; therefore, like any other FP question, each client's response will be unique to her experience.
2. Remind the participants of the cycle of violence, and that the types of IPV—physical, sexual and psychological abuse—align with the cycles of violence. There will be times in an IPV relationship when the abuse may not appear, particularly in the honeymoon phase. However, if a client answers "yes" to any of the screening questions, or can describe a time in which her partner harmed her emotionally, physically or sexually, the client is screened positive for IPV. Reiterate, it only takes one "yes" or the description of one incident in order for a client to screen positive IPV. Tell the participants that you will address safety planning with clients at a later time.

TRAINERS' TIP

- Be prepared for the participants to argue the fact that it only takes one "yes" or one incident for a client to screen positive for IPV. While it may be realistic that an argument can "get out of control" at times, the manner in which an individual responds during that argument is crucial to identifying potential risk factors for IPV. If, at any point, one partner feels as if the other partner is exacting power or control of the situation—using threats or physical force—in order to control the other person, it is an IPV incident. The key is the unequal distribution of power, and using that power to harm another individual.

3. Inform participants that there will be instances when those who choose not to disclose of the IPV they are experiencing, regardless of the strength of the rapport the provider has built with the client. Ask the participants to list some of the reasons a client might choose not to disclose of IPV. Some of the participants' answers may include:

- The client is afraid of what might happen if they disclose.
- The client is not ready to discuss the abuse they are experiencing.
- The client may not know that what they are experiencing is IPV.
- The client has been socialized to believe that their experiences do not matter.

Share with the participants that it's okay and *acceptable* for a client to choose not to disclose of the abuse they are experiencing. Remind the participants that part of restoring power and control to a survivor of IPV, is to allow that person to guide their clinical visit. If IPV is not something they want to talk about, then the provider should move forward with the FP visit.

4. With that said, encourage the participants to read the body language of their clients. Individuals often become fidgety (move around in their chair) or tend to look away (avoid eye contact) if something makes them uncomfortable. Ask the participants to describe what an individual might do if they become uncomfortable in a particular situation. Some of their answers might include:

- Shifting eye contact
- Tearing of the eyes
- Picking at fingers
- Closing their body language—crossing arms, shifting body away from the provider
- Increasing the speed of their words
- Becoming quite or withdrawn

Encourage the participants to acknowledge to a client what they are seeing. For example, a provider might say, “I noticed that your eyes teared when I asked you that question. Was there something about the question that upset you?” Asking this type of question shows that the provider is genuinely interested in how the client is feeling—it's another example of rapport building. Secondly, encourage the participants to acknowledge the directness of the questions they are asking, and the impact those questions may have on a client. For example, a provider might say, “Some of my clients have felt like these questions have been intrusive. I want to assure you that I am asking them because I genuinely care about your well-being.” During these instances, it is important that a provider check in with a client about whether or not the client is comfortable with the provider continuing with the screening questions. The provider should follow the client's wishes.

5. Explain that if a client answers “no” to the screening questions, or is unable (or choosing not) to describe an incident associated with the screening questions, the provider should express that the clinic is a safe place for a client to come for help, should that ever happen. This should also be expressed to clients who screen positive for IPV.
6. Finally, explain to the participants that the screenings questions can allude to the severity of the IPV a client is experiencing. Additionally, the screening questions are designed to help the provider obtain a general sense of where in the cycle of violence the client is currently residing—whether the violence may escalate (tension building) or why the incidences of

violence are slowing (honeymoon). Regardless of whether the client has experienced only one or all six of the screening question, the provider is to offer the following services, of which will be covered in subsequent training sessions: counseling and education; tailored FP counseling that takes into consideration the IPV; referrals options for additional reproductive health services; a referral to a community based organization; and, the option to safety plan for reducing the harm caused by IPV.

Step 7: Closing and Transition (5 minutes)

1. Thank the participants for their attention and hard work during this training module. Reiterate the positive outcomes of screening FP clients for IPV. Provide encouraging words about the positive impact a providers' care and compassion can have on a client experiencing IPV.
2. Inform the participants that the next activity will provide them with the opportunity to practice screening a client for IPV, and debrief with the experience with their peers.
3. Ease any anxiety or tension the participants might have about working with clients experiencing IPV. Further explain that the next two days will consist of skills-building activities that will prepare them to effectively work with clients experiencing IPV. The skills-building activities are designed to build upon their existing skills as providers.
4. Distribute *Handout 3.2: Screening Basics*, to reiterate the large group discussion regarding the interpretation of screening questions.

TRAINING DAY 3

HANDOUT 3.2A: SCREENING FOR IPV WITH CARE AND COMPASSION

By following these screening guidelines, providers strive to make the screening process as comfortable for the client as possible. During the screening, the provider continues to build rapport with the client. The manner in which a provider responds—verbally and nonverbally—to a client's responses may impact how much information the client is willing to disclose. While some of these screening guidelines may seem trivial or common sense behavior, they should not be overlooked.

THINGS TO DO WHILE SCREENING A CLIENT FOR INTIMATE PARTNER VIOLENCE	THINGS TO AVOID WHILE SCREENING A CLIENT FOR INTIMATE PARTNER VIOLENCE
<ol style="list-style-type: none">1. Believe the client.2. Show compassion and empathy, and validate the client's emotions and expression of these emotions. Be prepared for a variety of emotional responses, including a lack of emotional response.3. Reassure the client. Remind the client of the confidentiality policy. Tell the client that the abuse she is experiencing is not her fault, and that many other clients experience the same type of violence she is experiencing.4. Empower the client. Show respect for the client. Acknowledge the client's strengths (for example, having the courage to disclose IPV). Tell the client you will help them explore their options and allow the client to make her own decision.5. Listen closely to the client. Be open-minded and patient when listening. Avoid pushing for more information. Allow the client to disclose only the information she wishes to disclose.6. Reinforce that the client is not to blame.7. Be open and honest with the client. Maintain open and honest communication with the client throughout the screening process. Keep the client informed of the next steps of the FP visit.8. Recognize personal limitations. Tell the client what you are able to provide them, given the information she has shared with you. Do not make promises that you cannot keep or answer questions without knowing the answer.9. Use open and respectful body language. Do not cross your legs, or cross your arms over your chest. Nod your head in acknowledgement of what the client is saying. Avoid facial expressions that suggest disagreement, disgust or frustration.10. Minimize the power imbalance. Sit across from the client without a barrier (desk, chair, exam table) between the client and you. Lower your chair or stool so you are sitting eye-level with the client. Tell the client that they are in control of the visit—they may stop the line of questioning at any point and/or decline to answer a question. Neither will impact the level of care she receives at the clinic.	<ol style="list-style-type: none">1. Make assumptions or passing judgment about the client.2. Minimize the abuse in an attempt to make the client feel better. (Example: "At least you weren't hurt more seriously.")3. Place blame on the client.4. Impose personal values and/or opinions, or share personal stories. The information you share should stem from a medical perspective, and your acquired knowledge of IPV. Your personal opinion about the client should never interfere with the level of care you provide the client.5. Ask "Why" questions, or too many questions. Allow the client to provide as much information as she is comfortable sharing. Ask questions that pertain to the FP needs of the client only—never ask questions that stem from personal curiosity.6. Fail to follow through. Rapport is damaged, and trust is violated, when a provider fails to tailor FP care based on the disclosure. Do not screen for IPV if you do not plan to use the disclosure information to better assist the client in making an informed and voluntary decision about her family planning options.7. Allow interruptions from outside parties. The counseling room should be a private setting where there is little to no interruption from others, including telephone inquiries. The door should remain closed before, during and following the screening session.8. Fidget, interrupt or look away. Doing so implies that you are not actively listening to the client, or that you are uninterested in what she is saying.9. Imply that the client's situation is out of the ordinary. Do not act surprised by the information the client is sharing with you. Rather, explain that you have worked with many clients who have endured similar experiences (even if you have not).

TRAINING DAY 5

HANDOUT 3.2B: IPV-FP FORMS AND PROVIDER TOOLS

INTIMATE PARTNER VIOLENCE SCREENING AND DOCUMENTATION TOOL

Date _____ Client ID# _____ yes no IPV confirmed by patient
 Patient Name _____ yes no IPV suspected but not confirmed
 Provider Name _____

SCREENING QUESTION	TYPE OF VIOLENCE	CLIENT RESPONSE			OFFERING OF SAFETY PLANNING MEASURES
		NO	YES	<i>If yes, indicate approximate date of last incident (DoLI).</i>	
Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?	Psychological Abuse			DoLI:	At the provider's discretion.
Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?	Psychological Abuse			DoLI:	At the provider's discretion.
Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?	Sexual Abuse, emphasis on Sexual and Reproductive			DoLI:	Yes.
Has your partner ever made you to participate in or do things you don't want to do sexually?	Sexual Abuse			DoLI:	Yes. Especially, if incident occurred in the last 12 months.
Has your partner ever used a part of his body or another object to hurt you physically? (Examples may include: scratch, hit, slap, kick, punch, squeeze, pin down, strike with object etc.)	Physical and Psychological Abuse			DoLI:	Yes. Especially, if incident occurred in the last 12 months.

Report: With the client's permission, record notes client's account of physical, emotional or sexual abuse.

Provider Evaluation

Special Considerations for Reproductive Health Services (additional services needed as a result of IPV)
 yes no Risk of STIs—including HIV) was explained to client
 yes no Screening for STIs was offered to client
 yes no Screening for STIs was completed

Special Considerations for Family Planning (chosen method and reason for chosen method)

Notes: _____

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

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 _____

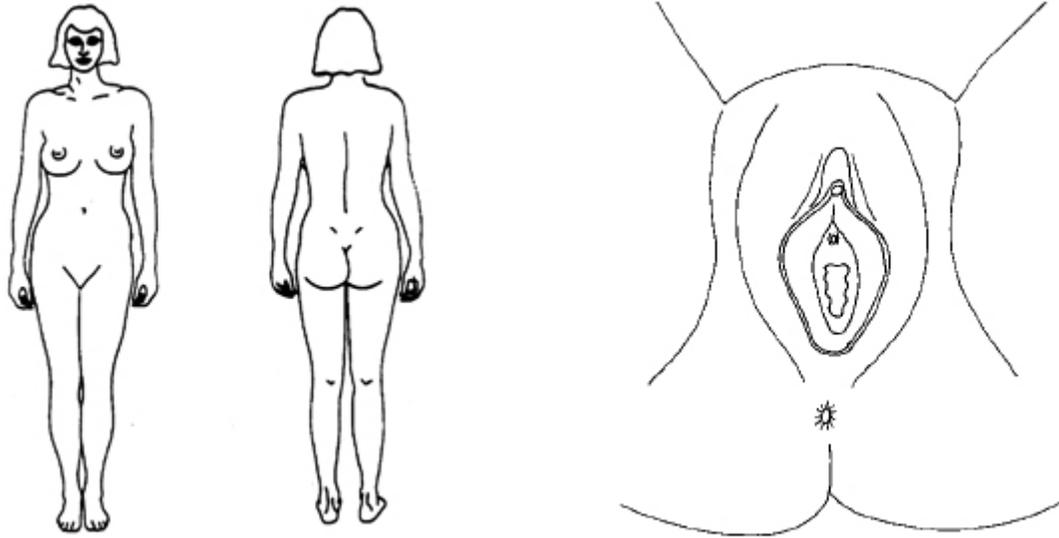
Physical Findings of IPV: Describe any visual injuries.

Personalized Safety Plan
 yes no Safety planning was offered to client
 yes no Safety plan was completed by client

SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS

VISUAL SCAN—Physical Finding of IPV: Ask the client if they have physical injuries that they would like the provider to record on the body map.

Note: This is *not* a forensic exam, rather, a visual scan of the body. Indicate in the referral section if the client requests and/or opts for a forensic exam referral.



	TENDERNESS	CONTUSION	ABRASION	LACERATION	BLEEDING
Head					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulder					
Arms					
Hands					
Chest					
Breasts					
Back					
Abdomen					
Genitals					
Anus					
Buttocks					
Legs					
Feet					

HANDOUT 3.2C: SCREENING BASICS

The Provider Interview

In health care settings, the provider interview is the most common place for disclosures of IPV to occur, as it is when the provider uses a series of questions—screening questions—to identify possible signs of IPV. 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 nonverbal elements into the family planning visit:

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.”

It is likely that some of the questions on the *Intimate Partner Violence Screening and Documentation Tool* 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—every day—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.

TRAINERS' TOOL 3.2A: SCREENING DEMONSTRATION

Provider:

“This is the time when I inquire more about the relationship you have with your partner. I have a list of five questions I would like to ask. Some of these questions might not appear to be related to FP. However, the answers you provide may actually impact the type of birth control you choose at the end of today’s visit. Again, these are questions we ask all of our clients. You should only answer the questions you feel comfortable answering. I don’t want you to feel pressured to answer anything you don’t want to answer. Does that work for you?”

Client:

“Okay.”

Provider:

“Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?”

Client:

“Uhh...well, like I said, sometimes we do have really bad fights. Maybe I’m just overreacting. He tells me that I do that a lot. I don’t believe him when he says I’m stupid, but it still hurts my feelings. The other day he told me he wished I would die because anyone in the world could care for our son better than I could. Why would he say such a thing? He did have a really bad day at work.”

Provider:

“That’s sounds really hard. I’m sorry he hurt your feelings like that...”

Client:

[client interrupts provider]

“Don’t get me wrong... We have a loving relationship. He really wants to have a baby. I think I want another baby, too. I just worry that he might leave me one day.”

Provider:

[provider nods heads and looks at the client with empathy]

“I can see how that might impact your FP goal. I believe you when you say you have a loving relationship. Can we continue to discuss your relationship?”

Client:

“Yes...”

Provider:

“Okay, thank you. Next question: “Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?”

Client:

[Client pauses to think. Lowers head down.]

“Um, maybe once or twice. But that was during a really, really awful fight.”

Provider:

“Thank you for sharing that. That does sound like an awful fight. Would you like to talk more about that?”

Client:

“No, not really. But if I ever do want to talk about it, can I come back here?”

Provider:

“Yes, please do come back if you need anything. Many of the clients I meet with have expressed some of the things you have shared. Please know that you’re not alone in this. May I move to the next question?”

Client:

“Yes.”

Provider:

“This question has to do with your family planning. Does your partner respect your family planning needs and desires?”

Client:

“I’m not sure I really understand that question.”

Provider:

“Okay, let me see if I can help to clarify the question by giving you a scenario. You mentioned earlier that you would like to use birth control pills. Does your partner know about and support that decision?”

Client:

“He doesn’t know about this at all. Please don’t tell him, he’ll be very angry if he finds out I was even here. I can’t tell him because he’s pushing me to have a baby and I’m just not ready yet.”

Provider:

“I will not tell your partner about the visit here, nor will I tell him about the FP method you choose. What you share with me is confidential. You’re safe here. I am glad you told me about the situation, this way we can explore methods that might be easier for you to keep hidden away.”

Client:

“I didn’t know that was even possible! Yes, can we find something that I can hide?”

Provider:

“Yes, of course. I want you to be in control of your family planning as you possibly can. We’ll come back to this when we discuss options. In the meantime, I have two more questions. My next question is a question about the intimacy between you and your partner: Has your partner ever made you to participate in or do things you don’t want to do sexually?”

Client:

[client covers face with hands and remains silent]

Provider:

“I can see that question has caused you to have a strong emotion. Can you share with me what you’re feeling right now?”

Client:

[uncovers face]

“I...I...I’m just embarrassed. And I feel sad. And then I feel bad that I’m talking about my partner is such an awful way. I don’t want you to judge me or to judge my partner.”

Provider:

“Thank you for being honest with me. I’m sorry that you’re feeling this way. Again, those feelings are feelings that a lot of our clients have. They’re normal reactions to really difficult, personal questions. I want you to know that I’m not here to judge you or your partner. I’m here to assist you with whatever you need in order to address your FP goal. The answers to these questions often impact our client’s FP decisions. We ask them so we can help you explore the options that take into consideration everything else that is happening in your life. Is there anything I can do to make this process easier for you?”

Client:

“No. No thanks. To answer your question: No, my partner has never forced me to do anything sexually or forced me to have sex. But I do know that he is having sex with other woman. I can’t say anything about it because I’m not supposed to know. He’s told me before that I don’t please him enough, so I have been doing more and more. If I let him do what he wants, maybe he won’t sleep with other woman. Sometimes it hurts when we have sex and I don’t know why. I have also noticed that I have to go to the bathroom all the time and it burns when I go.”

Provider:

“Thank you for sharing all of that with me. I’m sorry you’re dealing with all of this. I think you’re a really strong person, and that you are doing the best you can. In addition to thinking about your options, as they pertain to some of the things you have shared with me, I want us to also address the burning feeling you just described. Before we do so, may I ask you one final question?”

Client:

[Nods ‘yes.’]

Provider:

“Has your partner ever used a part of his body or another object to hurt you physically?”

Client:

“No, never. He would never hit me.”

Provider:

“I’m glad to hear that. No one deserves to be hurt by a partner. I’m sorry you’re experiencing some of these other things. Perhaps we can continue to talk about it throughout the visit? Particularly when we are discussing your options. Would you be interested in doing that?”

Client:

“Yes, very much so. Thank you so much.”

Provider:

“I am happy to assist you in the best ways that I can. Please don’t hesitate to ask questions if you have them. Shall we move on to discussing what your options might be?”

Client:

“Yes.”

SESSION 3.3: PARTICIPANT PRACTICE—SCREENING FOR IPV

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Conduct universal screening for intimate partner violence.

TIME

1 hour

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or timer
- Flipchart titled, “Positive Outcomes of Screening for Intimate Partner Violence”
- Handout 3.2A: Screening for IPV with Care and Compassion*
- Handout 3.2B: Intimate Partner Violence Screening and Documentation Tool*
- Handout 3.3A: Case Study #1—Participant Practice*
- Handout 3.3B: Case Study #2—Participant Practice*
- Handout 3.3C: Case Study #3—Participant Practice*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print two copies of *Handout 3.3A: Case Study #1—Participant Practice*.
- Print two copies of *Handout 3.3B: Case Study #2—Participant Practice*.
- Print two copies of *Handout 3.3C: Case Study #3—Participant Practice*.

TRAINING STEPS

Step 1: Introduction (2 minutes)

1. Explain to the participants that they will now have the opportunity to practice screening an FP client for IPV using the five screening questions from the *Intimate Partner Violence Screening and Documentation Tool*.
2. Acknowledge that this may be the first time the participants are engaging in a formal IPV screening process. Promote the activity by telling the participants that this is their opportunity to grapple with the material, find a system that works for them and experience the screening process, *before* they are charged with screening an actual FP client.

Step 2: Participant-Led Demonstrations (45 minutes)

1. Divide the participants into groups of three, with as much room between the groups as possible.
2. Inform the groups that there will be three rounds of role plays; each participant will have the opportunity to embody the role of a provider, client and observer. Ask the small groups to determine the order in which they will play the roles of provider, client and observer.
3. Explain that each round will last 15 minutes—roughly, seven minutes for the role play and seven minutes for the short discussion. The participant playing the role of the provider is to utilize the screening questions from the *IPV Screening Questionnaire and Documentation Form*, while the participant playing the role of the client improvises their part based on the client profile provided to them.
4. Explain that the client profiles consist of basic information about the client—name, age, history of pregnancy and IPV-related examples that should surface during the screening. In addition to basic information, there is a short, detailed story about the client. The story is intended to help the participants prepare for the respective roles. Explain that not *all* of the details need to be covered during the screening; the full story will emerge during the counseling and educating module.
5. Distribute the same case study to each group (one of the three case studies provided), and allow the participants one minute to read through the case study.
6. Instruct the participant who is observing to closely monitor the following aspects of the process:
 - The body language and facial expressions of the both provider and the client.
 - The manner in which the provider builds rapport with the client.
 - How the client and provider—verbally and nonverbally—respond to one another.
7. Stop the role play after seven minutes and lead a brief discussion using the following questions:
 - What was challenging about the screening process?

- How did the client respond to the screening questions? In what ways did the provider help the client to feel comfortable answering the screening questions? What could the provider do better next time?
- What nonverbal interactions took place during this role play?

8. Repeat steps 5–7, two more times with two different case profiles.

Step 3: Large Group Debrief (20 minutes)

1. After the third demonstration, return the participants to the large group.
2. Lead a large group discussion by asking the following questions:
 - What do you find encouraging about screening for IPV? Is there anything that worries you about screening for IPV?
 - How might a provider's sex impact the way in which a client answers the screening question? How might a client's experience of IPV influence their answers and reactions to the screening questions?

Examples of responses:

- If the provider is male the client may be fearful that the provider has similar qualities as her abusive partner given her understanding of rigid gender roles.
- The client might assume that a male provider will not be sympathetic to her needs.
- Given your role as the provider, and the power granted to you because of your role, how will you actively level the power imbalance between you and your client? If you are a male provider, how would you address the power imbalance, and assure the client that you are a safe person to speak to?

Examples of responses:

- By taking the time to listen to the client, and responding appropriately to the client.
- By validating her feelings and responses to what she is experiencing.
- By encouraging the client to lead the pace of the FP visit, and to ask any questions she may have.
- By helping the client to make an informed decision, trusting that decision and helping her identify ways to implement her decision.
- Because stories of IPV can be difficult to hear and respond to, how have you personally handled disclosures of IPV in the past? How do you maintain professional composure, as you will likely need to see another client immediately following? How would you make sure to take care of your emotional needs following a disclosure of IPV?

Examples of responses:

- Being aware of what triggers or ignites a visceral response in me.
- Talking to a colleague if I need someone to debrief with.
- Allowing myself the time and space to feel sad, angry or frustrated about a client's situation.
- By attempting to leave work at the end of the day and not think about my client or my client's situation.
- Believing that I have done everything that I could do for the client, that the client is well informed about her options.

Step 4: Closure and Transition (5 minutes)

1. Ask the participants to briefly list the things they will need to change about their practice in order to accommodate screening for IPV. Record the participant's answers on a flipchart. Explain to the participants that you will revisit this information on Day 5, Session 5.3:
Preparing the Clinic Environment

HANDOUT 3.3A: CASE STUDY #1—PARTICIPANT PRACTICE

Client Name: Abena

Age: 27

Marital status: Married 6 years

Educational Level: No formal education

Economic Level: Low

History of Pregnancy: One pregnancy that resulted in miscarriage

Family Planning Need: Unknown

Intimate Partner Violence Screening:

- *Physical Abuse:* 3 incidents of severe physical violence—one resulting in a miscarriage
- *Psychological Abuse:* Occurs on a daily basis
- *Sexual Abuse:* Forced sexual intercourse on 3 different occasions

I am 27 and have been married to my husband for six years. He is different from other husbands I know. He has never been warm or loving. From the day we met, he started saying awful things to me and it has only gotten worse over the last six years. I wouldn't have married him, but I felt like I didn't have a choice. My family is very poor and my husband's family is not. You see, my father works at my husband's business, and my husband let my father take extra jobs here and there to help supplement his income. I want to leave my husband and disappear but what will happen to my father?

My last pregnancy resulted in a miscarriage. My husband tells people there was something wrong with the baby, but I don't believe that. I was really happy when I found out I was pregnant, but I was sick through a lot of the pregnancy. I couldn't eat because I would vomit all the time, and not eating made me feel weak. I had to leave my job, and doing things around the house felt impossible. My husband says I was lazy; he told me that I was spending too much time worrying about the baby and not enough time taking care of him.

He would often punch and kick my stomach. He covered my face with a pillow so I couldn't breathe. I tried to tell my last doctor about this and he didn't believe me. He said my husband was going through a phase. That same day was the night my baby died. I didn't want to have sex and fought my husband. He kicked me between my legs and then over and over in the stomach. I bled for days after that.

I don't know how I can stay with him, but my father can't lose his job. I worry that if I get pregnant again, my husband will beat me to death.

TRAINING DAY 3

HANDOUT 3.3B: CASE STUDY #2—PARTICIPANT PRACTICE

Client Name: Chika

Age: 33

Marital status: Married 8 years

Educational Level: No formal education

Economic Level: Unknown

History of Pregnancy: One pregnancy that resulted in the birth of a son

Family Planning Need: Birth Control

Intimate Partner Violence Screening:

- *Physical Abuse:* Happens at least once every three months
- *Psychological Abuse:* Escalates and deescalates. Never quite sure of when abusive partner is going to explode.
- *Sexual Abuse:* None that she is willing to disclose.

Sometimes we don't fight for months. Then, for some reason, he just gets so angry that he explodes. I always seem to be on the receiving end of his anger. I can sense when the tension is building, and sometimes I can stop it before it happens. But when it does happen, it's really bad.

He gets angry over the smallest things. One night our son got sick and vomited on the floor. My husband started screaming at him, asking what was wrong with him. My son started to cry, but my husband kept going. Generally, I just let him yell, but I couldn't stand the thought of him screaming at my son for being sick. So, I threw a cup at him.

My husband called me a "bitch" and told me to clean up the vomit. As I was down on my hands and knees, he put his foot over my hand and began to press down. The more I showed pain on my face, the harder he pressed. When he stepped away, I quickly pulled my hand away. He instructed me to put it back down on the ground. I didn't, and he grabbed me by the back of my hair, spit in my face and screamed for me to put my hand on the floor. I did, and he stomped on it.

I would never treat him the way that he treats me. I asked him why he acts that way. He told me that the more he loves someone, the angrier he can get at them. I suppose that might be true, but I've never seen him treat anyone else he loves like this.

HANDOUT 3.3C: CASE STUDY #3—PARTICIPANT PRACTICE

Client Name: Oni

Age: 37

Marital status: Married 20 years

Educational Level: No formal education

Economic Level: Unknown

History of Pregnancy: 5 pregnancies, only one resulted in a live birth

Family Planning Need: Does not desire to have more children

Intimate Partner Violence Screening:

- Physical Abuse: At least one time per week.
- Psychological Abuse: Has become “accustomed” to the violence after twenty years
- Sexual Abuse: Is not interested in fighting with partner about not wanting to have sex, so “gives in to” his demands.

Supplemental Information:

Yes, my husband hits me, and sometimes does worse things than that, but I’m a strong woman. The way he acts used to bother me, but I’ve become used to it. My father hit my mother, brother and me growing up. It’s just something that happens. If there’s nothing I can do about it, I have to learn to live with it.

Sometimes, I fight back. I’ve yelled at him and I even kicked him once. He kept blocking the doorway when I was trying to leave the bathroom. Every time I took a step forward, he’d push me back into the room. I got so angry I screamed and kicked him. It felt really good even though I caught hell for doing it.

I’ve been with him for twenty years. I don’t really have any friends. He would never let me leave the house and so my friends eventually stopped reaching out to me. Both of my parents have passed away now, and my brother moved to another city. Our daughter is 14 and I’m glad we didn’t have any more children. I really don’t have anyone to talk to at this point.

I worry about my daughter. I wonder what she thinks of me, and if she’ll end up in a similar situation. She won’t talk to me about her experiences with boys, but I’ve seen her with a boy from her school. He already has a reputation.

I’m about to turn 37, and I’m tired—more tired than I’ve ever been. I do feel lonely, I guess, now that I think about it. Every day I have to listen to him say terrible things about me, but he only hits me occasionally. The only time he really hurts me is when he drinks alcohol. I suppose that is something I can be grateful for. He knows I can’t stand being with him and lately he’s been saying that he’ll find a way to make me stay forever. I don’t know what that means. I just don’t want anything to do with him.

TRAINING DAY 3

SESSION 3.4: PROVIDING COUNSELING TO CLIENTS EXPERIENCING IPV—DEMONSTRATION¹²

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. List and describe the key skills for counseling and educating clients on intimate partner violence.
2. Identify how this skill can be integrated into client visits.

TIME

1 hour, 20 minutes

MATERIALS

- Flipchart paper
- Markers
- Tape
- Index cards or small pieces of paper for demonstration cards
- Three flipcharts containing the definitions of the three key IPV counseling skills
- Trainers' Tool 3.4A: Informational and Emotional Needs of Clients Experiencing IPV*
- Trainers' Tool 3.4B: Demonstration Cards*
- Trainers' Tool 3.4C: Demonstration of Counseling Skills--Examples of Provider Responses*
- Handout 3.4: Messages to Convey to Clients Experiencing Intimate Partner Violence*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Prepare and post two flipcharts at the front of the room. Title one “Clients’ Informational Needs.” Title the other “Clients’ Emotional Needs.”
- Prepare six demonstration cards—three cards per skill—to be distributed to participants.
- Memorize your responses to each demonstration card (see Trainers’ Tool 3.4C).
- Create a flipchart detailing the counseling skill “Active Listening and Paraphrasing.” Post the flipchart as you introduce the skill.
- Create a flipchart detailing the counseling skill “Validating and Educating.” Post the flipchart as you introduce the skill.

¹² Adapted from: The ACQUIRE Project/EngenderHealth. 2008. *Counseling for effective use of family planning: Trainer’s manual*. New York.

COUNSELING SKILL:**Active Listening and Paraphrasing**

Definition: Listening closely in order to restate the client's message simply and in your own words

Purpose: Conveys a vested interest in, and comprehension of, what the other person is saying. Summarizes or clarifies what that person is trying to say.

COUNSELING SKILL:**Validating and Educating**

Definition: Acknowledging and confirming what was said, followed by additional information that supports what is said, or corrects any misinformation that was shared.

Purpose: Conveys nonjudgmental support, provokes thought and attempts to spark additional conversation. Seeks to eliminate any perception that IPV is justified or that it should be condoned

- ❑ Print one copy of *Handout 3.4: Messages to Convey to Clients Experiencing Intimate Partner Violence* for each participant.

TRAINING STEPS

Step 1: Introduction (5 minutes)

1. Explain that FP counseling requires good communications skills. The term “communication” does not just apply to the ways in which we talk to one another, it also has to do with how we interact with one another—our nonverbal cues, our body language, responding to emotions, etc. In FP clinics, the ability to establish rapport, to gather and process information, to provide emotional support and to educate, are all forms of communication. Our communication and the way in which we counsel our clients can greatly impact a client's ability to make an informed decision about her family planning. Bad communication and counseling can leave a client feeling disempowered, frustrated and misunderstood. Good communication and counseling helps to level the power dynamic between the provider and the client, so the client feels comfortable to express her needs and concerns, which is particularly important for clients who have experienced IPV.
2. Share with the participants that using even the most basic counseling skills can be impactful. For clients experiencing IPV, counseling and educating can help to validate the client's experience, address the impact IPV may be having on the client's family planning, and help to restore power and control to the client. Using this technique is not only helpful for the client, but also helpful for the provider. If done well, counseling and educating leads to more comprehensive discussions between the provider and the client, and thus, the provider will know how to better assist the client.
3. Remind the participants that counseling and educating will happen throughout the entire family planning visit, and that you will explain this more when you introduce the two key counseling skills.

Step 2: Brainstorm—Informational and Emotional Needs of Clients Experiencing IPV (15 minutes)

1. Explain that family planning visits should address both the informational and emotional needs of a FP client. Ask the participants to quickly name some of the informational needs and emotional needs of FP clients.

Examples may include:

- Informational Needs: FP methods available to them, education on proper use of FP methods, STI education and prevention, what a pelvic examination entails, how often to return to the clinic, how various medications can render their family planning ineffective, addressing any misconceptions about their body and/or their family planning, etc.
- Emotional Needs: Being encouraged to define their family planning desires and needs, having nerves or anxieties about the FP visit calmed by the provider, receiving validation that they are making the best decision for themselves and for their family, having their decision trusted and honored by the provider.

Explain that identifying a client's informational and emotional needs is an exercise providers can do in their head, or jot down on a piece of paper as the client shares details of the purpose for their visit.

2. Share that clients experiencing IPV often have additional informational and emotional needs as compared to clients who have not experienced IPV.
3. To help the participants to brainstorm the emotional and informational needs of clients who have experienced IPV, explain that you will be reading to them the narrative associated with the screening demonstration. Ask the participants to listen closely to the story, as you will be asking them to identify the needs of the main character after the reading.
4. Using *Trainers' Tool 3.4A: Informational and Emotional Needs of Clients Experiencing IPV*, read the story aloud.
5. Refer to the two flipcharts on the wall titled, "Informational Needs of Clients Experiencing IPV" and "Emotional Needs of Clients Experiencing IPV." Ask the participants to give examples of each need, based on the story. Encourage the participants to also identify other informational and emotional needs of clients experiencing IPV, which may not have been reflected in the story.
6. Explain to the participants that you will now demonstrate the key counseling skill that seek to address the informational and emotional needs of clients experiencing IPV.
 - Active listening and paraphrasing
 - Validating and educating
7. Distribute the nine demonstration cards—three for each counseling skill. Explain that you will have the participants read what is on the card.

Step 3: Demonstration of Counseling Skill—Active Listening and Paraphrasing (25 minutes)

1. Ask the participants to quickly give their definition of active listening and paraphrasing, as it pertains to counseling.
2. Post the flipchart titled, “Key Skill: Active Listening and Paraphrasing,” and read the definition and purpose of the skill.
3. Explain that active listening is conveyed through our nonverbal and verbal communication. Remind participants that how we behave while a client is talking is just as important, and sometimes more important, than what we say in the moment.
4. Ask the participants to describe how they know when someone is actively listening to them—what does their body language look like? If they struggle to articulate the answer, prompt them with the following questions:
 - What is the person doing with their eyes?
 - How are they sitting or standing?
 - Are they moving in anyway?
 - Are they making any sounds?
5. Share that paraphrasing conveys an interest in what another person is saying, and summarizes or clarifies what that person is trying to say.
6. Demonstrate the skill by asking the participants holding the “Active Listening and Paraphrasing” cards to take turns reading the statements to you. As they read, demonstrate active listening, then paraphrase back what was said to you.
7. Ask the participants if they feel like you adequately addressed the emotional and informational needs of the client during your demonstration. Have them list things that went well, and things they may have done differently.

Step 4: Demonstration of Counseling Skill—Validating and Educating (25 minutes)

1. Ask the participants to quickly give their definition of validating and educating, as it pertains to counseling.
2. Post the flipchart titled, “Key Skill: Validating and Educating,” and read the definition and purpose of the skill.
3. Explain that validating a client’s experience with IPV helps to convey that you are not going to pass judgment on the client. Additionally, this skill helps to provoke thought and additional conversation. Finally, this skill seeks to eliminate any perception that IPV is justified or that it should be condoned. Paired with an educational message about IPV, this skill helps to affirm that IPV, can take a tremendous toll on a client’s physical and emotional wellbeing. This skill helps to build rapport with clients by acknowledging the difficulty of their experience.

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4. Do caution the participants from providing too much education on IPV at that very moment. Some clients do not want additional information, or may feel overwhelmed by too much information. Conveying one educational message is plenty, until the provider has the permission of the client to discuss IPV with more depth.
 5. Demonstrate the skill by asking the participants holding the “Validating and Educating” cards to take turns reading the statements to you. After each statement, demonstrate the validation and education skill.
 6. Ask the participants if they feel like you adequately addressed the emotional and informational needs of the client during your demonstration. Have them list things that went well, and things they may have done differently.

**Step 5: Closure and Transition—Messages to Convey to a Client Experiencing IPV
(10 minutes)**

1. Close the session by telling students that it is possible to counsel, educate and show empathy using very few words.
2. Distribute *Handout 3.4: Messages to Convey to Clients Experiencing Intimate Partner Violence*, a compilation of messages that the participants should weave into their counseling sessions as they align with the three counseling skills.
3. Read the messages aloud by going around the room and having each participant read a message.
4. Inform the participants that the next session is a participant practice session, in which they will be working in small groups to strengthen their IPV counseling skills.

TRAINERS' TOOL 3.4A: INFORMATIONAL AND EMOTIONAL NEEDS OF CLIENTS EXPERIENCING IPV

Instructions

1. Read the case study to the participants.
2. Help the participants identify the informational and emotional needs of the client, as well as additional informational and emotional needs of clients experiencing IPV.

Case Study

I am 21 years old and have been married to my husband for three years. He works very hard every day and provides food and a good home for our family. Our son is two years old, and they love spending time together. My husband helps take care of him, and cooks dinner at least once a week so I can visit my mom and sister. I feel really lucky to have him; after all, he could have found someone better than me. We want to have another baby in the next year.

Sometimes I worry that he'll leave me. I don't have a job so I'm not contributing to our income. I take really good care of our home and our son in order to make up for the fact that I don't work. He says I do a good job with the house, but that I'm a terrible cook. He gets mad at me if I spend too much money on groceries. He has started giving me an allowance so I don't spend too much money. The last time I spent too much money, he didn't let me eat dinner for two weeks so we could spread out the food. I understood why and I agreed to it. That was six months ago, and he still gets angry with me about it. Sometimes he's really mean about it and I cry, which makes him even angrier. The other day when I cried, he drew back his hand like he was going to hit me. When I shielded my face, he started to laugh at me. I was really embarrassed. It was stupid of me to act like that. I shouldn't have overspent on our food in the first place.

We have a loving relationship. He really wants to have another baby. I think I want another baby, too. I just worry that he might leave me one day. I know he is having sex with other women. I can't say anything about it because I'm not supposed to know. He's told me before that I don't please him enough, so I have been doing more and more. If I let him do what he wants, maybe he won't sleep with other women. Sometimes it hurts when we have sex and I don't know why. I have also noticed that I have to go to the bathroom all the time and it burns when I go.

Maybe I'm just overreacting. He tells me that I do that a lot. I don't believe him when he says I'm stupid, but it still hurts my feelings. The other day he told me he wished I would die because anyone in the world could care for our son better than I could. Why would he say such a thing? He did have a really bad day at work.



INFORMATIONAL NEEDS	EMOTIONAL NEEDS
<ul style="list-style-type: none">• To know that she can, in fact, control her risk of becoming pregnant• An explanation of her FP options• An explanation of how birth control prevents pregnancy• An explanation of her right to confidential care• An explanation of additional resources that may be of assistance to her (legal, medical, psychosocial or financial)• To know that the only person who can stop the abuse is her partner• To know of her risk of STIs (based on the information provided) and how to identify symptoms of, and how to prevent, STIs• To be informed of additional reproductive health services she may need• To be informed of the other services you might be able to offer her, including safety planning	<ul style="list-style-type: none">• To have her emotional reactions acknowledged and validated• To know that the abuse she is experiencing is not her fault• To be told that she not overreacting and she is not stupid• To assure her that she is not a bad person for coming to the clinic for assistance• To know that she is not the only person who has experienced this type of treatment from their partner• To be encouraged to make the best decision for her family planning needs• To be supported in her decision to prevent pregnancy• To be listened to and treated with compassion

TRAINERS' TOOL 3.4A: DEMONSTRATION CARDS

Instructions

1. Cut apart along the lines to create six separate cards.
2. Distribute the cards randomly among the participants.
3. Ask the participants to read the cards one by one, pausing in between each card to allow you to demonstrate the skill.

Active Listening and Paraphrasing

Sometimes I worry that he'll leave me. I don't have a job so I'm not contributing to our income. I take really good care of our home and our son in order to make up for the fact that I don't work. He says I do a good job with the house, but that I'm a terrible cook. He gets mad at me if I spend too much money on groceries. He has started giving me an allowance so I don't spend too much money. The last time I spent too much money, he didn't let me eat dinner for two weeks so we could spread out the food.

Active Listening and Paraphrasing

Sometimes I worry that he'll leave me. I don't have a job so I'm not contributing to our income. I take really good care of our home and our son in order to make up for the fact that I don't work. He says I do a good job with the house, but that I'm a terrible cook. He gets mad at me if I spend too much money on groceries. He has started giving me an allowance so I don't spend too much money. The last time I spent too much money, he didn't let me eat dinner for two weeks so we could spread out the food.

Active Listening and Paraphrasing

We have a loving relationship. He really wants to have a baby. I think I want another baby, too. I just worry that he might leave me one day. I know he is having sex with other women. I can't say anything about it because I'm not supposed to know. He's told me before that I don't please him enough, so I have been doing more and more. If I let him do what he wants, maybe he won't sleep with other women. Sometimes it hurts when we have sex and I don't know why. I have also noticed that I have to go to the bathroom all the time and it burns when I go.

Active Listening and Paraphrasing

We have a loving relationship. He really wants to have a baby. I think I want another baby, too. I just worry that he might leave me one day. I know he is having sex with other women. I can't say anything about it because I'm not supposed to know. He's told me before that I don't please him enough, so I have been doing more and more. If I let him do what he wants, maybe he won't sleep with other women. Sometimes it hurts when we have sex and I don't know why. I have also noticed that I have to go to the bathroom all the time and it burns when I go.

Active Listening and Paraphrasing

Maybe I'm just overreacting. He tells me that I do that a lot. I don't believe him when he says I'm stupid, but it still hurts my feelings. The other day he told me he wished I would die because anyone in the world could for our son better than I could. Why would he say such a thing? He did have a really bad day at work.

Active Listening and Paraphrasing

Maybe I'm just overreacting. He tells me that I do that a lot. I don't believe him when he says I'm stupid, but it still hurts my feelings. The other day he told me he wished I would die because anyone in the world could for our son better than I could. Why would he say such a thing? He did have a really bad day at work.

TRAINING DAY 3

TRAINERS' TOOL 3.4C: DEMONSTRATION OF COUNSELING SKILLS— EXAMPLES OF PROVIDER RESPONSES

Counseling Skill: Active Listening and Paraphrasing

- *Definition:* Listening closely in order to restate the client's message simply and in your own words
- *Purpose:* Conveys a vested interest in and comprehension of what the other person is saying, and summarizes or clarifies what that person is trying to say.

<p>Active Listening and Paraphrasing</p> <p>Sometimes I worry that he'll leave me. I don't have a job so I'm not contributing to our income. I take really good care of our home and our son in order to make up for the fact that I don't work. He says I do a good job with the house, but that I'm a terrible cook. He gets mad at me if I spend too much money on groceries. He has started giving me an allowance so I don't spend too much money. The last time I spent too much money, he didn't let me eat dinner for two weeks so we could spread out the food.</p>	<p>Active Listening and Paraphrasing</p> <p>We have a loving relationship. He really wants to have a baby. I think I want another baby, too. I just worry that he might leave me one day. I know he is having sex with other women. I can't say anything about it because I'm not supposed to know. He's told me before that I don't please him enough, so I have been doing more and more. If I let him do what he wants, maybe he won't sleep with other women. Sometimes it hurts when we have sex and I don't know why. I have also noticed that I have to go to the bathroom all the time and it burns when I go.</p>	<p>Active Listening and Paraphrasing</p> <p>Maybe I'm just overreacting. He tells me that I do that a lot. I don't believe him when he says I'm stupid, but it still hurts my feelings. The other day he told me he wished I would die because anyone in the world could for our son better than I could. Why would he say such a thing? He did have a really bad day at work.</p>
<p>Provider Response</p> <p>It sounds like you have a lot on your mind. Instead of working outside of the home, you take good care of your home and son. I'm not a very good cook either, so we have that in common. I'm concerned about you not being able to eat dinner. It sounds like you may have overspent on the food allowance, and your husband forced you to take drastic measures to conserve food. Is that correct?</p>	<p>Provider Response</p> <p>I am glad to hear that you feel you have a loving relationship. Maybe we could discuss more about whether or not you would like to have another baby, given that you are fearful he might leave. It sounds like it might be difficult for you to address certain things with your husband, like the fact that he is sleeping with other women. If you feel comfortable, I would like to discuss more about that, as well as the pain you are feeling during sex and the burning you feel when you use the bathroom.</p>	<p>Provider Response</p> <p>I can tell that this hurts your feelings, and that you worry that you might be overreacting about the situation. What he said to you was really hurtful—no one wants to be told they should die.</p>

Counseling Skill: Validating and Educating

- *Definition:* Acknowledging and confirming what was said, followed by additional information that supports what is said, or corrects any misinformation that was shared.
- *Purpose:* Conveys nonjudgmental support, provokes thought and attempts to spark additional conversation. Seeks to eliminate any perception that IPV is justified or that it should be condoned.

<p>Validating and Educating</p> <p>Sometimes I worry that he'll leave me. I don't have a job so I'm not contributing to our income. I take really good care of our home and our son in order to make up for the fact that I don't work. He says I do a good job with the house, but that I'm a terrible cook. He gets mad at me if I spend too much money on groceries. He has started giving me an allowance so I don't spend too much money. The last time I spent too much money, he didn't let me eat dinner for two weeks so we could spread out the food.</p>	<p>Validating and Educating</p> <p>We have a loving relationship. He really wants to have a baby. I think I want another baby, too. I just worry that he might leave me one day. I know he is having sex with other women. I can't say anything about it because I'm not supposed to know. He's told me before that I don't please him enough, so I have been doing more and more. If I let him do what he wants, maybe he won't sleep with other women. Sometimes it hurts when we have sex and I don't know why. I have also noticed that I have to go to the bathroom all the time and it burns when I go.</p>	<p>Validating and Educating</p> <p>Maybe I'm just overreacting. He tells me that I do that a lot. I don't believe him when he says I'm stupid, but it still hurts my feelings. The other day he told me he wished I would die because anyone in the world could care for our son better than I could. Why would he say such a thing? He did have a really bad day at work.</p>
<p>Provider Response</p> <p>I'm sorry that you have to worry about these types of thing—it's never easy to be in this kind of situation. I want you to know that you are not the only client I have worked with who has experienced things like this. I also want you to know that regardless of whether or not you overspent on food, you did not deserve to go without food for two weeks. It sounds to me like he might be treating you unfairly and disrespecting you.</p>	<p>Provider Response</p> <p>I know this may feel like a loving relationship to you. And at times it probably is a loving relationship. Couples should be able to discuss things with each other without fear of what might happen. You deserve to be able to ask questions and express your opinions. I want us to discuss more about the burning feeling you are having. That's not something that you should be experiencing, and perhaps we can also find a solution to that.</p>	<p>Provider Response</p> <p>I know if might feel like you are overreacting, but I don't believe that you are. I know a lot of women who would also feel hurt if their partner was treating them in this manner. What you're feeling is a reaction to emotional abuse, and it is common reaction to have. I know quite a few women who have also experienced this. Perhaps we could discuss ways to help you during the times when you're feeling the worst.</p>

TRAINING DAY 3

HANDOUT 3.4: MESSAGES TO CONVEY TO CLIENTS EXPERIENCING INTIMATE PARTNER VIOLENCE

1. I'm sorry this is happening to you.
2. This is not your fault. There is nothing you have done wrong to be treated in this way.
3. No one deserves to be treated in this way.
4. Violence is never justified between two people who are supposed to love one another.
5. If, at any point, you do not want to talk about this anymore, please do tell me. I won't be upset. I want you to help lead the direction of this conversation.
6. Thank you for trusting me with this information.
7. The information you are sharing with me is very important, and we will take that into consideration when we are addressing your FP needs and desires.
8. What you're experiencing is very common among women. I have worked with many clients who been in similar situations. You are not alone.
9. I want you to know that while you are here, you are in control of what happens.
10. I want you to feel safe while you are here at the clinic. Is there anything we can do to help you feel more comfortable?
11. You only have to share as much as you want to share.
12. Your thoughts, needs and opinions matter to me.
13. I want to help you do what you think is best for you.
14. I think you're a strong and brave person.
15. I am concerned about you, and care about what happens to you.
16. If it is okay with you, I would like to discuss how these experiences might impact your FP decisions and goals.
17. I want you to know that there are services available for women who are experiencing similar things as you.
18. I am concerned about your safety and wellbeing. If you would like, together we can discuss how you might keep yourself safer from the harm you are experiencing.
19. While my expertise is in FP, I do have knowledge and information on what you are experiencing. If you would like, we can spend a few minutes discussing your experiences.
20. I trust that you know what is best for you. I will do as you would like me to do.
21. What you're feeling is a normal reaction to this kind of harm. Many women have the same reaction.

SESSION 3.5: PARTICIPANT PRACTICE— IPV COUNSELING AND EDUCATING

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Provide counseling and educational support to a family planning client who is experiencing intimate partner violence.

TIME

1 hour, 45 minutes

MATERIALS

- Flipchart paper
- Markers
- Tape
- Counseling skills flipcharts from Session 3.4
- Handout 3.5A: Participant Practice—Client Profile #1: IPV Counseling and Educating*
- Handout 3.5B: Participant Practice—Client Profile #2: IPV Counseling and Educating*
- Handout 3.5C: Participant Practice—Client Profile #3: IPV Counseling and Educating*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Post the three counseling skill flipcharts from Session 3.4
- Print one copy of *Handout 3.5A: Participant Practice—Client Profile #1: IPV Counseling and Educating* for each participant.
- Print one copy of *Handout 3.5B: Participant Practice—Client Profile #2: IPV Counseling and Educating* for each participant.
- Print one copy of *Handout 3.5C: Participant Practice—Client Profile #3: IPV Counseling and Educating* for each participant.

TRAINING STEPS

Step 1: Introduction (3 minutes)

1. Review the definition and purpose of each counseling skill. Refer to the corresponding flipcharts from Session 3.4.

2. Explain to the participants that this session will allow them the opportunity to practice their IPV counseling skills using some of the scenarios presented during the screening session, as well as new scenarios.

Step 2: Participant Practice—Counseling and Educating (1 hour, 15 minutes)
(each case scenario should last no more than 25 minutes)

1. Divide the participants into groups of three, with as much room between the groups as possible.
2. Inform the groups that there will be three rounds of role play; each participant will have the opportunity to embody each role. Ask the small groups to determine the order in which they will play the roles of provider, client and observer.
3. Tell the groups they are to read through the scenario together, first. Then, following the same format as the demonstration in the previous module, the client is to reread the preselected paragraph to the provider, to which the provider will respond with two different responses (this is to ensure that the participant assuming the role of the provider adequately practices each skill at least twice). The observer is to document the interaction and effectiveness of the counseling and educating session.
4. Remind participants of the two skills for counseling and educating clients on IPV by drawing their attention to the flipcharts on counseling skills.
5. Inform the groups that each round will last 15 minutes total—seven minutes for the role play and seven minutes for a short discussion.
6. Distribute the case scenario. Quickly, point the participant's attention to the paragraphs in which they will be asked to demonstrate the skills. Make note of the time, and instruct the participants to begin the process. Stop the participants after seven minutes.
7. Stop the role play after 14 minutes and lead a brief discussion using the following questions for the remainder of the 25 allotted minutes:
 - Was there anything the provider said that seemed particularly helpful to the client?
 - Was there anything the provider said that might be potentially harmful to the client?
 - What nonverbal interactions took place during the round?
8. Repeat #5 and #6, two more times, for a total of three scenarios.

Step 3: Large Group Debrief and Discussion (25 minutes)

1. Return the small groups to the large group.
2. Lead a large group discussion using the following questions:
 - What did you find particularly difficult about this activity? Why was that the case?
 - What did you find particularly rewarding about this activity? Why was that the case?

- How did you decide what you were going to say? What words or phrases did you consciously use? What words or phrases did you choose not to use? Why?
- How might the socialization of women influence how she might react to her situation? How might your personal attitudes and values influence the consultation process?

Examples of responses:

- The client may feel as if she deserves the treatment she is experiencing.
 - The client may believe that this is normal behavior.
 - The client may feel as if she is unable to say anything, or do anything, about her situation because she was taught that her needs, opinions and thoughts are lesser than a man's needs, opinions and thoughts.
 - The provider's attitudes or values may align with the elements described above, and be unable or unwilling to address the IPV.
 - The provider may be unaware that what the client is experiencing is IPV but, rather, believe this is rational behavior on the part of her husband.
- How might this activity change the way you work with clients?

Examples of responses:

- To be more aware of how the socialization of women may affect how my client understands her situation.
- To be more thoughtful about the words and/or language I am using when speaking to my client, as to not reinforce rigid, inequitable gender norms.
- To be aware of the power and control I have in the room, and be certain to restore the power to my client.

Step 4: Closure and Transition (2 minutes)

1. Thank the participants for their hard work, and congratulate them on learning two crucial intervention skills—screening for IPV and counseling and educating a client experiencing IPV.
2. Inform the participants that they will continue to hone those two skills, while building their capacity to provide other IPV-related services throughout the training.

TRAINING DAY 3

HANDOUT 3.5A: PARTICIPANT PRACTICE— CLIENT PROFILE #1: IPV COUNSELING AND EDUCATING

I am 27 and have been married to my husband for six years. He is different from other husbands I know. He has never been warm or loving. From the day we met, he started saying awful things to me and it has only gotten worse over the last six years. I wouldn't have married him, but I felt like I didn't have a choice. My family is very poor and my husband's family is not. You see, my father works at my husband's business, and my husband lets my father take extra jobs here and there to help supplement his income. I want to leave my husband and disappear but what will happen to my father?

My last pregnancy resulted in a miscarriage. My husband tells people there was something wrong with the baby, but I don't believe that. I was really happy when I found out I was pregnant, but I was sick through a lot of the pregnancy. I couldn't eat because I would vomit all the time, and not eating made me feel weak. I had to leave my job, and doing things around the house felt impossible. My husband says I was lazy; he told me I was spending too much time worrying about the baby and not enough time taking care of him.

He would often punch and kick my stomach. He covered my face with a pillow so I couldn't breathe. I tried to tell my last doctor about this and he didn't believe me. He said my husband was going through a phase. That same day was the night my baby died. I didn't want to have sex and fought my husband. He kicked me between my legs and then over and over in the stomach. I bled for days after that.

I don't know how I can stay with him, but my father can't lose his job. I worry that if I get pregnant again, my husband will beat me to death.



CLIENT DETAIL	PROVIDER (PARTICIPANT) RESPONSE
<p>He is different from other husbands I know. He has never been warm or loving. From the day we met, he started saying awful things to me and it has only gotten worse over the last six years. I wouldn't have married him, but I felt like I didn't have a choice. My family is very poor and my husband's family is not. You see, my father works at my husband's business, and let's my father take extra jobs here and there to help supplement his income. I want to leave my husband and disappear but what will happen to my father?</p>	<p>Active Listening and Paraphrasing (develop at least two different responses)</p>
<p>He would often punch and kick my stomach. He covered my face with a pillow so I couldn't breathe. I tried to tell my last doctor about this and he didn't believe me. He said my husband was going through a phase. That same day was the night my baby died. I didn't want to have sex and fought my husband. He kicked me between my legs and then over and over in the stomach. I bled for days after that.</p>	<p>Validating and Educating (develop at least two different responses)</p>

TRAINING DAY 3

HANDOUT 3.5B: PARTICIPANT PRACTICE— CLIENT PROFILE #2: IPV COUNSELING AND EDUCATING

Yes, my husband hits me, and sometimes does worse things than that, but I'm a strong woman. The way he acts used to bother me, but I've become used to it. My father hit my mother, brother and me growing up. It's just something that happens. If there's nothing I can do about it, I have to learn to live with it.

Sometimes, I fight back. I've yelled at him and I even kicked him once. He kept blocking the doorway when I was trying to leave the bathroom. Every time I took a step forward, he'd push me back into the room. I got so angry I screamed and kicked him. It felt really good even though I caught hell for doing it.

I've been with him for twenty years. I don't really have any friends. He would never let me leave the house and so my friends eventually stopped reaching out to me. Both of my parents have passed away now, and my brother moved to another city. Our daughter is 14 and I'm glad we didn't have any more children. I really don't have anyone to talk to at this point.

I worry about my daughter. I wonder what she thinks of me, and if she'll end up in a similar situation. She won't talk to me about her experience with boys, but I've seen her with a boy from her school. He already has a reputation.

I'm about to turn 37, and I'm tired—more tired than I've ever been. I do feel lonely, I guess, now that I think about it. Every day I have to listen to him say terrible things about me, but he only hits me occasionally. The only time he really hurts me is when he drinks alcohol. I suppose that is something I can be grateful for. He knows I can't stand being with him and lately he's been saying that he'll find a way to make me stay forever. I don't know what that means. I just don't want anything to do with him.

CLIENT DETAIL	PROVIDER (PARTICIPANT) RESPONSE
<p>I've been with him for twenty years. I don't really have any friends. He would never let me leave the house and so my friends eventually stopped reaching out to me. Both of my parents have passed away now, and my brother moved to another city. Our daughter is 14 and I'm glad we didn't have any more children. I really don't have anyone to talk to at this point...I worry about my daughter. I wonder what she thinks of me, and if she'll end up in a similar situation. She won't talk to me about her experiences with boys, but I've seen her with a boy from her school. He already has a reputation.</p>	<p>Active Listening and Paraphrasing (develop at least two different responses)</p>
<p>Yes, my husband hits me, and sometimes does worse things than that, but I'm a strong woman. The way he acts used to bother me, but I've become used to it. My father hit my mother, brother and me growing up. It's just something that happens. If there's nothing I can do about it, I have to learn to live with it.</p>	<p>Validating and Educating (develop at least two different responses)</p>

TRAINING DAY 3

HANDOUT 3.5C: PARTICIPANT PRACTICE— CLIENT PROFILE #3: IPV COUNSELING AND EDUCATING

Sometimes we don't fight for months. Then, for some reason, he just gets so angry that he explodes. I always seem to be on the receiving end of his anger. I can sense when the tension is building, and sometimes I can stop it before it happens. But when it does happen, it's really bad.

He gets angry over the smallest things. One night our son got sick and vomited on the floor. My husband started screaming at him, asking what was wrong with him. My son started to cry, but my husband kept going. Generally, I just let him yell, but I couldn't stand the thought of him screaming at my son for being sick. So, I threw a cup at him.

My husband called me a "bitch" and told me to clean up the vomit. As I was down on my hands and knees, he put his foot over my hand and began to press down. The more I showed pain on my face, the harder he pressed. When he stepped away, I quickly pulled my hand away. He instructed me to put it back down on the ground. I didn't, and he grabbed me by the back of my hair, spit in my face and screamed for me to put my hand on the floor. I did, and he stomped on it.

I would never treat him the way that he treats me. I asked him why he acts that way. He told me that the more he loves someone, the angrier he can get at them. I suppose that might be true, but I've never seen him treat anyone else he loves like this.

CLIENT DETAIL	PROVIDER (PARTICIPANT) RESPONSE
<p>My husband called me a “bitch” and told me to clean up the vomit. As I was down on my hands and knees, he put his foot over my hand and began to press down. The more I showed pain on my face, the harder he pressed. When he stepped away, I quickly pulled my hand away. He instructed me to put it back down on the ground. I didn’t, and he grabbed me by the back of my hair, spit in my face and screamed for me to put my hand on the floor. I did, and he stomped on it.</p>	<p>Active Listening and Paraphrasing (develop at least two different responses)</p>
<p>Sometimes we don’t fight for months. Then, for some reason, he just gets so angry that he explodes. I always seem to be on the receiving end of his anger. I can sense when the tension is building, and sometimes I can stop it before it happens. But when it does happen, it’s really bad.</p>	<p>Validating and Educating (develop at least two different responses)</p>



SESSION 4.1: WELCOME AND REFLECTIONS

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Reflect on the previous day's accomplishments.
2. Articulate at least two new points of knowledge.
3. Describe the agenda for the day.

TIME

30 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or cell phone that can tell time
- Handout 1.1: Training Agenda*

ADVANCE PREPARATION

- Create and post two flipcharts, one titled “Reflections from Day 3,” the other “New Knowledge.”

TRAINING STEPS

Step 1: Welcome and Introduction (5 minutes)

1. Welcome the participants back to the training. Thank the participants for the attention the previous day and for the insight they brought to the training. Encourage the participants to continue to challenge themselves throughout the day, engage with the material and ask questions of each other and of themselves.
2. Direct their attention to *Handout 1.1: Training Agenda* and review the material they will be addressing throughout the day. Ask the participants if they have anything they would like you to be certain to cover in the agenda.



Step 2: Training Reflections (20 minutes)

1. Ask the participants to take a moment to think about two things: What they learned in the previous day's training, and how the previous day's training made them feel. Specifically, you would like them to do the following:
 - a. Identify at least 2 new points of knowledge they acquired in the previous day's training.
 - b. Identify at least 2 reflections from the previous day's training—how the training made them feel, what continues to circulate in their mind, or something they need additional clarification on.
2. Ask the participants to jot down their answers on a piece of paper. One by one, ask the participants to share their answers.
3. Record the participant's answers on the flipcharts titled, "Reflections from Day 3" and "New Knowledge."

Step 3: Closure and Transition (5 minutes)

1. Ask the participants if there is anything they would like to add before you begin the training modules.
2. Provide encouraging words for what they might gain from today's material.

SESSION 4.2: EXPLORING FAMILY PLANNING OPTIONS WITH CLIENTS EXPERIENCING IPV

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explore family planning options that take into consideration the dynamics of IPV.
2. Provide family planning methods that take into consideration the dynamics of IPV.

TIME

1 hour, 15 minutes

MATERIALS

- Flipchart paper
- Markers
- Tape
- Computer, if possible
- LCD Projector, if possible
- Pens for participants
- Watch or clock to keep track of time
- Trainers' Tool 4.2A: PowerPoint: Intimate Partner Violence and Considerations for Family Planning*
- Trainers' Tool 4.2B: Example Exercise: Intimate Partner Violence and Considerations for Family Planning*
- Handout 4.2A: Intimate Partner Violence and Considerations for Family Planning*
- Handout 4.2B: Family Planning Methods*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Set up equipment necessary to project the PowerPoint presentation.
- Print *Trainers' Tool 4.2B: Example Exercise—Intimate Partner Violence and Considerations for Family Planning*.
- Print three copies of *Handout 4.2A: Intimate Partner Violence and Considerations for Family Planning* for each participant.
- Print one copy of *Handout 4.2B: Family Planning Methods* for each participant.

TRAINING STEPS

Step 1: : Introduction (2 minutes)

1. Explain that the dynamics of IPV must be taken into consideration when exploring FP options with clients experiencing IPV. Share that perpetrators of IPV have been known to use specific tactics to control their partner's sexual and reproductive health. These tactics can include, but are not limited to, sabotage of FP methods, forced pregnancy and or forced abortion. Most survivors of IPV will struggle at times to negotiate barrier methods.
2. Inform the participants that this module will focus on IPV-FP facts and perpetrator tactics similar to the ones you mentioned above. Explain that they will work in pairs to study one to two of the IPV-FP facts and perpetrator tactics, and then explore potential FP methods of which a client experiencing said fact may benefit.
3. Quickly refer to the IPV-FP integration flipchart, and share that exploring family planning options is an important step to take in counseling women who may have experienced intimate partner violence.

Step 2: Presentation “Considerations for Care: Intimate Partner Violence and Family Planning (8 minutes)

1. Using *Trainers’ Tool 4.2A: PowerPoint: Intimate Partner Violence and Considerations for Family Planning*, present the IPV-FP information to the participants. Pause after each slide, to quickly ask at least one of the following questions.
 - How might this IPV-FP fact play out in the life of a client experiencing IPV. What might the client be experiencing at home?
 - How might a client who is experience this feel? What emotions might the client be experiencing?
 - What information might a client facing this need from a provider?

Do not spend too much time on this discussion, as you will have time to debrief during the large group discussion and closing.

OPTION: Write down each of the PPT slides statements on individual sheets of flipchart paper and flip through each one and discuss per instructions above.

2. After the presentation is over, ask the participants to pair up with one another. Encourage them to pair with a participant that holds a different job function, as they may different ideas for how to approach the IPV-FP consideration. This way, the participants will learn from one another.

Step 3: Pair Work—Considerations for Care (25 minutes)

1. Distribute three copies of *Handout 4.2A: Intimate Partner Violence and Considerations for Family Planning* to each participant (two for the exercise, one for the group example). Additionally, provide each participant with *Handout 4.2B: Family Planning Methods* (a list of FP options), which they may reference throughout the activity.

2. Using 10 minutes of the allotted 25 minutes, complete the following IPV-FP fact as a large group to help the participants understand the activity process:

IPV-FP Fact: “Violence increases if a client’s FP desire does not align with an abusive partner’s desire.”

Refer to *Trainers’ Tool 4.2: Example Exercise—Intimate Partner Violence and Considerations for Family Planning* to assist you through the exercise.

3. Allow the participant pairs a few minutes to find a comfortable spot in the room. Assign each pair two of the IPV-FP facts addressed in the PowerPoint presentation.
4. Make note of the time on the clock, and inform the participants that they will have 20 minutes to complete the two IPV-FP fact exercises. Inform the participants when they have five minutes left on the clock.
5. Invite the pairs to return to the large group after the allotted time has passed.

Step 4: Debrief and Large Group Discussion (35 minutes)

1. Invite each pair to quickly share their findings with the large group. Following each IPV-FP fact presentation, open up the dialogue for other participants to add their insight. Spend roughly four minutes on each IPV-FP fact.
2. Push the participants to think critically about how they would discuss various options with the client within the context of IPV. Prompt the with the following client examples:
 - The client is not able to return to the clinic on a regular basis because her partner monitors her time.
 - The client whose partner is denying her the ability to use FP methods.
 - The client whose partner is pushing/forcing the client to become pregnant.
 - The client who does not want to use a method that is implanted in her body, but her partner denies her right to use barrier methods and/or BC pills.
3. If you have time, ask two of the participants to demonstrate a conversation between a provider and client that explores FP options within the context of IPV. You may use one of the examples listed above to cue the conversation, or you can allow the participants to choose their own topic for exploration.

Step 5: Closing and Transition (5 minutes)

1. Ask the participants if they have any final thoughts about the activity, or about FP considerations for clients experiencing IPV.
2. Inquire about how a provider may need to alter their practice to accommodate for FP counseling of clients experiencing IPV. Record the responses and revisit them on Day 5, if time permits.
3. Tell participants that they will revisit this activity during the decision-making training module. Instruct them to hold on to their worksheets.

TRAINING DAY 4

TRAINERS' TOOL 4.2A: POWERPOINT: INTIMATE PARTNER VIOLENCE AND CONSIDERATIONS FOR FAMILY PLANNING

<p>Considerations for Care: Intimate Partner Violence and Family Planning</p> <p>Session 4.2: Exploring Family Planning Options with Clients Experiencing IPV</p>	<p>IPV is more common among women who are forced to hide the decision to terminate a pregnancy from their partner.</p>
<p>Violence increases women's risk for unplanned pregnancies.</p> <p>Unplanned pregnancies increase women's risk for violence.</p>	<p>Tactic of Perpetrators of IPV:</p> <p>Destroying or throwing away contraceptives.</p>
<p>Tactic of Perpetrators of IPV:</p> <p>Tampering with barrier methods to render them ineffective.</p>	<p>Tactic of Perpetrators of IPV:</p> <p>Forcing a pregnancy as a means of increasing their partner's dependency on him (financially, emotionally, socially and physically).</p>

TRAINERS' TOOL 4.2A: POWERPOINT: INTIMATE PARTNER VIOLENCE AND CONSIDERATIONS FOR FAMILY PLANNING

continued

<p>Clients who are forced to hide their FP method from their abusive partner, also – very often – struggle to return to the clinic for follow-up visits.</p>	<p>Women who are experiencing physical and emotional IPV are more likely to report not using their preferred method of contraception.</p>
<p>Young mothers, who experience physical or sexual IPV within three months of giving birth, are nearly twice as likely to become pregnant within 24 months of their delivery</p>	<p>HIV-positive clients, who report of recent IPV, are more likely to also report:</p> <ul style="list-style-type: none"> • Difficulty negotiating condom usage. • Unplanned pregnancy. • Inconsistent use of birth control methods.

TRAINING DAY 4

**HANDOUT 4.2A: INTIMATE PARTNER VIOLENCE
AND CONSIDERATIONS FOR FAMILY PLANNING**

IPV-FP Fact:	
Taking into consideration the IPV-FP fact, what two FP options do you think would be the most effective for this client? Option #1. Option #2.	What are the benefits, disadvantages and consequences of the options you are providing? Option #1. Option #2.
What two additional thoughts, questions or actions might you need to consider if you were to suggest the options you indicated above? 1. 2.	
What emotional needs might this client have?	What informational needs might this client have?

HANDOUT 4.2B: FAMILY PLANNING METHODS

FAMILY PLANNING METHODS					
Type of Method	Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Hormonal Methods	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
	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

TRAINING DAY 4

HANDOUT 4.2B: FAMILY PLANNING METHODS *continued*

FAMILY PLANNING METHODS					
Type of Method	Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Intrauterine Device	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	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
	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

HANDOUT 4.2B: FAMILY PLANNING METHODS *continued*

FAMILY PLANNING METHODS					
Type of Method	Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Permanent Methods	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
	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	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	A temporary family planning method based on the natural effect of breastfeeding on fertility
				98% as commonly used	
Temporary Methods	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	One of the least effective methods, because proper timing of withdrawal is often difficult to determine
				73% as commonly used	
Temporary Methods	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	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.
				75% as commonly used	

TRAINING DAY 4

TRAINERS' TOOL 4.2B: EXAMPLE EXERCISE—INTIMATE PARTNER VIOLENCE AND CONSIDERATIONS FOR FAMILY PLANNING

IPV-FP Fact:

Violence increases if a client's FP desire does not align with an abusive partner's desire.

Taking into consideration the IPV-FP fact, what two FP options do you think would be the most effective for this client?

*Potential Answers from Participants
(not an exhaustive list)*

- Implant
- Intrauterine device (IUD)
- Monthly injectables or combined injectable contraceptives (CIC)
- Fertility Awareness
- Tubal ligation

What are the benefits, disadvantages and consequences of the options you are providing?

*Potential Answers from Participants
(not an exhaustive list)*

Benefits:

- Suggested methods are easy to conceal
- The effectiveness of the selected method
- Implant and IUD do not require the client to return to the clinic for quite some time
- Monthly injectables are an option for clients who do not like the idea of having a FP device remain in their body
- Monthly injectables can be easily hidden as there is no physical sign of a FP device
- Tubal ligation is a permanent option for those whom no longer wish to have children
- Monthly injectables require consistent visits (may be helpful for clients who need to escape for short periods of time, though challenging for clients whose movement is tightly controlled by a spouse)
- Eliminates condom negotiation
- Fertility awareness is 100% natural

Disadvantages:

- Removal of an implant and IUD must be performed by a provider
- Monthly injectables require consistent visits to the clinic
- Tubal ligation is permanent and not a viable option for those whom might later want children
- IUD can cause heavy bleeding and cramping for the first two months
- Partner may become suspicious if client has been negotiating for condom usage, but has stopped doing so
- Suggested methods will not protect the client from sexually transmitted infections
- Sexual assault is unavoidable, and client will be unprotected if assaulted during ovulation

Consequences:

- Depending on method, client is protected from pregnancy for long periods of time
- Client could still contract an STI
- Client may feel reassured about pregnancy protection

What two additional thoughts, questions or actions might you need to consider if you were to suggest the options you indicated above?

Potential Answers from Participants (not an exhaustive list)

- Does the client wish to have more children now? Or, does the client wish to have more children in the near future? (If so, none of the above are proper options)
- What would happen to the client if she were to go against her partner's wishes?
- Does the client have the ability to return to the clinic on a regular basis?
- Does the client experience any side effects to hormonal FP methods?
- Is the client at risk of contracting an STI?
- Has the client been negotiating FP methods? Will the partner become suspicious if the negotiation conversation shifts or ceases to happen?

What emotional needs might this client need?

Potential Answers from Participants (not an exhaustive list)

- Validation and confirmation that she has the right to control her family planning and her reproductive health, to the best of her ability
- A support person
- Assurance that she is capable of making a decision about FP for herself

What informational needs might this client have?

Potential Answers from Participants (not an exhaustive list)

- Concealable methods do not protect the client from STIs
- Implanted options require a return visit should the client wish to become pregnant
- How to properly use the method
- How often she will need to return to the clinic

TRAINING DAY 4

SESSION 4.3: DOCUMENTING INTIMATE PARTNER VIOLENCE

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Describe the importance of documenting intimate partner violence.
2. Document intimate partner violence using the IPV Screening Questionnaire and Documentation Form

TIME

1 hour, 35 minutes

MATERIALS

- Flipchart paper
- Markers
- Tape
- Stop watch or clock to track time
- Handout 4.3: Large Group Documentation Exercise Tool*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Create a flipchart titled, “Documenting Intimate Partner Violence,” and list the purposes and benefits of documenting IPV in a client’s medical record:
 - 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.
- Print three copies of *Handout 4.3: Large Group Documentation Exercise Tool* for each participant.

TRAINING STEPS

Step 1: Group Brainstorm (5 minutes)

1. Explain to the participants that this session will focus on documenting intimate partner violence in a client's medical record.
2. Ask the participants to reflect on the clinic's current documentation process. Lead a brief brainstorm by asking the following questions:
 - What kinds of things do you currently document during and following a visit with a FP client?

Examples of responses:

- Date of last menstrual cycle
- Number of pregnancies
- STI screening status
- Abnormal pap smear results
- Prescribed medication
- Date of follow-up visit
- What is the purpose of the documentation?

Examples of responses:

- Creates a timeline of the client's sexual and reproductive health history
- Serves to remind the client and provider about what was done in previous visits
- Eliminates the need for the client to share her story each time the client comes to the clinic
- Can help with the process of making a referral to an outside agency
- In what ways do you utilize the documentation in subsequent visits?

Examples of responses:

- It can create a starting point for conversation between the provider and client
- Reminds the provider of the client's previous visits to the clinic
- If the client is at high risk for a particular condition, documentation reminds the provider to look for symptoms of that condition.

Step 2: Documentation 101—How, What and When (10 minutes)

1. Share with the participants that documenting IPV is different from documenting a client's FP and reproductive health history. IPV is not a medical diagnosis, nor is IPV intervention a form of medical treatment. Inquire about why documentation is important. Then, explain the purposes of documentation including: (refer to flipchart titled, "Documenting Intimate Partner Violence):

- 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.
2. Ask the participants if they have anything to add to the list of benefits, and record their responses at the bottom of the flipchart.
 3. Inform the participants that they must ask for the client's permission to document their disclosure of IPV. It is the provider's duty to explain the purpose of documenting IPV, and to assure the client of the clinic's confidentiality policy. It is also the provider's responsibility to know where the client's confidential file will be stored and who has access to the information contained in the files, should the client request inquire about it.
 4. Ask the participants to refer back to the *Intimate Partner Violence Screening and Documentation Tool*, and note the section titled, "For Clinic Use Only." Explain that the form is intended to be a guide for the provider—a reminder of specific aspects that the provider should focus on with a client experiencing IPV:
 - The provider's overall evaluation of the client;
 - Considerations for FP; and,
 - Psychological assessment of the client experiencing IPV—the provider's assessment of the client's demeanor; and,
 - Physical findings of IPV—a description of the injuries.
 5. State to the participants that IPV-FP documentation should not be confused with the documentation that may take place during a forensic medical exam, in which evidentiary findings are used for the purpose of prosecution. Rather, IPV-FP documentation consists of short notes—descriptive sentences and bullet points—that describe the client's account of IPV and any findings that the provider happens upon during examination. This information is to be recorded using the *Intimate Partner Violence Screening and Documentation Tool*.
 6. Remind the participants that it is not uncommon to complete an exam on a client that yields no physical findings—wounds can heal quickly, but the psychological and emotional impact of IPV is long lasting. Therefore, the provider should be certain to record the client's account of IPV in the allotted space, following the screening questions. Additionally, 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 *Intimate Partner Violence Screening and Documentation Tool*) to document the area on the body, and the type of injury that occurred.
 7. Ask the participants if they have any questions about how, what and when to document. Record their questions on a blank flipchart, and be certain to address the questions during the large group documentation exercise and/or during the small group documentation exercises.

Step 3: Large Group Role Play (1 hour)

(Each role play shall last 20 minutes, followed by a 10-minute debrief)

1. Distribute 3 copies of *Handout 4.3: Large Group Documentation Exercise Tool* to each participant.
2. Explain to the participants they will now have the opportunity to practice documenting IPV in two different role plays. Inform the participants that you will be playing the role of the provider; as the role play unfolds the participants will complete their documentation forms on their own. Following the role play, the participants will compare their documentation forms.
3. Ask two of the participants if they would be willing to assist you with one role play each, by assuming the role of a FP client experiencing. Provide your two volunteers with a “Client Profile #1” and “Client Profile #2” from *Handout 4.3: Large Group Documentation Exercise*. Explain to the volunteer participant that the client profile is intended to be a guide, but encourage them to add to or take away from the profile. Together, you will be demonstrating an abbreviated client visit, from start to finish.

TRAINING TIP

- The case studies were created to help the volunteer-participant get into a particular mindset. The studies should serve as a roadmap—guiding the process—as opposed to being used verbatim. The stories are quite complex in order to give participants plenty of opportunity to practice documentation.
- Using the case studies is optional. If you and/or the volunteer-participant prefer to develop your own story line, you may absolutely do so. Be certain that the story line you create has a wide range of details that the participants can practice documenting.

4. Explain to the participants that each role play will depict an integrated IPV-FP visit, from screening to the point at which the client has made a decision about her FP method. While the role play is happening, the participants are to complete the documentation form to the best of their ability. This will require that the participants listen closely to the role play.
5. Ask the participants if they have any questions about what they have been instructed to do. Ask the volunteer participants if they have any questions about what they have been instructed to do.
6. Once you have answered all of the questions, you may begin the first role play. You will have roughly 20 minutes to complete each role play, so move through the family planning visit as precisely and quickly as you possibly can.
7. At the end of 20 minutes, allow the participants to compare their documentation forms with one another. Allow for 10 minutes of debrief. Inquire about the following:
 - How is your form different from or similar to the others’ documentation forms?
 - What words and/or phrases did you use in the short narrative sections? After seeing other documentation forms, would you document something differently?

- Is there a form you saw that you really liked? What did you like about it?
 - Is there a form you saw that you thought needed improvement? In what ways?
8. After 30 minutes (20 for the role play, 10 for the debrief), begin the second role play. Debrief the second role play using the questions listed above.

Step 4: Large Group Debrief and Discussion (15 minutes)

1. Lead a large group discussion by asking the following discussion questions:
 - What do you anticipate being the most challenging aspect of documenting IPV? How might you overcome those challenges?
 - Do you feel as if there is anything missing from the form that you would want or need to document? (If so, return to this suggestion during Session 5.4: Preparing the Clinical Environment.)
 - Imagine this scenario: You are providing care to a returning FP client—you have never provided care to this person, but your colleague has. In preparing for the session, you see that the client disclosed IPV at the last visit because your colleague documented the account. How would you address this with the client? What if the note was incomplete? Would you conduct a full screening? Or would you only address the sections that were completed by the provider?
2. Ask the participants if they have any final thoughts before you conclude the activity.

Step 5: Closure and Transition (5 minutes)

1. Thank the participants for their continued hard work, and reflect on how much they have learned and accomplished at this point in the training.
2. Express to the participants that the skills they have acquired—screening for IPV, IPV counseling, tailoring FP and RH to address the needs of clients experiencing and documenting IPV—are all methods of intervention. The remaining skills building modules will consist of safety planning and providing effective referral services to clients experiencing IPV.

TRAINING DAY 4

HANDOUT 4.3: LARGE GROUP DOCUMENTATION EXERCISE

Case Study #1

You are 21 years old and have been married to your husband for three years. He works very hard every day and provides food and good home for our family. Your son is two years old, and your son and husband love spending time together. Your husband helps take care of him, and cooks dinner at least once a week so you can visit my mom and sister. You feel really lucky to have him; after all, he could have found someone better than me. You both want to have another baby in the next year.

Sometimes you worry that he'll leave you. You don't have a job so you're not contributing to the family income. You take really good care of your home and your son in order to "make up for" the fact that you don't work. He says you do a good job with the house, but that you're a terrible cook. He gets mad at you if you spend too much money on groceries. He has started giving you an allowance so that you don't spend too much money. The last time you spent too much money, he didn't let you eat dinner for two weeks so you could spread out the food. You understood why and you agreed to it. That was six months ago, and he still gets angry with you about it. Sometimes he's really mean about it and it makes you cry, which makes him even angrier. The other day when you cried, he drew back his hand like he was going to hit you. When you shielded your face, he started to laugh at you. You were really embarrassed, and felt stupid about it. But you still feel to blame because you overspent on the food in the first place.

You think you and your husband have a loving relationship. He really wants to have a baby. You think you want another baby, too. You just worry that he might leave me one day. You know he is having sex with other woman. You can't say anything about it because you're not supposed to know. He's told you before that you don't please him enough, so you have been doing more and more. You feel like if you let him do what he wants, maybe he won't sleep with other woman. Sometimes it hurts when you have sex and you're not sure why. You have also noticed that you have to use the restroom frequently and that it burns when you urinate.

You feel like you might be overacting. He tells you that you do overact a lot. You don't believe him when he says that you're stupid, but it still hurts my feelings.

FP and RHS Considerations:

- Your partner has threatened physical violence if use a contraceptive method.
- Your partner has destroyed FP methods in the past.
- You likely have some form of infection—urinary tract or vaginal.
- You have missed two previous appointments with the provider

Additional Factors to Consider:

- The last incident of physical abuse happened two days ago. You have a few visible bruises on your left wrist.

Client Profile #2

You are 27 years old and have been married to your husband for six years. You feel as if your husband is different from other husbands you know. He has never been warm or loving. From the day you met, he has been saying awful things to you and it has only gotten worse over the last six years. You didn't want to marry him but you felt like you had no choice. Your father works for your husband's business; your husband lets your father take extra jobs here and there to help supplement his income. You want to leave your husband and disappear, but your family would be angry with you. They believe him to be a kind and trustworthy man. If you leave, your father will likely lose his job, which is your family's only source of income.

Your last pregnancy resulted in a miscarriage. Your husband has been telling people that there was something wrong with the baby but you know that is not true. You were very happy when you found out you were pregnant, but the pregnancy was very difficult. You couldn't eat much because you struggled with horrible nausea and vomiting. This made you feel weak all the time and you were forced to leave your job. Doing things around the house felt impossible because of the weakness. Your husband screamed at you, calling you lazy and that you were focusing too much of your time worrying about the baby and not enough time taking care of him.

During those rages, he would punch and kick your stomach. One time, he covered your face with a pillow so you couldn't breathe. You tried to tell your last doctor about this, but that doctor didn't believe you. He said your husband was going through a phase. When you went home that night, your husband raged at you for being gone too long. He kicked you between your legs and repeatedly in the stomach. You bled for days after that causing you to have to return to the doctor. The doctor told you that you had suffered a miscarriage.

You don't know how you can stay with him. You worry about all of the things that could happen to you and the baby if you get pregnant again.

FP and RHS Considerations:

- Your husband forces you to have sex because he says it is "time that we tried to have another baby."
- You have tried birth control in the past, but you have to hide them from your husband.
- You are able to leave the house in order to come to the clinic as your husband sometimes travels

Additional Factors to Consider:

- You are easily startled and agitated if you hear a loud noise.
- You have no visible markings of physical violence.

SESSION 4.4: SAFETY PLANNING WITH CLIENTS EXPERIENCING IPV

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Describe the importance of a safety plan.
2. Discuss safety planning measures with a client experiencing intimate partner violence.

TIME

1 hour, 15 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or timer
- Handout 4.5A: Job Aid for Safety Planning*
- Handout 4.5B: Supplemental Provider Tool—Intimate Partner Violence Assessment*
- Trainers' Tool 4.4: Case Studies for Safety Planning*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing
- Print one copy of *Handout 4.5A: Job Aid for Safety Planning* for each participant.
- Print one copy of *Handout 4.5B: Supplemental Provider Tool—Intimate Partner Violence Assessment* for each participant.
- Print *Trainers' Tool 4.4: Case Studies for Safety Planning*
- Write a flipchart titled “Key Elements of a Safety Plan,” using the information on page 173.

TRAINING STEPS

Step 1: Introduction and Brainstorm (20 minutes)

1. Begin this session by providing encouraging words to the participants. Reflect on the work the participants have completely up to this point. Acknowledge the new responsibility they are charged with—providing intervention services to clients experiencing IPV—and the incredible impact they can have on the lives of their clients.

2. Ask the participants if they have ever heard of the terms *harm reduction* and *safety plan*. If so, ask the participants to help you define the term. If not, allow the participants to brainstorm what the term might entail.

Definition of “Harm Reduction”: A set of practical strategies or formal policies aimed at reducing—lessening—the negative consequences of something that is destructive.

Definition of “Safety Plan”: Steps and/or suggestions to follow in order to avoid a dangerous situation, or to increase an individual’s sense of safety.

3. Explain that this session will focus on assessing a client’s level of danger, and how to engage the client in a conversation about their safety. Creating a safety plan is another way a provider can help a restore power and control to a client experiencing IPV, and one of the five key services they will be integrating within the family planning visit.
4. Inquire about how the participants might be feeling about the assisting clients with safety planning. What might be some of the challenges of safety planning with a client?
5. Acknowledge that, while these are certainly factors to consider, safety planning is designed to respond to these factors. With the support of a caring and compassionate provider, a client experiencing IPV can recognize her strength and power. In turn, the client can use her power to increase her sense of safety and reduce the harm IPV causes her.
6. Share the following strength-based sentiments about victims of IPV with the participants (you might consider writing them on a flipchart so the participants can refer back to them):
- Victims of IPV are often perceived by outsiders as being weak. They often believe that to be true about themselves; however, victims of IPV are incredibly perceptive and intuitive individuals. They have to be in order to endure their partner’s abuse.
 - Because of the cycle of violence, victims of IPV become hyperaware of their surroundings. Even though a situation might change in an instant, they can often sense when their environment is about to change. The act of being hyperaware—overly alert—is a survival mechanism.
 - Victims of IPV know their abusers well. While they may not always be able to predict their partner’s actions, they often are acutely aware of their partner’s “triggers”—moments, words or instances that ignite abusive behavior. Victims develop tactics to deescalate their partner, whether or not the victim realizes that that is what they are doing.
 - Many victims develop tactics to reduce the impact of the violence they experience at the hands of their partner. Some victims disassociate during instances of violence; they momentarily detach their thoughts and feelings during instances of severe violence. Disassociation is another survival mechanism.
 - Victims of IPV sometimes resist the violence—in small and big ways. It is not uncommon for victims to fight back with their words or with physical force, if they have reached a limit with their partner’s abuse. This can be a confusing experience for victims; they might feel as if they are just as abusive as their partner, and myths about IPV support that idea. The difference between resistance and abuse is an unequal distribution of power. The abuser inherently has more power and control than the victim; resistance is the act of reclaiming power and control. Resistance is a survival mechanism.

- For victims of IPV with children: It is not uncommon for victims of IPV to initiate an incident of abuse if they feel their partner is perpetrating harm against the children. Diverting their partner's attention from the children to her is a mechanism victims use to protect their children.

Inform the participants that these sentiments are only a few examples of how victims of IPV harness their strength to increase their sense of physical and emotional safety, and reduce the harm IPV causes them.

7. Ask the participants if they can identify other strengths of IPV survivors, or if they have any questions.

Step 2: Introduction of Provider Tool for Safety Planning (20 minutes)

1. Inform the participants that the screening questions are designed to help assess the level of danger a client may be in. The more times a client answers “yes” to a screening question, the more she is at risk for serious injury and/or dealing with the long-term, psychological impact of violence. Clients who have already experienced some form of sexual or physical violence, or clients whose partners are controlling their sexual and reproductive health, are at highest risk for serious injury and long-term psychological effects as a result of the intimate partner violence. Therefore, it is important for the provider to offer the option of safety planning with a client whom indicates the presence of sexual or physical violence, or a lack of control over their family planning desires.
2. Reiterate that safety plans are intended to *increase* a sense of safety and *reduce* the harm caused by IPV. Be certain to 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 far more likely to be successful in reducing the harm caused by IPV.
3. Inquire about what the participants think needs to be included in a safety plan. Allow them a few minutes to brainstorm. Post the flipchart entitled “Key Elements of a Safety Plan.” Ask for a participant to volunteer to read aloud the elements:
 - Support people;
 - Emotional safety;
 - Safety in the home;
 - Family planning safety;
 - Safety with children;
 - Safety on the job or in public places;
 - List of important telephone numbers;
 - Resource options and map; and
 - Safety if preparing to leave.

4. Distribute *Handout 4.4A: Job Aid for Safety Planning*. Explain to the participants that this tool was developed to help guide the provider through the safety planning process. Ask the participants to take turns reading through the tool.
5. Explain that safety planning can take on many forms depending on the experience level of the provider. For example, if an individual's sole job is to provide psychosocial support to a client, the safety plan is generally longer. If an individual does not have an expertise in providing formal, intimate partner violence services—the safety plan may be shorter. This is why referral services are important; if need be, the FP provider can refer the client to an organization that has the expertise to assist her developing a more comprehensive safety plan.
6. Inform the participants that the safety planning they do with clients will happen in the form of a conversation. Point their attention to the talking points listed on *Handout 4.5: Job Aid for Safety Planning*. Assure the participants that a provider need not go beyond the talking points listed, unless they feel comfortable doing. If a client is in need of additional support, the provider can refer the client to an organization that can assist her.
7. Explain that providers can draw from the counseling skills—“Active Listening and Paraphrasing” and “Validating and Educating”—to introduce the idea of safety planning at *any* point during the client's visit. If creating a safety plan is introduced towards the beginning of the visit and the client declines, the provider should present the option again, towards the end of the visit. It may be that the client is unclear about the purpose of a safety plan until after the provider explores family planning options, the dynamics of IPV and its impact on the client's reproductive health.
8. Ask the participants if they have any questions about the provider tool.

Step 3: Large Group Discussion—Identifying Safety Measures (30 minutes)

1. Share with the participants that you will now return to one of the case examples from the documentation exercise. Explain that you will read the story aloud, the participants need only to listen closely to the story.
2. Using *Trainers' Tool 4.4: Case Studies for Safety Planning*, read the “Case Study #1” study aloud.
3. Ask the participants to refer to *Handout 4.4A: Job Aid for Safety Planning*. Facilitate a group discussion by asking the following questions:
 - Based on the information you have, what types of violence is this client experiencing?
 - Based on the danger measures, what is her level of danger? Is this client a good candidate for safety planning? Why or why not?
 - What appears to be of the most concern to her? Is this something you might be able to address in the safety plan?
 - How would you introduce the idea of safety planning with her? Please tell us as if you were speaking directly to the client.

4. Acknowledge that this case example was straightforward and easy to recognize that the client could benefit from safety planning. Other times, it may not be as easy; you will not share an example of such.
5. Read aloud “Case Study #2” from *Trainers’ Tool 4.4: Case Studies for Safety Planning*.
6. Ask the participants to, again, refer to *Handout 4.4A: Job Aid for Safety Planning*. Facilitate a group discussion by asking the following questions:
 - Based on the information you have, what types of violence is this client experiencing?
 - Based on the danger measures, what is her level of danger? Is this client a good candidate for safety planning? Why or why not?
 - Would you safety plan with this client? If so, what measures would you focus on? If not, how else might you support this client.
7. Remind the participants that safety planning can be done as per the discretion of the provider. If the last violent incident occurred more than 12 months ago (especially if with a former partner), and the client is not currently at risk of physical and/or sexual violence, the provider may opt not to safety plan.
8. If opting out of safety planning, encourage the participants to still have a conversation with a client about the dynamics of IPV even if they opt not to safety plan with the client. A provider can simply say, “Sometimes this type of behavior can escalate over time. I want you to know that you can come back here if you ever need to, and we will try to assist you as best as we can.”
9. Ask the participants if they have any questions before you close this session.

Step 4: Closure and Transition (5 minutes)

1. Distribute *Handout 4.5B: Supplement Provider Tool—Intimate Partner Violence Assessment*. Explain that this document is a reference tool, only, and may help a provider further assess a client’s need for safety planning if the provider is unsure of whether or not to safety plan.
2. Acknowledge that safety planning can be a challenging process, but an opportunity for a client to gain a sense of power and control over her situation.
3. Remind the participants that safety plans may not be able to prevent an incident of IPV, but they may be able to reduce the harm caused by an incident of IPV.
4. Remind the participants that clients who are experiencing IPV will likely need the provider to help them identify their strengths and the power (however much that may be) the client has over their situation.
5. Finally, stress the importance of self-care when working with clients experiencing IPV. Encourage the participants to debrief with other staff members after working with a client who has experienced IPV, and particularly after safety planning with a client. Do so will help the provider to not feel overwhelmed or solely responsible for the client’s safety.

TRAINING DAY 4

HANDOUT 4.4A: JOB AID FOR SAFETY PLANNING

Safety planning is a tool that can be used with clients experiencing intimate partner violence. While safety planning will not prevent the violence that is being perpetrated against the client, safety planning can increase the sense of control a client has over her life by helping her to identify ways to potentially avoid harm and/or what to do during an act of violence.

Understanding the level of danger in which the client is living, will help the provider and client think through what her options may be. The danger measures listed below align with the screening questions pertaining to sexual and physical violence, and tactics used to control a client's sexual and reproductive health. If the client has confirmed her experience with the indicated danger measures, the provider is to utilize their counseling skills to introduce the idea of safety planning to the client at any point during the counseling visit, and offer to help the client identify safety planning opportunities. If the client accepts the provider's offer, the provider may incorporate the suggested talking points to help guide the conversation.

The provider should infuse the safety planning conversation with supportive statements, which acknowledge client's strength and her ability to regain her sense of power and control.

DANGER MEASURE	NO	YES	If yes, then offer to safety plan.
1. Has the violence perpetrated against the client increased over the last 12 months?			
2. Does the abusive partner deny the client her the right to control her sexual and reproductive health (i.e. Deny or sabotage family planning methods, deny her access to care and treatment, force pregnancy and/or termination, etc.)?			
3. Does the abusive partner force the client to perform sexual acts against her will?			
4. Does the abusive partner use physical force to cause pain and/or injury?			
Each measure indicates a high risk for danger. The more measures the client confirms, the higher her risk of danger.			

EXAMPLES FOR INTRODUCING SAFETY PLANNING USING COUNSELING SKILLS

Counseling Skill: Active Listening And Paraphrasing	Counseling Skill: Validating And Educating
<p>Definition Listening closely in order to restate the client's message simply and in your own words</p> <p>Purpose Conveys a vested interest in, and comprehension of, what the other person is saying. Summarizes or clarifies what that person is trying to say.</p>	<p>Definition Acknowledging and confirming what was said, followed by additional information that supports what is said, or corrects any misinformation that was shared.</p> <p>Purpose Conveys nonjudgmental support, provokes thought and attempts to spark additional conversation. Seeks to eliminate any perception that IPV is justified or that it should be condoned.</p>

EXAMPLES FOR INTRODUCING SAFETY PLANNING USING COUNSELING SKILLS *continued*

Suggestions For Introducing Safety Planning To The Client	Suggestions For Introducing Safety Planning To The Client
<ul style="list-style-type: none"> • “I think I heard you say _____ is that accurate?” • “It sounds to me like you are doing _____ already, to help reduce the harm you’re experiencing. Is that accurate?” • “I’m hearing you say _____. Would it be okay if we focused on that for a moment, and look at the safety plan to see how we might address that?” 	<ul style="list-style-type: none"> • “I heard you say _____. Is it okay if I share with you what I know about this type of experience? I also think we might be able to address this in your safety plan. May I also share that information with you?” • “You share with me that you are experiencing _____. I want you to know that that particular experience is quite common among my other clients in similar situations. May I share with you some of the ways in which my other clients have safety planned around this issue?”

Suggested Talking Points For Safety Planning

- ▶ Would you like to discuss things you can do to protect yourself as much as possible? (Including discussing what you already do and what you feel you can do to be safer)
- ▶ Have you confided in anyone about what you have been experiencing? Is there anyone you would feel comfortable speaking to about this? You deserve the support.
- ▶ What do those people do to support you or what can they do to support you? Is there a way you could alert them that you are in danger if you needed to?
- ▶ Should your partner threaten your physical safety, might you be able to move the argument to an area in your home that may be safer than other areas? What might be those safer spots? (Avoid: bathrooms, small spaces, standing next to a window, the kitchen or other areas with potential weapons, attempt to put a large object between abuser and self.)
- ▶ What have you done or can you do to deescalate a situation with your partner? What have you done or can you do to protect yourself during an outburst by your partner?
- ▶ If you have children, what have you done and can you do to help keep them safer? (Examples: speak to them about your partner’s behavior, develop a signal for when you or they might be in danger, discuss where they can go for help, etc.).
- ▶ If you need to leave your home, can you identify at least two locations where you might go?
- ▶ If you do leave your home, what important items will you need to take with you? (Examples: money, identification, contact numbers/addresses, cellular phone, court/legal papers, etc.)
- ▶ Would you like to discuss how you might safe guard your family planning desire? (Examples: Choosing a method that is not easily detectable, hiding the chosen method, etc.)
- ▶ You may always come to the clinic if you need assistance dealing with this abuse and its consequences. We will help you to the best of our ability and/or find a referral for someone who can assist you.

EXAMPLES FOR INTRODUCING SAFETY PLANNING USING COUNSELING SKILLS *continued*

Supportive Statements To Be Shared With Clients

- I'm sorry this is happening to you.
- This is not your fault. There is nothing you have done wrong to be treated in this way.
- No one deserves to be treated in this way.
- Violence is never justified between two people who are supposed to love one another.
- If, at any point, you do not want to talk about this anymore, please do tell me. I won't be upset. I want you to help lead the direction of this conversation.
- Thank you for trusting me with this information.
- The information you are sharing with me is very important, and we will take that into consideration when we are addressing your FP needs and desires.
- What you're experiencing is very common among women. I have worked with many clients who been in similar situations. You are not alone.
- I want you to know that while you are here, you are in control of what happens.
- I want you to feel safe while you are here at the clinic. Is there anything we can do to help you feel more comfortable?
- You only have to share as much as you want to share.
- Your thoughts, needs and opinions matter to me.
- I want to help you do what you think is best for you.
- I think you're a strong and brave person.
- I am concerned about you, and care about what happens to you.
- If it is okay with you, I would like to discuss how these experiences might impact your FP decisions and goals.
- I want you to know that there are services available for women who are experiencing similar things as you.
- I am concerned about your safety and wellbeing. If you would like, together we can discuss how you might keep yourself safer from the harm you are experiencing.
- While my expertise is in FP, I do have knowledge and information on what you are experiencing. If you would like, we can spend a few minutes discussing your experiences.
- I trust that you know what is best for you. I will do as you would like me to do.
- What you're feeling is a normal reaction to this kind of harm. Many women have the same reaction.

TRAINERS' TOOL 4.4: CASE STUDIES FOR SAFETY PLANNING

Case Study #1:

I am 27 and have been married to my husband for six years. He is different from other husbands I know. He has never been warm or loving. From the day we met, he started saying awful things to me and it has only gotten worse over the last six years. I wouldn't have married him, but I felt like I didn't have a choice. My family is very poor and my husband's family is not. You see, my father works at my husband's business, and my husband lets my father take extra jobs here and there to help supplement his income. I want to leave my husband and disappear but what will happen to my father?

My last pregnancy resulted in a miscarriage. My husband tells people there was something wrong with the baby, but I don't believe that. I was really happy when I found out I was pregnant, but I was sick through a lot of the pregnancy. I couldn't eat because I would vomit all the time, and not eating made me feel weak. I had to leave my job, and doing things around the house felt impossible. My husband says I was lazy; he told me I was spending too much time worrying about the baby and not enough time taking care of him.

He would often punch and kick my stomach. He covered my face with a pillow so I couldn't breathe. I tried to tell my last doctor about this and he didn't believe me. He said my husband was going through a phase. When I went home that night, my husband screamed at me for being gone too long. He kicked me between the legs and repeatedly in the stomach. I bled for days after that. The doctor told me that you had suffered a miscarriage.

I don't know how I can stay with him, but my father can't lose his job. It just keeps getting worse. I worry that if I get pregnant again, my husband will beat me to death. I've tried birth control pills in the past but he found them and took them away from me.

Case Study #2:

Sometimes we don't fight for long periods of time. Then, for some reason, he just gets so angry that he explodes. I always seem to be on the receiving end of his anger. I can sense when the tension is building, and sometimes I can stop it before it happens. But when it does happen, it's really bad.

He gets angry over the smallest things. About a year ago, our son got sick and vomited on the floor. My husband started screaming at him, asking what was wrong with him. My son started to cry, but my husband kept going. Generally, I just let him yell, but I couldn't stand the thought of him screaming at my son for being sick. So, I threw a cup at him.

My husband called me a "bitch" and told me to clean up the vomit. As I was down on my hands and knees, he put his foot over my hand and began to press down. The more I showed pain on my face, the harder he pressed. When he stepped away, I quickly pulled my hand away. He instructed me to put it back down on the ground. I didn't, and he grabbed me by the back of my hair, spit in my face and screamed for me to put my hand on the floor. I did, and he stomped on it.

I would never treat him the way that he treats me. I asked him why he acts that way. He told me that the more he loves someone, the angrier he can get at them. I suppose that might be true, but I've never seen him treat anyone else he loves like this.

TRAINING DAY 4

HANDOUT 4.4: SUPPLEMENTAL PROVIDER TOOL— INTIMATE PARTNER VIOLENCE ASSESSMENT

PROVIDER TOOL FOR ASSESSING INTIMATE PARTNER VIOLENCE					
Form of IPV	Psychological Abuse (at risk of physical and sexual abuse, as per the cycle of violence)		Psychological, Physical and Sexual Abuse		
	Screening Question	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 that bad feeling last?	Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?	Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?	Has your partner ever made you to participate in or do things you don't want to do sexually?
Client Responses to Screening Questions	<p>It is normal for couples to occasionally say hurtful things out of spite and anger. However, it is problematic if those hurtful statements are used to belittle, intimate, shame, or gain control over another person. Think about the following as your client responds to the question:</p> <p>a.) Have the statements impacted your client's sense of self-worth?</p> <p>b.) Is there an unequal power balance between the client and partner? What would happen if your client were to make a similar statement to her partner?</p>	<p>It is normal for couples to be concerned about how a partner might react to a particular situation; however, fearing a partner's behavior is a warning sign for IPV. Additionally, threatening physical violence is never an acceptable form of behavior. Think about the following as your client responds to the question:</p> <p>a.) Threats can be implied or explicit. For example, an abusive partner can imply physical violence with his words, as well as with a physical gesture.</p> <p>b.) Threats of physical violence can also include damaging property and/or harming an animal for a purpose other than consumption.</p> <p>c.) Does it appear that fear is a tactic being used to control your client's everyday interactions?</p>	<p>Couples may disagree on family planning issues. For example, one partner may want to have a baby, the other may not feel ready. However, you want to find out if the partner is using his power to control your client's sexual and reproductive health. Think about the following as your client responds:</p> <p>a.) Is your client able to negotiate the use of family planning methods?</p> <p>b.) Does your client have to hide the fact that she is receiving services and/or using FP methods</p> <p>c.) Does your client as if she must obey her partner's order in order to remain safe.</p>	<p>Forcing someone to participate in sexual acts is never an acceptable form of behavior. Sexual abuse is not limited to unwanted touch and/or forced sexual intercourse. It can also include, but is not limited, the following: forced oral and anal contact (with mouth, body parts and/or objects); lewd/unwanted comments and/or gestures; exposing sex organs (of oneself or another person); forced sexual contact with an individual other than a partner; and, forcing an individual to witness sexual contact and/or watch pornography. While the question implies unwanted sexual behavior within the relationship, sexual abuse can also include the following: having sexual partners outside of an intimate relationship; lying about sexually transmitted infections; and, putting one at risk for acquiring a sexually transmitted infection.</p>	<p>Physical violence is never an acceptable form of behavior. Traditionally, physical violence is described as scratching, slapping, hitting and pushing, etc. However, it can also include forms of violence that seek to harm an individual's physical safety and or wellbeing. Think broadly when discussing this question with the client:</p> <p>a.) Has the client's partner ever deprived her of her basic needs—food, clothing, shelter?</p> <p>b.) Has the client's partner ever forced the client to put herself in physical danger?</p>

PROVIDER TOOL FOR ASSESSING INTIMATE PARTNER VIOLENCE *continued*

Form of IPV	Psychological Abuse (at risk of physical and sexual abuse, as per the cycle of violence)	Psychological, Physical and Sexual Abuse
IPV Assessment	<p>If your client answers the question with anything other than a simple “no,” you might consider further exploring the question. Trust your intuition and the warning signs listed above, when making your assessment as to whether the client is experiencing IPV.</p> <p>It is normal clients to be surprised by the questions, especially if they have never been asked such a question before. However, if your client has an emotional or physical response to the question (i.e. crying or closing their body language, respectively), explore that reaction by asking, “I noticed you [insert observed response] when I asked you that question. Can you tell me what you might be feeling?”</p> <p>Use your counseling skills—active listening and paraphrasing, validating and educating—to help you navigate the conversation with your client.</p> <p>Remember, it is not expected of you to resolve the IPV, or prevent IPV from happening, in the lives of your clients. However, screening for IPV, providing basic support, presenting the client with their options, and assisting the client in making an FP decisions that take IPV into consideration, are all ways of empowering your client, and helps restores their power and control.</p>	
Result of Assessment	<p>Client is experiencing emotional and psychological IPV. The effects of emotional and psychological abuse can take a tremendous toll on a person’s physical and mental health. This type of IPV will be ongoing throughout the relationship, and will likely be accompanied by physical and sexual violence at some point.</p>	<p>Client is experiencing psychological, physical and/or sexual IPV. All forms of IPV escalate quickly, and your client is at risk for serious injury. The client should be monitored closely at each clinic visit. Depending on the severity of the abuse, the client may need a more thorough physical examination, and/or a referral for further medical treatment.</p>
Safety Plan	<p>OPTIONAL: Because IPV is unpredictable and can escalate quickly, all clients experiencing IPV could benefit from safety planning. However, because the client is not currently in physical danger, you may use your discretion as to whether or not to safety plan with the client.</p>	<p>YES: The client’s physical wellbeing and sexual and reproductive health are being compromised by the harm her partner is perpetrating against her. The client should be offered the opportunity to safety plan with you. A safety plan may help increase her sense of safety, and reduce the harm caused by the IPV she is experiencing. Included in the safety plan are measures to protect her family planning decisions, to the best of her ability.</p>

TRAINING DAY 4

SESSION 4.5: SAFETY PLANNING— DEMONSTRATION AND PARTICIPANT PRACTICE

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Identify opportunities for safety planning with a client.
2. Engage a client in a conversation about safety planning.

TIME

2 hour

MATERIALS

- Handout 4.5A: Safety Planning—Participant Planning, Case Study #1*
- Handout 4.5B: Safety Planning—Participant Planning, Case Study #2*
- Handout 4.4A: Job Aid for Safety Planning*
- Trainers' Tool 4.5: Safety Planning Demonstration Script*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print one copy of *Handout 4.5A: Safety Planning—Participant Planning, Case Study #1* for each participant.
- Print one copy of *Handout 4.5B: Safety Planning—Participant Planning, Case Study #2* for each participant.
- Print one copy of *Handout 4.4A: Job Aid for Safety Planning* and plan to distribute these as they are needed.

TRAINING STEPS

Step 1: Demonstration of Safety Planning (45 minutes)

1. Explain to the participants that you will now model how to engage in a safety planning conversation with a client. Ask if one of the participants would be willing to assist you in the demonstration by playing the role of the client. You will both be working from a script.

2. Ask the participants to listen closely, as you:

- Reference the client's answers to the screening questions;
- Introduce the idea of safety planning;
- Empathize with the client; and,
- Engage the client in identifying safety measures.

Explain that you will be using the Provider's Tool for Safety Planning (*Handout 4.4A: Job Aid for Safety Planning*) to help guide you through the process.

3. Begin the role play demonstration using *Trainers' Tool 4.5: Safety Planning Demonstration Script*. All 15 minutes for the role play. Facilitate a group discussion immediately following the role play.

4. Following the role play, facilitate a group discussion using the following discussion questions:

- What did you think about the process of safety planning? Did it seem easier or more challenging than you thought. How was it easier? How was it more challenging?
- In what ways did you see the provider incorporate the knowledge gained from screening into the safety planning conversation?
- In what ways did see the provider educate the client about IPV dynamics and her risk for danger into the conversation?
- What supportive messages did the provider use to empathize and validate the client's experience of IPV?
- Is there anything you would have done differently? Is there anything you heard that you would use in your own safety planning conversation with a client?

5. Ask the participants if they have any final comments, thoughts, suggestions or concerns before you transition into the participant practice phase of the session.

Step 2: Small Group Participant Practice (30 minutes)

1. Inform the participants that they will now have the opportunity to practice having a safety planning conversation with a client.

2. Explain to the participants that they will work in pairs with a case study that will be assigned to them. The case study will include the following elements:

- The result of the IPV screening
- Details about the client's experience with IPV
- Additional information about the client's family planning decision
- Other pertinent information a provider may need to know about a client

3. Ask the participants to join in a pair with another participant. Together, the pair will need to complete the following steps:
 - Assess the client's level of danger
 - Select the safety planning measures the provider will discuss with the client (selected from the list of talking points)
 - A 5–7-minute role play to be demonstrated in front of the large group (similar to the demonstration)
4. Distribute one case study to each of the pairs. There are two different case studies included in the module. Assign the same case study to at least two pairs. This allows the group to compare and contrast the differences in how the pairs approached the safety planning conversation.
5. Distribute a second copy of *Handout 4.4A: Job Aid for Safety Planning*, in case the participants would like to take notes on the tool.
6. Allow the participants 30 minutes to develop their role play. Keep an eye on the time and tell the participants when they are half way through and when they have five minutes left.
7. After 30 minutes, bring the pairs back to the large group.

Step 3: Large Group—Sharing of Role Plays and Role Play Debrief (1 hour)

1. The participants will now demonstrate their role play for the large group. Provide encouraging words about the learning process—this is a time for the participants to provide feedback to one another in order to strengthen their skills and delivery.
2. Invite one of the pairs to come to the front of the room to demonstrate their safety planning conversation. Prior to starting the role play, have them introduce their case study to the group.
3. Remind the large group to listen closely as they will be asked to provide both positive and constructive feedback to the pair following the conclusion of the role play.
4. Allow the group to provide feedback. Be sure the feedback includes some of the following points:
 - Positive aspects of the role play
 - Specific points in the conversation when the communication between the provider and client could be strengthened
 - Specific elements that may have been missing (if the client was experiencing a particular form of violence that the provider did not address in the conversation)
5. Rotate through the pairs, allowing each to present their role play and receive feedback. Be certain to also compare and contrast the different approaches to safety planning the same case studies.

Step 4: Large Group Discussion and Debrief (20 minutes)

1. Lead a large group discussion using the following discussion questions:

- What aspects of the process do you feel most confident about? What aspects of the process do you feel least confident about?
- What skills have you gained that allow you to feel confident? In what areas do you plan to strengthen your ability to safety plan, as a means of boosting your confidence?
- How do you anticipate your clients will respond to the safety planning conversation? How would you respond to clients who declined your offer to safety plan?

Correct Answer: Encourage the client to reach out to the provider if they would like to have the conversation at a later time.

- How might you still introduce the idea of safety planning with clients whom you opt not to safety plan?

Desired Answer: The provider could explain the cycle of violence to the client—that violence often escalates over time, and that if the client is in need of safety planning the provider would be happy to do so at a later date.

Step 5: Closure and Transition (10 minutes)

1. Acknowledge that safety planning can be a challenging process, but an opportunity for a client to gain a sense of power and control over her situation.
2. Remind the participants that safety plans may not be able to prevent an incident of IPV, but they may be able to reduce the harm caused by an incident of IPV.
3. Remind the participants that clients who are experiencing IPV will likely need the provider to help them identify their strengths and the power (however much that may be) the client has over their situation.
4. Stress the importance of self-care when working with clients experiencing IPV. Encourage the participants to debrief with other staff members after working with a client who has experienced IPV, and particularly after safety planning with a client. Doing so will help the provider to not feel overwhelmed or solely responsible for the client's safety.
5. Finally, reiterate to the participants that the only person who can stop or prevent violence is the person perpetrating the violence. Survivors of intimate partner violence are resilient individuals, and the overwhelming majority of them *will* be okay when they leave the clinic after their visit. The provider can only do what is within their realm of expertise. For most clients, a provider's support will be a new and welcomed addition to their life.

TRAINING DAY 4

TRAINERS' TOOL 4.5: SAFETY PLANNING DEMONSTRATION SCRIPT

Provider:

“Fatoumata, I want to take a moment to thank you for sharing your stories with me. The information you have shared with me is very important, and I want to acknowledge that it sounds as if you have been faced with some really difficult times during your relationship. Many of my clients have experienced situations, and I like to have a conversation with them about how we might explore ways you might be able to increase your safety while your partner is at home. May I speak with you more about this?”

Client:

“I think that might be okay. Can you explore more what you mean my increase my safety?”

Provider:

“Yes, I certainly can. Remember the questions I asked you about your relationship with your partner? The answers that you provided me are concerning to me. I want you to feel comfortable while you’re at home. From what you’ve shared with me, your partner sometimes behaves in a manner that causes you to feel intimidated and scared. You also shared with me that your partner has used his hands to hurt you. Lastly, you expressed to me that you do not want to get pregnant, but that your husband is unwilling to use family planning methods that would prevent a pregnancy from happening. Am I recalling this correctly?”

Client:

[looking embarrassed...]

“Yes, but those things don’t happen all the time. Sometimes he is very good to me and we get along just fine.”

Provider:

“I understand that, and that is the case for most of my clients who are also experiencing this type of thing. But I was wondering if we might discuss what you can do during the bad times, and how you might still be able to prevent a pregnancy without your partner knowing.”

Client:

“Do you think it’s possible to stop him from doing what he’s doing?”

Provider:

“Fatoumata, that is an excellent question. I am so glad you asked about that. You see, the only person who can stop your partner from behaving in that manner is your partner, himself. His behavior is a choice, and it has nothing to do with you. This is not your fault, and there is nothing you are doing to cause him to behave in this way. What he is doing is not okay. Could we take a moment to speak about things you might be able to do during the bad times?”

Client:

“Yes, that would be fine.”

Provider:

“You mentioned that you would like to take birth control pills as a method for preventing pregnancy. Have you tried using pills in the past?”

Client:

“Yes, I have, but my partner found them and hid them from me. I found them later and took them back. We got in a terrible argument when he found out I was taking them again.”

Provider:

“When we discuss the other FP options you might have, would you be interested in discussing a family planning method that is less detectable? There are other methods like an IUD, an implant or an injectable that do not require you to take a pill everyday.”

Client:

“Yes, I would be interested in discussing my other options. I didn’t know about the other options.”

Provider:

“That’s why I’m so glad you’re here. So you can learn about your options, and to be in as much control of your family planning as you can. In the meantime, if you do decide to stick with birth control pills, I want you to start thinking of places you might be able to hide the pills. This brings me to my next question. Do you have anyone in your life that you talk to about what you are experiencing?”

Client:

“Not really. I mentioned something to my sister a long time ago, but nothing since then.”

Provider:

“Was your sister supportive of you?”

Client:

“She seemed upset. Not with me, but with my partner. I just don’t want to burden her with all of this. She has three kids she is taking care of and is always so busy. We used to be close, but my partner got jealous of our relationship so I stopped seeing her as much.”

Provider:

“I am sorry to hear of your partner’s jealousy. We should be allowed to have close relationships with our family and friends without our partners becoming jealous. Do you think you might try to reach out to your sister soon? She sounds like she might be a positive support person in your life, even if she doesn’t know of what you’re experiencing. Perhaps at some point you might think about telling her about what you’re experiencing?”

Client:

“I could try that. I know she would really like to hear from me. Maybe I could reach out to hear the next time my partner is at work.”

Provider:

“That sounds like an excellent plan, and you might think about at least one other person in your life that you could reach out to for support. Again, you don’t have to tell them what is happening in your life, but we all deserve support. Another option, there are organizations that work with women who are experiencing similar things as you. They provide counseling and additional support services that we are not able to fully provide here. I think you might benefit from that type of resource if you decide you at some point you might like to look into it.”

Client:

“It’s good information to know, but for now I’m not interested. I can try to reach out to my sister. I also have a neighbor that is an older woman. She is always very nice to me. Maybe I could start having more conversations with her.”

Provider:

“That’s a great idea. Like I said, you deserve to have supportive people in your life. The next thing I wanted to speak with you about is your physical safety when your partner becomes aggressive. You mentioned that your partner has hit and kicked you. This concerns me very much, as that type of violence can get progressively worse and escalate quickly. Could we talk about that for a bit?”

Client:

“I know it sounds bad. It probably sounds worse than it really is, but yes we can talk about it.”

Provider:

“I am wondering two things: if there is a place you could go if things got “really bad” and if there is an area in your house you might go that is safer than other areas.”

Client:

“It’s never been bad enough that I would need to leave, and I can’t really think of where I would go. Maybe my sister’s house? I don’t know what you mean about a safer area in my house.”

Provider:

“Some of my other clients have simply left the house to take a walk, or have gone to the market. Others have gone to a family member’s home or the neighbor’s house. All of these are good options, and there are many other options. I encourage you to continue to think about this, even if we don’t come to a conclusion today.

What I mean by a “safer area” is an area in your home that a place where you can’t be trapped or where objects in the room can be used as potential weapons to harm you. For example, bathrooms and closets tend to be small areas. It is a natural response to immediately run to a bathroom or closet, especially if those rooms have a lock. However, because it’s such a small space, it can be hard to get out of if another person invades the room. Additionally, kitchens tend to have utensils

that could potentially be used to cause serious injury. This goes for areas where there might be tools. Finally, a safer area is away from windows and stairs. Did I answer your question?”

Client:

“Yes, and thankfully, I haven’t had to deal with that yet.”

Provider:

“I am thankful that, too. The point is, you likely will not be able to prevent a violence argument from happening, but you can try to reduce the potential harm caused by your partner. If the time comes, and if you are able, try to move your arguments to a safer place in your home. Can you think of an area in your home that might be safer than other areas?”

Client:

“I think the bedroom sounds like the best place. I could try to stand on one side of the bed, while he is on the other side. I have tried the bathroom before, but he pushed through the door and I did get stuck in there. I’m glad you mentioned this, because I hadn’t thought about it before.”

Provider:

“I’m glad we’re talking about this, too. I am so impressed with your strength, and I appreciate your willingness to engage in this conversation. The last thing I wanted to mention: You shared with me that your partner is pushing you to have another baby, and sometimes does things to your body in order to try to get you pregnant. Please know that you can always come here to the clinic if you are worried that you are pregnant and do not wish to be. It is important that you come as soon as possible so that we can think through your options, and assist you in carrying out whatever plan you decide—whether that be taking emergency contraception, termination and/or carry the pregnancy to full term.”

Client:

“Thank you for that information and for being so supportive. I’m really glad I came here today.”

Provider:

“I’m glad you came, too. Shall we discuss some of your family planning options?”

TRAINING DAY 4

HANDOUT 4.5A: CASE STUDY FOR SAFETY PLANNING #1

INSTRUCTIONS

Read through the case study. With your partner, complete the following steps:

1. After reviewing the results of the IPV screening questions, and using the Provider Tool for Safety Planning, assess the client's "Level of Danger".
2. Select the safety planning measures the provider will discuss with the client. Refer to the "Talking Points" listed on the Provider Tool for Safety Planning.
3. Create a 5–7-minute role play to be demonstrated in front of the large group.

CLIENT PROFILE

Name: Hawa

Age: 29

Marital Status: Married 6 years

Education Level: Six years of formal education

Economic Level: Low

History of Pregnancy: Three pregnancies—one live birth, one stillbirth, one termination

Family Planning Decision: Does not wish to get pregnant for the time being. Expressed an interest in using birth control pills but does not want partner to know about her use.

IPV History: See below, information obtained through screening and counseling

SCREENING QUESTION	TYPE OF VIOLENCE	CLIENT RESPONSE			OFFERING OF SAFETY PLANNING MEASURES
		NO	YES	<i>If yes, indicate approximate date of last incident (DoLI).</i>	
Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?	Psychological Abuse		✓	DoLI: A few days ago	At the provider's discretion.
Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?	Psychological Abuse		✓	DoLI: 1 month	At the provider's discretion.
Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?	Sexual Abuse, emphasis on Sexual and Reproductive	✓		DoLI: Last week	Yes.
Has your partner ever made you to participate in or do things you don't want to do sexually?	Sexual Abuse	✓		DoLI:	Yes. Especially, if incident occurred in the last 12 months.
Has your partner ever used a part of his body or another object to hurt you physically? (Examples may include: scratch, hit, slap, kick, punch, squeeze, pin down, strike with object etc.)	Physical and Psychological Abuse		✓	DoLI: Within the last 6 months	Yes. Especially, if incident occurred in the last 12 months).

Report: With the client's permission, record notes client's account of physical, emotional or sexual abuse.

Physical: Kicking, punching, arm-twisting, grabbing and confining. **Psychological:** name-calling, shaming, degrading, threats of severe violence. **Reproductive:** denies the use of FP methods, condom negotiation impossible. _____

HAWA'S STORY, IN HER WORDS

My partner is almost always angry with me. I can't ever seem to do anything right. He criticizes everything about me—the way that I parent our children, my cooking, the amount of time I spend with my mother. I've tried to address the things that make him angry but it doesn't seem to help. He often tells me that I'm a bad partner because I don't love him enough, and when I do try to show him more affection, he tells me I'm smothering him too much. I don't know what to do.

He thinks I'm stupid. I know I'm not; I did really well in school and I feel like I'm good at a lot of things. It hurts my feelings that he makes fun of me, and it's embarrassing when he does it in public. About six months ago, I confronted him about how he makes me feel. He became very defensive and told me that I need to "learn my place." I shouted something back at him and he slapped me across the face. He twisted my arm behind my back and told me to shut up or else I would be sorry.

He has threatened me on multiple occasions, but he has only become physical on a couple of occasions.

I feel really overwhelmed and with everything and I am worried about getting pregnant. My son is only 2, and the thought of having another baby is terrifying to me. I want to use condoms, but my partner won't allow it. Maybe pills would work for me, I don't know.

I've talked to my mom and sister about all of this. It makes my mom cry, but my sister gets angry. She said I could come and stay with her for a while. I don't know if I should or not. I don't really want to but I don't know what to do.

TRAINING DAY 4

HANDOUT 4.5B: CASE STUDY FOR SAFETY PLANNING #2

INSTRUCTIONS

Read through the case study. With your partner, complete the following steps:

1. After reviewing the results of the IPV screening questions, and using the Provider Tool for Safety Planning, assess the client's "Level of Danger".
2. Select the safety planning measures the provider will discuss with the client. Refer to the "Talking Points" listed on the Provider Tool for Safety Planning.
3. Create a 5–7-minute role play to be demonstrated in front of the large group.

CLIENT PROFILE

Name: Rama

Age: 17

Marital Status: Not married, but has a boyfriend

Education Level: Some formal education

Economic Level: Low

History of Pregnancy: No pregnancies

Family Planning Decision: Is not ready to have children.

IPV History: See below, information obtained through screening and counseling

SCREENING QUESTION	TYPE OF VIOLENCE	CLIENT RESPONSE			OFFERING OF SAFETY PLANNING MEASURES
		NO	YES	<i>If yes, indicate approximate date of last incident (DoLI).</i>	
Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?	Psychological Abuse		✓	DoLI: yesterday	At the provider's discretion.
Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?	Psychological Abuse		✓	DoLI: Last week	At the provider's discretion.
Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?	Sexual Abuse, emphasis on Sexual and Reproductive	✓		DoLI: Last week	Yes.
Has your partner ever made you to participate in or do things you don't want to do sexually?	Sexual Abuse		✓	DoLI: 1 month ago	Yes. Especially, if incident occurred in the last 12 months.
Has your partner ever used a part of his body or another object to hurt you physically? (Examples may include: scratch, hit, slap, kick, punch, squeeze, pin down, strike with object etc.)	Physical and Psychological Abuse		✓	DoLI: 2 days ago	Yes. Especially, if incident occurred in the last 12 months.

Report: With the client's permission, record notes client's account of physical, emotional or sexual abuse.

Physical: Grabbing and confining. Psychological: name-calling, shaming, degrading, makes her feel "crazy." _____ **Reproductive:** denies the use of FP methods. Sexual Abuse: forced sexual intercourse. _____

RAMA'S STORY, IN HER WORDS

I met Moussa when we were kids; his family moved into the house next to my parent's house. He is a few years older than me, and he is very handsome. My mother introduced me to him, and our families want us to get married. He makes me laugh, and he buys me things I can't afford. He tells me I'm the most beautiful woman he has ever met. No one has ever called me a woman before, and it makes me feel really good. I feel like he knows me better than I know myself. He's just so smart.

We argue from time to time, but he's mean to me during the arguments. He calls me names and the other day he grabbed me by the shoulders and wouldn't let me go. I try to focus on the problem at hand, but he makes everything so personal. He tells me I'm being disrespectful if I disagree with him; he says I'm supposed to honor him because that's what women do. That's not how I was raised. My father let my mother voice her opinions. I don't think they would like it if they knew how Moussa was treating me.

I think Moussa tries to trick me sometimes. He'll tell me one thing, and then two hours later, he'll tell me the exact opposite thing. When I confront him about it, he accuses me of not listening to him. He tells me that I'm a horrible person and that no one will ever want to be with me if I can't figure out how to be a better person. I've never had a problem with listening in the past, but maybe I do?

Moussa and I have had sex once, but I didn't want to do it. He told me it would bring us closer together. He's pushing me to have a baby, but I'm just not ready. Today, when I told Moussa I was coming to the clinic, he tried to make me miss my appointment. The only reason he finally let me come was because I told him I was having a doctor look at me to make sure I could get pregnant. I know I shouldn't lie, but I had to. I just need more time to figure out if he's the person I want to be with for the rest of my life. I feel a little afraid about what might happen if Moussa finds out that I'm actually here to prevent a pregnancy.

Do you think you can help me?



SESSION 5.1: WELCOME AND REFLECTIONS

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Reflect on the previous day's accomplishments.
2. Articulate at least two new points of knowledge.
3. Describe the agenda for the day.

TIME

30 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or cell phone that can tell time
- Handout 1.1: Training Agenda*

ADVANCE PREPARATION

- Create and post two flipcharts, one titled “Reflections from Day 4,” the other “New Knowledge.”

TRAINING STEPS

Step 1: Welcome and Introduction (5 minutes)

1. Welcome the participants back to the training. Thank the participants for the attention the previous day and for the insight they brought to the training. Encourage the participants to continue to challenge themselves throughout the day, engage with the material and ask questions of each other and of themselves.
2. Direct their attention to *Handout 1.1: Training Agenda* and review the material they will be addressing throughout the day. Ask the participants if they have anything they would like you to be certain to cover in the agenda.



Step 2: Training Reflections (20 minutes)

1. Ask the participants to take a moment to think about two things: What they learned in the previous day's training, and how the previous day's training made them feel. Specifically, you would like them to do the following:
 - a. Identify at least 2 new points of knowledge they acquired in the previous day's training.
 - b. Identify at least 2 reflections from the previous day's training—how the training made them feel, what continues to circulate in their mind, or something they need additional clarification on.
2. Ask the participants to jot down their answers on a piece of paper. One by one, ask the participants to share their answers.
3. Record the participant's answers on the flipcharts titled, "Reflections from Day 4" and "New Knowledge."

Step 3: Closure and Transition (5 minutes)

1. Ask the participants if there is anything they would like to add before you begin the training modules.
2. Provide encouraging words for what they might gain from today's material.

SESSION 5.2: PROVIDING REFERRALS TO CLIENTS EXPERIENCING INTIMATE PARTNER VIOLENCE

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Describe community-based resources available to a client experiencing intimate partner violence.
2. Provide a proper referral to a client experiencing intimate partner violence.

TIME

1 hour, 10 minutes

MATERIALS

- Flipchart paper
- Markers
- Handout 5.2A: Community Resource Guide*
- Handout 5.2B: Community Resource and Service Map*
- Handout 5.2C: Client Confidentiality Release Form*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Create and post four flipcharts with each of the following titles:
 - “Medical Needs of Clients Experiencing IPV”
 - “Psychosocial Needs of Clients Experiencing IPV”
 - “Financial Needs of Clients Experiencing IPV”
 - “Legal Needs of Clients Experiencing IPV”
- Create a flipchart titled “Components of a Good Referral” and complete it with the six points on page 198.
- Print a copy of *Handout 5.2A: Community Resource Guide* for each participant.
- Print a copy of *Handout 5.2B: Community Resource and Service Map* for each participant.
- Print a copy of *Handout 5.2C: Client Confidentiality Release Form* for each participant.

TRAINING STEPS

Step 1: Introduction and Brainstorm (30 minutes)

1. Ask the participants if they ever need to refer clients to outside agencies. Inquire about those referrals—what is the basis (need) for the referral and whether the referral process is formal or informal. Ask them to describe the process.
2. Acknowledge that the needs of IPV-FP are diverse and sometimes fall outside realm of services the clinic can offer. Share that IPV-FP clients often have needs that can be grouped into four categories: Medical Needs; Psychosocial Needs; Financial Needs; and Legal Needs. Refer to the flipcharts titled with each category.
3. Spend 15 minutes having the participants develop a list of specific examples for each category. If the participants struggle with this task, ask them to reflect on the clients from the case studies and the different forms of IPV (physical, sexual and psychological). Prompt the participants with the following questions:
 - What were the immediate needs of those clients? What were the long-term needs of those clients?
 - Did they express any concerns that were nonmedical?
 - Did they express anything they wanted to change about their situations?
 - What mechanisms does a perpetrator of IPV use to control his partner? What might a client need in order to reduce the harm the IPV causes her?

Record the participants' responses on the corresponding flipchart (medical, psychosocial, financial or legal).

4. Highlight the components that contribute to a good referral; refer to flipchart titled, "Components of a Good Referral."
 - Meets the client's most pressing need at the present time.
 - Describes the relevant services available to the client, and the cost of the services.
 - Informs the client how to access the resources.
 - Includes a name of a contact person at the referral agency and, if possible, the address of the agency (some locations must remain confidential for the safety of its clientele).
 - Includes the days and hours the services are available to the client.
 - A staff member assists a client in accessing the referral resources.
5. Explain that clients experiencing IPV sometimes struggle to identify what their needs are. This presents the provider with the opportunity to utilize their active listening and paraphrasing skills. Encourage the participants to help clients identify their needs by using the following phrases:

- I heard you say...
 - I can tell you are concerned about...
 - It sounds like you have tried the following...
 - I think I hear you expressing...
6. Share with the participants that clients experiencing IPV need to be reminded of their strengths, as the impact of the IPV has caused them to have a diminished sense of self-worth. When discussing outside resources available to clients experiencing IPV, providers should be attuned to the client's body language. Some clients may feel embarrassed or ashamed about their lack of knowledge regarding the resources available. The provider should respond to the body language accordingly.
 7. Remind the participants to be cognizant of the power imbalance between them and the client, based on the volume of information they have, and their ability to connect the client with additional information. Tell the participants that it is important to ask the client if they would like additional information about the resources available to them before giving them the information. For some clients, the information the provider has shared during the counseling session is enough information at the present time. The provider should respect the client's wishes as to not overwhelm the client.
 8. Remind the male-identified participants to also be aware of the power imbalance based on gender. The client may feel pressured to abide by the provider's wishes, versus their own wishes, if the client has been conditioned to believe that men know what is best for women.
 9. Remind the participants to be mindful of their clients' reading and writing comprehension if the referral information is in written form. Providers should offer to assist all clients in accessing referral resources while the client is still in the clinic (if possible) and especially in circumstances when the client is unable to read or write.
 10. Encourage the participants to ask the following questions of their clients: Is it safe for you to have written information regarding your visit in your possession; what will happen if your partner finds this information in your possession? Encourage the participants to offer clients the ability to store their referral information within their medical record, but only after the provider has assisted the client in accessing the referral resources.
 11. Lastly, tell the participants that the process for providing referrals should be similar to the informed and voluntary decision making process: The provider is to help the client identify their need, provide the client with their options, assist the client is weighing the benefit and risk of their options, and help the client arrive at a decision that best fits their circumstances an desired outcome. The provider should make it clear that they trust that the client is capable of making such a decision.

Step 2: IPV-Related Services Available to Clients in Conakry, Guinea (20 minutes)

1. Distribute the *Handout 5.2A: Community Resource Guide* and *Handout 5.2B: Community Resource Map*, which were both developed for the Conakry, Guinea.
2. Show the participants that the resource guide is organized based on the type of service provided: legal and financial assistance; psychosocial, counseling and advocacy services; and medical services, including forensic medical services.
3. Allow the participants five minutes to read through the resource guide quietly or with their neighbor, and to review the community map.
4. Lead a 15-minute discussion about the resources available using the following questions:
 - Which of the organizations are you familiar with? What has been your experience, or your client's experience, working with these organizations?
 - Which of the resources are you just learning about? What about these organizations seems beneficial to clients experiencing IPV?
 - Are there other resources you know of that aren't listed here? Which ones? Why would you recommend these?
 - What challenges might you anticipate your clients facing in accessing these resources?
 - In what ways might you assist a client in addressing those challenges?
5. Inform the participants that the guide and map are items they may distribute to their clients, but that it is their responsibility to communicate to the client the danger in having a hard copy, should the client's abusive partner discover the information.

Step 3: Clinic Protocol—Confidentiality Release Form (15 minutes)

1. Explain to participants that in order to refer a client to a community-based resource, a provider is required to complete the form titled "Confidentiality Release Form."
2. Stress to the participants that under no circumstances may the 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.
3. Ask the participants to explain why there is strict protocol regarding the release of client information. Further probe the participants by asking how this procedure might be associated with the safety of a client experiencing IPV.
4. Additionally, stress to the participants the importance of allowing the client to set parameters on what information is released to an outside party. This is another example of how a provider can restore power and control to a client experiencing IPV.

5. Distribute *Handout 5.2C: Confidentiality Release Form*. Ask for participants to volunteer to read through the form aloud. Ask the participants if they believe anything is missing from the form. Make note of the participants' answers and address them in Session 5.4: Preparing the Clinical Environment.

Step 4: Closure and Transition (5 minutes)

1. Reiterate the benefits of referring clients experiencing IPV to community-based resources, including but not limited to:
 - Clients are able to receive services that meet their immediate needs.
 - Clients are able to develop/expand their support network.
 - Restores a sense of power and control to the client.
 - Accessing community-based resources is a step in the process of healing from IPV.
2. Reiterate the challenges clients experiencing IPV face when attempting to access community-based resources:
 - Services are cost prohibitive.
 - Organizations may be hard to get to and/or client is unable to travel to the location of the organization.
 - Services may be time-limited.
3. Given the challenges clients face, stress the importance of safety planning for harm reduction. Reiterate to the participants that clients are capable of being their own best resource when they are reminded of their strength and resilience.
4. Finally, tell the participants to be prepared to have the client decline any and all referral services available to them. 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, stress the importance of following up with clients during subsequent FP visits. Encourage the participants to tell clients that they may return to the clinic at any point, should they decide they would like a referral.

HANDOUT 5.2A: COMMUNITY RESOURCE GUIDE

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	National Coalition of Guinea for the Rights of Women (CONAG-DCF)	Ecoute et assistance juridique aux victimes pour la constitution des dossiers, le contact des juridictions, les examens médicaux; Reference des victimes pour la prise en charge psychologique	Le service d'écoute et de référence est gratuit pour les victimes ; L'assistance juridique est gratuite mais c'est la victime qui paye les frais des examens médicaux, son transport et les honoraires de l'avocat (entre 500 000 à 3 500 000 FG).	Les bureaux sont ouverts du lundi au vendredi, de 9h à 17 h	Les victimes peuvent appeler sur les numéros du service ou venir elle-même ; Les victimes peuvent être référées par des structures partenaires.	Landréa, Commune de Dixinn, Conakry	Utilisation des codes pour conserver l'anonymat; Respect des procédures opérationnelles standards (SOPs) du Ministère de la sante.	622.62.17.38 631.21.00.25 664.53.51.65 coalitionguinee@yahoo.fr
Legal Assistance	National Office for Protection of Gender and Children's Welfare (OPROGEM)	Provides security and legal support Coordonne au niveau national le respect des droits des personnes vulnérables.	Services gratuits mais les frais médicaux et juridiques sont à la charge de la victime	Service disponible 24h/24 et 7/7 avec une permanence assurée.	Les victimes viennent elles-mêmes ou sont référées par des structures partenaires. Le service peut aussi référer les victimes vers les hôpitaux et saisir la justice pour les cas de crime.	Manquepas, Commune de Kaloum, Conakry	Respect de la confidentialité, Prévoit une maison de transit pour les victimes, respect des principes de droit.	64.00.12.28
Legal Assistance	Avocats sans frontière	Accompagnement judiciaire pour assurer un procès équitable et obtenir une sanction contre les auteurs.	En moyenne 3500000 Gnf par client pour toute la procédure.	Tous les jours de 9h à 17 h	Reference par les partenaires ou les victimes viennent directement	Gbessia, commune de Matoto	Chaque victime est suivie par un avocat, audition en privé, respect du sermon d'avocat, accès limite au dossier.	666.28.15.13 628.50.98.99 664.63.49.29 664.40.18.73

HANDOUT 5.2A: COMMUNITY RESOURCE GUIDE *continued*

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/ Forensic Medicine	Ignace Deen Hospital	Provides legal support for forensic medicine	80000 GNF, excluding any laboratory or exam at another specialist (Gynecology for example)	Les bureaux sont ouverts du lundi au dimanche, de 8h à 22h	Referral by the police, justice or any other structure or organization (ideally through established)	Sandervalia, commune de Kaloum, Conakry	Produce confidential examination certificate	664.00.68.32 657.21.25.45 hassane2002gn@yahoo.fr
Legal Assistance & Counseling Services	Mother and Child Association	Soutien psychologique et réintégration Accompagnement social et juridique	Les services sont gratuits mais c'est la victime qui paye les frais des examens médicaux, son transport et les honoraires de l'avocat (entre 500 000 à 3 500 000 FG)	Les bureaux sont ouverts du lundi au vendredi, de 9h à 17 h	Les victimes peuvent appeler sur les numéros du service ou venir elle-même; Les victimes peuvent être referées par des structures partenaires.	Landreah, Commune de Dixinn, Conakry	Utilisation des codes pour conserver l'anonymat; Respect des procédures opérationnelles standards (SOPs) du Ministère de la sante.	621.37.94.33
Psychosocial & Counseling Services	Guinean Association of Social Workers (AGUIAS) Donka National Hospital - Psychiatry	Provides psychosocial assistance (identification, orientation, reference des victims, reinsertion et integration, mediation). Apporte un soutien psychologique et des soins psychiatriques	Les services offerts par l'ONG sont gratuits pour les victimes Selon le niveau d'atteinte psychiatrique, à partir de 500 000 GNF	Les locaux sont ouverts de 8 h à 16h30 tous les jours du lundi au vendredi. C'est offert du lundi au samedi, de de 8h à 17 h	Les victimes peuvent appeler sur un numéro vert (116) qui est disponible 24h/24 et 7 jours sur 7; Elles peuvent venir elles-mêmes ou peuvent être referées par des structures partenaires. La victime est souvent referée par une structure publique ou privée. Parfois la victime est envoyée par la famille.	Jardins du 2 Octobre, Moussodougou, Commune de Kaloum, Conakry Camayenne, Commune de Dixinn, Conakry	Une armoire qui se ferme à clé sert pour la conservation des dossiers des victimes. Respect des procédures opérationnelles standards (SOPs) du Ministère de la sante. Confidentialité et respect du code de déontologie médicale. Un rapport médical confidentiel est produit à la demande.	657.57.57.72

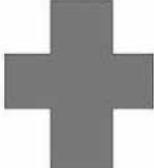
HANDOUT 5.2A: COMMUNITY RESOURCE GUIDE *continued*

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
Financial Assistance	Yattayah SOS Village Social Center	Assists survivors with socioeconomic reintegration	Gratuity si la femme est identifiée par SOS mais payant si référée par une autre structure (à discuter au cas par cas).	Ouvert du lundi au vendredi de 8h à 17h	Les victimes peuvent venir d'elles-mêmes ou être référées par des structures partenaires.	Yattayah, Commune de Ratoma, Conakry	Respect des procédures opérationnelles standards (SOPs) du Ministère de la sante.	657.54.53.37
Medical Services	John Paul II National Centre for Applied Social Education of GBV Division	Provides medical care and reorientation	Les frais de consultation et de dossier coutent environ 30 000 GNF; Les autres frais de laboratoire et tout examen spécialisé (écographie par ex.) sont à la charge de la victime.	Le service au niveau du centre de santé est ouvert du lundi au dimanche, de 8h à 20 h	La victime peut directement se présenter à l'hôpital ou être référée par un personnel de santé ou une structure (ONG par exemple).	Konimodou, Commune de Ratoma, Conakry	Une armoire qui se ferme à clé sert pour la conservation des dossiers des victimes. Un rapport médical confidentiel est adressé à qui de droit, sous pli fermé.	
Medical Services	Donka National Hospital—Maternity	Provides medical care and reorientation	Les frais de consultation et de dossier coutent environ 50 000 GNF; Les autres frais de laboratoire et tout examen spécialisé (écographie par ex.) sont à la charge de la victime.	Le service au niveau du centre de santé est ouvert du lundi au dimanche, de 8h à 20 h	La victime peut directement se présenter à l'hôpital ou être référée par un personnel de santé ou une structure (ONG par exemple).	Camayenne, Commune de Dixinn, Conakry	Une armoire qui se ferme à clé sert pour la conservation des dossiers des victimes. Un rapport médical confidentiel est adressé à qui de droit, sous pli fermé.	64.57.36.24

HANDOUT 5.2B: COMMUNITY RESOURCE AND SERVICE 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

TRAINING DAY 5

HANDOUT 5.2C: CLIENT CONFIDENTIALITY RELEASE FORM

INTERNAL AND EXTERNAL CONFIDENTIALITY RELEASE FORM

This form defines the release parameters for which a client's confidential health information, including a disclosure of intimate partner violence, may be shared internally (within the clinic) and externally (referral agencies). This form may be voided at any time, but will remain in effect until the indicated expiration date. This form must be signed by the client receiving services (additional signature required for referral, see back).

I (the client) consent to the release of the following confidential health information, internally and externally (please check all that apply):

Consent to release information <i>internally</i> (within the clinic)	Consent to release information <i>externally</i> (for the purposes of a referral)	Specific element of confidential information.
		My health information (medical record). Notes (if necessary): _____ _____ _____
		My disclosure of intimate partner violence. Notes (if necessary): _____ _____ _____
		Both, my health information and disclosure of intimate partner violence. Notes (if necessary): _____ _____ _____
		I want to release <i>only the following information</i>: Notes: _____ _____ _____

Name and title of provider completing this form: _____

Name of client: _____

Time period during which release of information above is authorized: From _____ To _____

Signature of provider: _____ Date: _____

Signature of client: _____ Date: _____

(COMPLETE BACK FOR REFERRAL TO EXTERNAL AGENCY)

Complete the following sections if making a client referral to an external agency.

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 *limited* to specific individuals at the agency, please specify:

Name and title of provider completing the referral: _____

Name of client whose information is being released: _____

Reason for release of information: _____

Time period during which release of information above 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: _____

TRAINING DAY 5

SESSION 5.3: PREPARING THE CLINIC ENVIRONMENT

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Identify aspects of the clinic that can be improved in order to integrate intimate partner violence services within the clinic.

TIME

1 hour, 20 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or timer
- Handout 5.3: Preparing the Clinic Environment*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print one copy of *Handout 5.3: Preparing the Clinic Environment* for each participant
- Create a flipchart titled, “Clinic Characteristics Conducive to Serving Clients Experiencing IPV.” List the following characteristics under the title:
 1. Physical Space
 2. Resources Available to Client
 3. Basic Training and Ongoing Education
 4. Support for and Oversight of Staff
 5. Evaluating Patient Satisfaction
 6. Promotional and Support Materials

Do not post the flipchart until the very end of Step 1

TRAINING STEPS

Step 1: Introduction and Brainstorm (10 minutes)

1. Share a positive sentiment with the participants about how much they have learned over the last four days, and how hard they have worked to engage thoughtfully with the material.
2. Explain that now, the participants will be charged with putting their knowledge into practice. Remind the participants that, in order to provide the new services they will be offering their clients, the clinic environment and clinic practices might need to be altered.
3. Ask the participants to help you develop a list of environmental and practical (policy/procedure) characteristics they feel are needed in order to serve clients who have experienced intimate partner violence. It will likely be easier for the participants to think of physical characteristics about the clinic, you may need to prompt them with the following questions:
 - Think about the day-to-day operations of the clinic. For example, the flow of the clinic. What aspects regarding the clinic flow might you need to consider? What about other day-to-day operations?
 - What about your print materials? Do you have any? What do you communicate to your clients?
4. Post the flipchart titled, “Clinic Characteristics Conducive to Serving Clients Experiencing IPV.” Ask one of the participants to read the characteristics aloud:
 - Physical Space (examples: where client case files are stored, confidential counseling room)
 - Resources (example: informational materials, resources for providers)
 - Basic Training and Ongoing Education (example: identifying which staff members are responsible for which tasks)
 - Support For and Oversight of Staff (example: monthly check-ins, review of case files)
 - Evaluating Patient Satisfaction (examples: verbal questionnaires, focus group)
 - Promotional and Support Materials (example: visual messaging that promotes healthy relationships)
5. Explain to the participants that they will spend the next 40 minutes in pairs or small groups, analyzing the current characteristics of the clinic, and as they pertain to the characteristics listed on the flipchart.

Step 2: Small Group Work (40 minutes)

1. Distribute *Handout 5.3: Preparing the Clinic Environment*. Depending on the number of participants, divide the group into pairs or small groups.
2. Use five minutes to explain to the group what you would like them to do. Inform the participants that the handout is divided into three categories: Current environment; Ideal Environment; and, Realistic Recommendations. Explain that participants are to think about the current clinic environment and describe it in the allotted space. Next, the participants

are to brainstorm and describe what an ideal, or perfect, environment might look like—if resources were endless and there were no barriers to creating such an environment. Finally, participants are to compare the current environment with the ideal environment, and develop modifications that allow for the current and ideal environments to meet in the middle. Essentially, you would like the participants to develop recommendations that are realistic, given the resources available to them, and which better support the needs of clients experiencing IPV.

3. Ask the participants if they have any questions.
4. Ask one of the participants to reiterate what they are supposed to do, in order to check for comprehension.
5. Take note of the time on the clock; provide the students with the projected end time (35 minutes from the time noted on the clock). Inform the participants when they have 15 minutes left, and five minutes left of the activity.

Step 3: Large Group Discussion (30 minutes)

1. After 35 minutes, bring the small groups back together as a large group.
2. Allow each small group five minutes to report back to the group. For the sake of time, ask the participants to only share their answers from their third category—Realistic Recommendations—for each characteristic.
3. After each of the groups has shared their recommendations, inform the participants that they will next develop an action plan for carrying out their top recommendations. In order to select their top recommendations, allow the group 10 minutes to talk through the characteristics one by one, dialogue about the recommendations presented and, jointly, choose 2–3 recommendations from each category. These 2–3 recommendations will be the recommendations for which they develop an action plan for creating a clinic environment conducive to serving clients experiencing IPV.

Step 4: Closure and Transition (0 Minutes)

1. Immediately move into action planning—Session 5.4.

SESSION 5.3: PREPARING THE CLINIC ENVIRONMENT

CLINIC CHARACTERISTIC	CURRENT ENVIRONMENT	IDEAL ENVIRONMENT	REALISTIC RECOMMENDATION
<p style="text-align: center;">Physical Space</p>			



CLINIC CHARACTERISTIC	CURRENT ENVIRONMENT	IDEAL ENVIRONMENT	REALISTIC RECOMMENDATION
<p data-bbox="240 1045 505 1213">Resources Available to Client</p>			



CLINIC CHARACTERISTIC	CURRENT ENVIRONMENT	IDEAL ENVIRONMENT	REALISTIC RECOMMENDATION
<p data-bbox="162 1008 438 1249">Basic Training and Ongoing Education</p>			



CLINIC CHARACTERISTIC	CURRENT ENVIRONMENT	IDEAL ENVIRONMENT	REALISTIC RECOMMENDATION
<p style="text-align: center;">Support for and Oversight of Staff</p>			



CLINIC CHARACTERISTIC	CURRENT ENVIRONMENT	IDEAL ENVIRONMENT	REALISTIC RECOMMENDATION
<p data-bbox="170 1039 430 1213">Evaluating Patient Satisfaction</p>			



CLINIC CHARACTERISTIC	CURRENT ENVIRONMENT	IDEAL ENVIRONMENT	REALISTIC RECOMMENDATION
<p data-bbox="233 1041 513 1213">Promotional and Support Materials</p>			

SESSION 5.4: ACTION PLANNING

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Identify action steps for creating a clinic environment that is conducive to serving clients experiencing IPV.
2. Identify resources and allies that can help them accomplish their goals.

TIME

1 hour, 45 minutes

MATERIALS

- Flipchart paper
- Easel
- Masking tape
- Thick markers—various colors
- Pencils/pens
- Watch or timer
- Handout 5.4: Action Planning Worksheet*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print one copy of *Handout 5.4: Action Planning Worksheet* for each participant

TRAINING STEPS

Step 1: Introduction (5 minutes)

1. Explain to the participants that they will now have the opportunity to strategize ways to accomplish their top recommendations from Session 5.3: Preparing the Clinic Environment.
2. Distribute *Handout 5.4: Action Planning Worksheet* and ask for a volunteer to read aloud the action plan. Explain that the participants will be working in pair (or small groups) to develop a comprehensive plan to address at least one of the six environmental categories.

3. Allow the participants to select their partner. Ask the participants to decide which category they would like to focus their efforts on addressing. If there is not an equal distribution among the categories, you may need to develop a mechanism for doing so (having students draw from a hat).
4. Inform the participants that they will have one hour to develop a comprehensive action plan.

Step 2: Small Group Work (1 hour)

1. Allow the participants to spread out in or around the clinic. As long as they are working diligently, it does not matter where they are sitting.
2. Take note of the time on the clock; provide the students with the projected end time (1 hour from the time noted on the clock). Inform the participants when they have 30 minutes left, 15 minutes left and five minutes left of the activity.

Step 3: Large Group Share and Discussion (45 minutes)

1. After 1 hour, bring the small groups back together as a large group.
2. Allow each small group five minutes to report back to the group.
3. After each of the groups has shared their action steps, lead a large group discussion by asking the following questions:
 - What was rewarding about the activity? What was challenging about this activity?
 - Do you feel as if these action steps are feasible? Which ones feel the easiest to accomplish? Which ones are the hardest? Why?
 - Are there any resources that are needed that you currently do not have at your disposal? What would it take to acquire those resources? If acquiring them is not possible, what are some alternative steps?
 - How will you prioritize these action steps? What categories are the most important to address first? How long do you anticipate it will take to accomplish these steps?
 - Are there individuals not present right now, that are integral in carrying out the action plan? Can you anticipate their reaction? Who will be responsible for briefing them on the action plan and engaging them in the process?
 - How will you make certain you remain on track with your action plan? Who will be responsible for keeping the plan moving forward?
4. Ask the participants if they have any additional thoughts they would like to share with the group.

Step 4: Closure and Transition (0 minutes)

1. Ask the participants if you may collect their action plan worksheets in order to photocopy them.
2. Photocopy the action plans and return the plans to the participants.

HANDOUT 5.4: ACTION PLANNING WORKSHEET

Clinic Characteristic:	Top Recommendations: 1. _____ 2. _____ 3. _____			
Action Steps	Date to be Completed	Information and/or Resources Needed	Potential Challenges	Person(s) Responsible for carrying out the work.
1)				
2)				

HANDOUT 5.4: ACTION PLANNING WORKSHEET *continued*

Action Steps	Date to be Completed	Information and/or Resources Needed	Potential Challenges	Person(s) Responsible for carrying out the work.
3)				
4)				

HANDOUT 5.4: ACTION PLANNING WORKSHEET *continued*

Action Steps	Date to be Completed	Information and/or Resources Needed	Potential Challenges	Person(s) Responsible for carrying out the work.
5)				

TRAINING DAY 5

SESSION 5.5: CLOSING AND POST ASSESSMENT

TIME

50 minutes

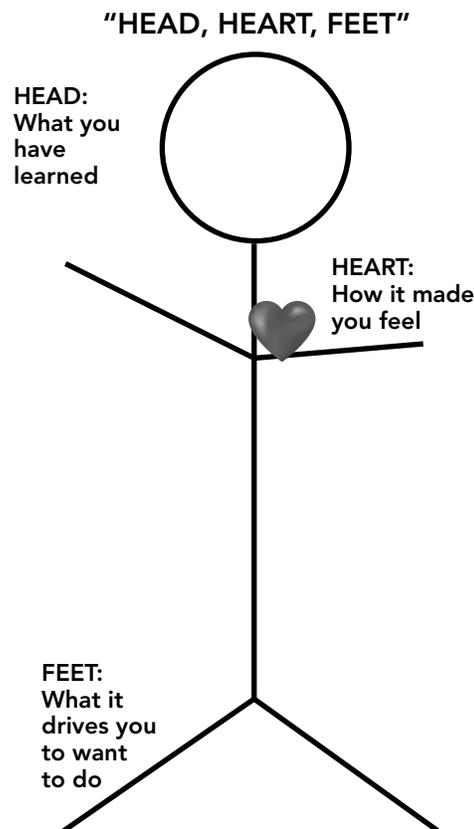
MATERIALS

- Flipchart paper
- Easel
- Markers
- Handout 5.5: Participant Self Assessment of Knowledge and Skills*
- 4 packages of Post-it Notes (or small slips of paper)

ADVANCE PREPARATION

- Review the training modules to be certain you understand content, methodology and timing.
- Print out one copy of *Handout 5.4: Participant Self Assessment of Knowledge and Skills* for each participant.
- Prepare and post a flipchart titled, “Head, Heart, Feet”.

Replicate the following diagram and information on the flipchart:



TRAINING STEPS

Step 1: Closing Thoughts (10 minutes)

1. Express gratitude to the participants for their incredible work over the course of the last four days. Highlight some of the barriers they have overcome, and the depth and vigor with which they approached the topic.
2. Explain that the participants will do one last activity—“Head, Heart, Feet”—which will help them to reflect on the training as a whole.
3. Refer to the flipchart “Head, Heart, Feet.” Ask the participants to take a few moments to think about what they have learned throughout the training; point to the head on the stick figure. Ask the participants to express how what they learned made them feel; refer to the heart on the stick figure. Finally, ask the participants to share what the knowledge and feelings “move” or drive them to want to do in their professional and personal lives.
4. As the participants are reflecting silently, distribute post-it notes among the group (small slips of paper, if you do not have post-it notes). Make a request that the participants write one thought per post-it note, and post the thought on the respective section of the flipchart.
5. Allow the participants 10 minutes to complete the exercise.

Step 2: Group Reflection (15 minutes)

1. Invite the participants to share some of what they wrote for the “Head, Heart, Feet” activity. Listen to what they have to say, rather than providing feedback.
2. Encourage the participants to thank one another for their participation and for their commitment to carrying this work forward after the training.
3. Add your thoughts and thank you.

Step 3: Participant Self-Assessment of Knowledge, Skills and Attitudes (25 minutes)

1. Distribute *Handout 5.4: Participant Self-Assessment of Knowledge and Skills*.
2. Remind the participants that their answers will not be graded. Instead, a comparison of the pre and post assessment will help you to evaluate the effectiveness of the training and your facilitation.
3. Inform the participants that once they are finished with the self-assessment, they may leave the training. Invite them to read through “Head, Heart, Feet” as they leave the room.
4. Allow participants as long as they need to complete the self-assessment.

TRAINING DAY 5

HANDOUT 5.5: PARTICIPANT SELF-ASSESSMENT OF KNOWLEDGE AND SKILLS

Participant Pre/Post Self-Assessment Intimate Partner Violence Integration Training

Name: _____ Job Function: _____

Indicate by circling whether assessment is pre training or post training: Pre Post

Decide whether each of the following statement is T (true) or F (false). Write your response for each statement in the space provided below.

1. ___ In health care settings, the interview is the most common place for disclosures of intimate partner violence to occur.
2. ___ Intimate partner violence has no documented impacted on family planning, sexual and reproductive health.
3. ___ Safety planning with a client who is experiencing IPV is a method used to restore power and control to a survivor of IPV.
4. ___ Counselors and providers should talk clients into pregnancy prevention methods if there is intimate partner violence in the home.
5. ___ Integrating intimate partner violence screening in family planning services, and providing tailored IPV-FP care, are considered methods of intervention.
6. ___ It is the clinic's responsibility to ensure the physical and psychological safety of clients experiencing IPV.
7. ___ Gender norms are socially assigned roles and responsibilities for both women and men.

The following are multiple choice questions. Please circle the correct response for each question. Unless otherwise indicated, there is only one correct response for each question.

8. The root causes of intimate partner violence is:
 - a. Stress and frustration
 - b. Substance abuse (drugs or alcohol)
 - c. Power and control
 - d. Mental health problems
9. Intimate partner violence includes the following forms of abuse:
 - a. Physical abuse
 - b. Psychological abuse
 - c. Sexual abuse
 - d. All of the above
10. Which of the following is not required of counselors and providers?
 - a. Screening for intimate partner violence.
 - b. Assisting the client in making an informed and voluntary decision about their family planning.
 - c. Providing shelter to a client experiencing intimate partner violence.
 - d. Making an appropriate referral, as per the request of the client.
11. Which of the following indicates that a counselor and/or provider is effectively listening to a client? (circle all that apply).
 - a. Occasionally paraphrasing or summarizing what the client has said.
 - b. Looking at the client when the client is speaking.
 - c. Thinking about what you will say next to the client.
 - d. Writing or reading notes when the client is speaking.
 - e. Asking specific questions related to what the client has told you.
 - f. Interrupting the client to give her advice.
 - g. Nodding your head or making encouraging sounds when the client is talking.

12. How should a provider respond to a client that discloses of intimate partner violence. (circle all that apply)
- a. Thank her for sharing this information with you.
 - b. Encourage her to leave the situation.
 - c. Explain how her experience might impact her family planning decisions.
 - d. Offer her the option of safety planning.
13. A “safety plan” is best described as:
- a. A step-by-step guide on how to leave an abusive relationship.
 - b. A comprehensive set of steps and suggestions to follow in order to avoid a dangerous situation, or increase an individual’s sense of safety.
 - c. A comprehensive guide to preventing intimate partner violence.
 - d. A document that is shared with an abusive partner so they can understand the impact of the violence they are perpetrating.

Please answer the following question in the space provided.

Define the following terms:

14. Intimate Partner Violence

15. Screening Questions



16. Integrated Services (Intimate partner violence and Family Planning)

17. Confidentiality

18. Name at least three IPV related services a counselor or provider can offer to a client experiencing IPV.

19. Name the three types of behaviors abusers use to wield power and control over their partner.

PHYSICAL VIOLENCE	EMOTIONAL/ PSYCHOLOGICAL VIOLENCE	SEXUAL VIOLENCE

20. Explain how IPV might impact a client's family planning decision.

21. Explain how a provider can create a safe and inviting environment for a client experiencing IPV.

22. Explain how a provider's personal attitudes and morals might negatively or positively impact a client experiencing IPV.

a. Negatively impact a client:

b. Positively impact a client:

PROTOCOL FOR THE INTEGRATION OF FAMILY PLANNING AND INTIMATE PARTNER VIOLENCE SERVICES IN CONAKRY, GUINEA

Background on the Association of Intimate Partner Violence and Reproductive Health

Gender-based Violence and Family Planning (FP). 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.¹³

Gender-based Violence and STIs/HIV. Gender-based violence (GBV), including intimate partner violence (IPV), is a risk factor for the transmission of HIV and sexually transmitted infections (STI).¹⁴ 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.¹⁵ Surveys have also shown that men who are physically and sexually violent are more likely to engage in behaviors that put them, and thus their partners, at greater risk for 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.¹⁶

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 preexisting conditions that are a direct result of IPV and that may influence family planning choices and reproductive health needs, including but not limited to: Unplanned pregnancy; sexually transmitted infections; mental health disorders; drug or alcohol dependencies; and untreated traumatic injuries.

¹³ Kishor, Sunita and Kiersten Johnson. 2004. *Profiling Domestic Violence – A Multi-Country Study*. Calverton, Maryland: ORC Macro.

¹⁴ <http://www.ghi.gov/resources/guidance/161891.htm>

¹⁵ Kishor, Sunita and Kiersten Johnson. 2004. *Profiling Domestic Violence – A Multi-Country Study*. Calverton, Maryland: ORC Macro.

¹⁶ 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.

- Provide an opportunity to connect survivors with additional care and support services.
- 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 procedures¹⁷ 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 any existing community-based resources and services that support survivors of IPV. This protocol incorporates principles of harm reduction¹⁸, and a supplemental tool (i.e., safety plan) 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.

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 for a physical examiner, or at least every 6 months. 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 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:

¹⁷ 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.

¹⁸ <http://harmreduction.org/about-us/principles-of-harm-reduction/>

- 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, if feasible.
- 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	<p>G: Greet the client respectfully.</p> <p>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 the clients’ intimate relationship during the counseling session.</p>
Step 2	<p>A: Ask the client about her family planning needs. Assess her risk for HIV/STIs or other physical or mental symptoms that may need to be treated.</p> <p>IPV Services Integration: Screen for potential incidences of intimate partner violence.</p>
Step 3	<p>T: Tell the client about different family planning methods.</p> <p>IPV Services Integration: Explain the STI/HIV risks and IPV risks resulting from each option.</p>
Step 4	<p>H: Help the client make a decision regarding family planning.</p> <p>IPV Services Integration: Take into consideration the impact of IPV. Help the client develop talking points to be used with her partner.</p>
Step 5	<p>E: Explain and demonstrate how and when to use the method of contraception.</p> <p>IPV Services Integration: Take into consideration the impact of IPV, and develop strategies for harm reduction.</p>
Step 6	<p>R: Return/refer - schedule a return visit and follow up with the client.</p> <p>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.</p>

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 clinic’s 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 (including those mandated by law), 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 IPV.
- **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 provider 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.

- **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—GATHER—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 are general questions asked in a FP conversation:

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 FP conversation. These factors can 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. "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?"
4. "Can you describe a time when your partner has threatened to harm you physically (scratch, slap, hit, bit or pushed)?"
5. "Can you describe a time when your partner has hurt you physically (scratch, slap, hit, bit or pushed)?"
6. "Has your partner ever forced you to participate in or do things you don't want to do sexually?"

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.

A provider should use the *Intimate Partner Violence Screening Assessment Tool* to gauge whether IPV is present in the client's intimate relationship. 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—every day—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:
 - 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 Risks 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. Restoring power to a client experiencing IPV
- II. Strategies for addressing FP methods with abusive partners
- III. Documenting intimate partner violence

- **Restoring power to a client experiencing IPV.** In general, the following five factors influence a 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.

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 a 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 using a 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 when doing a visual scan of the body and when speaking with the client:

- 
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.

When performing a visual scan of the body, the provider should keep in mind that it is not uncommon to complete a scan 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.

- **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.

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

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.

PARTICIPANT PRE/POST SELF-ASSESSMENT ANSWER KEY

Decide whether each of the following statement is T (true) or F (false). Write your response for each statement in the space provided below.

1. T In health care settings, the interview is the most common place for disclosures of intimate partner violence to occur.
2. F Intimate partner violence has no documented impacted on family planning, sexual and reproductive health.
3. T Safety planning with a client who is experiencing IPV is a method used to restore power and control to a survivor of IPV.
4. F Counselors and providers should talk clients into pregnancy prevention methods if there is intimate partner violence in the home.
5. T Integrating intimate partner violence screening in family planning services, and providing tailored IPV-FP care, are considered methods of intervention.
6. F It is the clinic's responsibility to ensure the physical and psychological safety of clients experiencing IPV.
7. T Gender norms are socially assigned roles and responsibilities for both women and men.

The following are multiple-choice questions. Please circle the correct response for each question. Unless otherwise indicated, there is only one correct response for each question.

8. The root causes of intimate partner violence is:
 - a. Stress and frustration
 - b. Substance abuse (drugs or alcohol)
 - c. Power and control**
 - d. Mental health problems
9. Intimate partner violence includes the following forms of abuse:
 - a. Physical abuse
 - b. Psychological abuse
 - c. Sexual abuse
 - d. All of the above**

10. Which of the following is not required of counselors and providers?
- a. Screening for intimate partner violence.
 - b. Assisting the client in making an informed and voluntary decision about their family planning.
 - c. Providing shelter to a client experiencing intimate partner violence.**
 - d. Making an appropriate referral, as per the request of the client.
11. Which of the following indicates that a counselor and/or provider is effectively listening to a client? (circle all that apply).
- a. Occasionally paraphrasing or summarizing what the client has said.**
 - b. Looking at the client when the client is speaking.**
 - c. Thinking about what you will say next to the client.
 - d. Writing or reading notes when the client is speaking.
 - e. Asking specific questions related to what the client has told you.**
 - f. Interrupting the client to give her advice.
 - g. Nodding your head or making encouraging sounds when the client is talking.**
12. How should a provider respond to a client that discloses of intimate partner violence. (circle all that apply)
- a. Thank her for sharing this information with you.**
 - b. Encourage her to leave the situation.
 - c. Explain how her experience might impact her family planning decisions.**
 - d. Offer her the option of safety planning.**
13. A “safety plan” is best described as:
- a. A step-by-step guide on how to leave an abusive relationship.
 - b. A comprehensive set of steps and suggestions to follow in order to avoid a dangerous situation, or increase an individual’s sense of safety.**
 - c. A comprehensive guide to preventing intimate partner violence.
 - d. A document that is shared with an abusive partner so they can understand the impact of the violence they are perpetrating.

Please answer the following question in the space provided.

Define the following terms:

14. Intimate Partner Violence

Intimate partner violence is a pattern of abusive behaviors and actions perpetrated by one person onto their intimate partner. IPV can include physical, sexual and psychological harm. Each of these categories include various methods for controlling an intimate partner.

15. Screening Questions

A series of questions asked in order to determine possible risk of the topic at hand. In the case of intimate partner violence screening questions: A series of questions asked in order to determine the presence of violence within the context of an intimate relationship.

16. Integrated Services (Intimate partner violence and Family Planning)

Integration is best seen as a continuum rather than as two extremes of integrated/ not integrated. Integration is about the organization of various tasks which need to be performed in order to provide a population with good quality health services. An overall working definition of integrated service delivery is “The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system. —World Health Organization

17. Confidentiality

A strict set of written, spoken or implied rules that limit access to certain types of information.

18. Name at least three IPV related services a counselor or provider can offer to a client experiencing IPV.

- Assistance in selecting a family planning method that takes into consideration the IPV the client is experiencing.
- Basic IPV counseling services (education, validation and empowerment)
- Referral services to a community based organization
- Safety planning
- Maintaining client confidentiality

19. Name the three types of behaviors abusers use to wield power and control over their partner.

PHYSICAL VIOLENCE	EMOTIONAL/ PSYCHOLOGICAL VIOLENCE	SEXUAL VIOLENCE
<ol style="list-style-type: none"> 1. Hitting 2. Kicking 3. Slapping 4. Punching 5. Grabbing 6. Pinching 7. Biting 8. Arm-twisting 9. Stabbing 10. Hitting with objects 11. Withholding or denying basic needs (food, water, medication, shelter, transportation) 12. Forcing the use of drugs or alcohol 	<ol style="list-style-type: none"> 1. Intimidations 2. Threatening physical harm to self, victim and/or family/ friends 3. Isolation 4. Undermining/compromising victim's personal relationships 5. Harassment 6. Spreading untruths the victim 7. Name-calling 8. Shaming/Criticizing 9. Crazy-making (rendering the victim confused about what is actually happening) 10. Instilling fear 11. Guilt-tripping (making the victim feel as if they are responsible for the abuse) 12. Invading privacy 	<ol style="list-style-type: none"> 1. Criticizing sexual performance 2. Forced intercourse (vaginal, oral or anal rape) 3. Unwanted touch or sexual advances 4. Controlling victim's sexual and reproductive health 5. Compromising victim's family planning method 6. Forced prostitution 7. Attacking sex parts of the body 8. Sex outside of the intimate relationship 9. Accusing the victim of cheating 10. Withholding sex/affection 11. Forced pregnancy

20. Explain how IPV might impact a client's family planning decision.

- 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.

21. Explain how a provider can create a safe and inviting environment for a client experiencing IPV.

- Building rapport with a client begins the moment the client walks through the clinic door, and during the counselor/provider greeting and introduction. In GATHER Step 2, the counselor/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.
- Communicating 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 counselor/provider should express trust in the client's ability to make healthy and sound decisions about her FP needs.
- Ensuring confidentiality
- Following through on referrals and/or other promised services
- Listening and validating the client's concerns and/or feelings.
- Respecting the client's boundaries.

22. Explain how a provider's personal attitudes and morals might negatively or positively impact a client experiencing IPV.

a. Negatively impact a client:

- A client may be concerned about access to services if her attitudes and morals do not align with the provider's attitudes and morals.
- A client's family planning decision might be impacted (or altered) in order to please the provider.
- A client might feel unwelcomed at the clinic if her attitudes or morals do not align with the provider's attitudes and morals.
- A client might withhold information if she anticipates that a provider will not approve of her lifestyle.

b. Positively impact a client:

- A client may feel supported and validated by a provider who verbally rejects abusive behavior and reactions perpetrated by the client's partner.
- A provider has the unique opportunity to restore power and control to a client experiencing IPV if the provider can express concern for client; thus, helping to ensure that the client's FP needs and desires take into consideration the IPV she is experiencing.
- Giving empathy towards a client helps to build rapport.
- Finding a commonality between a client and provider also helps to build rapport.



PILOTED TRAINING AGENDA¹⁹

**Supporting Survivors of Intimate Partner Violence:
Training Agenda for Family Planning Service Providers in Guinea**

DAY 1		
Schedule—Session 1	Time	Topic
9:00am–9:45am	45 minutes	Session 1.1: Welcome and Introduction <ul style="list-style-type: none"> • Welcome (10) • Group introductions (15) • Review of course agenda and learning objectives (10) • Group agreements (5) • Question and answer (4) • Closure and transition (1)
9:45am–10:20am	35 minutes	Session 1.2: Sex or Gender <ul style="list-style-type: none"> • Definitions of sex and gender (10) • Sex and Gender Game (20) • Closure and transition (5)
10:20am–11:00am	40 minutes	Session 1.3: Personal Reflection on Sex and Gender <ul style="list-style-type: none"> • Introduction and guided visualization (15) • Large group discussion (20) • Closure and transition (5)
11:00am–11:20am	20 minutes	Tea Break
11:20am–12:40pm	1 hour, 20 minutes	Session 1.4: Act Like a Man / Act Like a Woman <ul style="list-style-type: none"> • Brainstorm (10) • “Act Like a Man” activity (20) • “Act Like a Woman” activity (20) • Large group discussion (25) • Closure and transition (5)
12:40pm–1:45pm	1 hour, 5 minutes	Lunch
1:45pm–2:40pm	55 minutes	Session 1.5: Dynamics of Intimate Partner Violence <ul style="list-style-type: none"> • Group brainstorm (5) • Lecture and activity (40) • Closure and transition (10)
2:40pm–3:45pm	1 hour, 5 minutes	Session 1.6: Forms, Effects and Causes of Intimate Partner Violence—Problem Tree <ul style="list-style-type: none"> • Introduction and small group work—identifying effects of IPV (20) • Large group share (10) • Large group brainstorm—root causes (15) • Large group discussion and debrief (20) • Closure and transition (5)
3:45pm–4:00pm	15 minutes	Tea Break
4:50pm–5:35pm	45 minutes	Session 1.7: Intimate Partner Violence Case Studies <ul style="list-style-type: none"> • Case studies and discussion (40) • Closure and transition (5)

¹⁹ This agenda was used to pilot the training manual in Conakry, Guinea. It has since been adapted to better address the needs and desires of family planning and reproductive health providers

DAY 2		
Schedule—Session 2	Time	Topic
9:00am–9:30am	30 minutes	Session 2.1.: Welcome <ul style="list-style-type: none"> • Welcome and review of Day 2 agenda (5) • Reflections on Day 1 (20) • Closure and transition (5)
9:30am–10:35am	1 hour, 5 minutes	Session 2.2: Myths Related to Intimate Partner Violence <ul style="list-style-type: none"> • Brainstorm (5) • Dispelling the myths of IPV (20) • Large group discussion (25) • Closure and transition (15)
10:30am–11:30am	1 hour, 5 minutes	Session 2.3: Link Between Family Planning and Intimate Partner Violence <ul style="list-style-type: none"> • Family planning and intimate partner violence trivia game (35) • Large group discussion (20) • Closure and transition (10)
11:30am–11:45am	15 minutes	Tea Break
11:45am–1:00 pm	1 hour, 15 minutes	Session 2.4: Provider Values and Attitudes <ul style="list-style-type: none"> • Vote with Your Feet (20) • Values and Attitudes Clarification and Group Discussion (50) • Closure and transition (5)
1:00pm–2:00pm	1 hour	Lunch
2:00pm–3:00pm	1 hour	Session 2.5: The Impact of Intimate Partner Violence and Empathizing with the Survivor <ul style="list-style-type: none"> • Nkirukua's Story (45) • Closure and transition (15)
3:00pm–3:15pm	15 minutes	Tea Break
3:15pm–4:30pm	1 hour, 15 minutes	Session 2.6: Setting Boundaries and Maintaining Confidentiality <ul style="list-style-type: none"> • Brainstorm (10) • Setting boundaries and maintaining confidentiality (30) • Large group discussion (30) • Closure and transition (5)
4:30pm–5:20pm	50 minutes	Session 2.7: Integrating Intimate Partner Violence Services within the GATHER Framework <ul style="list-style-type: none"> • Small group work (13) • Large group discussion (15) • Introduction to five key intimate partner violence services (10) • Closure and transition (5)

DAY 3

Schedule—Session 3	Time	Topic
9:00am–9:30am	30 minutes	Session 3.1: Welcome and Reflections <ul style="list-style-type: none"> • Welcome and review of Day 3 agenda (5) • Reflections on Day 2 (20) • Closure and transition (5)
9:30am–11:15am	1 hour, 45 minutes	Session 3.2: Screening for Intimate Partner Violence—Overview and Demonstration <ul style="list-style-type: none"> • Large group brainstorm (10) • Introduction to “IPV Questionnaire and Documentation Form (25) • Screening for IPV with care and compassion—“The Dos and Don’ts (10) • Demonstration of IPV screening (15) • Large group screening debrief (20) • Large group discussion—interpreting answers to screening questions (20) • Closure and transition (5)
11:15am–11:30am	15 minutes	Tea Break
11:30am–12:45pm	1 hour, 15 minutes	Session 3.3: Participant Practice—Screening for Intimate Partner Violence <ul style="list-style-type: none"> • Introduction and participant practice (45) • Large group discussion (25) • Closure and transition (3)
12:45pm–1:45pm	15 minutes	Lunch
1:45pm–2:55pm	1 hour, 20 minutes	Session 3.4: Counseling and Educating Overview and Demonstration <ul style="list-style-type: none"> • Introduction and brainstorm (10) • Demonstration of counseling skill—“Active Listening and Paraphrasing” (25) • Demonstration of counseling skill—“Validating and Educating” (25) • Demonstration of counseling skill—“Responding to Emotions and Empathizing” (20) • Closure and transition (10)
2:55pm–3:15pm	20 minutes	Tea Break
3:15pm–5:00pm	1 hour, 45 minutes	Session 3.5: Participant Practice—IPV Counseling and Education <ul style="list-style-type: none"> • Introduction (3) • Participant practice—counseling and educating (75) • Large group discussion (25) • Closure and transition (2)

DAY 4		
Schedule—Session 2	Time	Topic
9:00am–9:30am	30 minutes	Session 4.1: Welcome and Reflections <ul style="list-style-type: none"> • Welcome and review of Day 4 agenda (5) • Reflections on Day 3 (20) • Closure and transition (5)
9:30am–10:45am	1 hour, 15 minutes	Session 4.2: Exploring FP Options with Clients Experiencing IPV <ul style="list-style-type: none"> • Introduction (2) • IPV and considerations for family planning (40) • Large group discussion (25) • Closure and transition (5)
10:45am–11:00am	1 hour, 15 minutes	Session 4.3: Providing Additional Reproductive Health Services to Clients Experiencing IPV <ul style="list-style-type: none"> • Introduction and brainstorm (5) • IPV and considerations for reproductive health services (35) • Large group discussion (25) • Closure and transition (5)
11:00am–11:15am	15 minutes	Tea Break
1:35pm–2:50pm	1 hour, 15 minutes	Session 4.4: Documenting Intimate Partner Violence <ul style="list-style-type: none"> • Group brainstorm (5) • Documentation 101—how, what and when (10) • Large group case study (20) • Participant practice—case studies (35) • Large group discussion (20) • Closure and transition (5)
12:35pm–1:35pm	1 hour	Lunch
1:50pm–3:05pm	1 hour, 15 minutes	Session 4.5: Participant Practice—Safety Planning with Clients Experiencing Intimate Partner Violence <ul style="list-style-type: none"> • Introduction and brainstorm (20) • Elements of a safety plan (15) • Active listening and safety identification—Nkirukua’s story (15) • Large group discussion (5)
3:05pm–3:20pm	15 minutes	Tea Break
3:20pm–5:20pm	2 hours	Session 4.5: Participant Practice—Safety Planning with Clients Experiencing Intimate Partner Violence <ul style="list-style-type: none"> • Introduction (15) • Participant practice—small group case studies (60) • Large group discussion (35) • Closure and transition (10)

DAY 5

Schedule—Session 2	Time	Topic
9:00am–9:30am	30 minutes	Session 5.1: Welcome and Reflections <ul style="list-style-type: none"> • Welcome and review of Day 5 agenda (5) • Reflections on Day 4 (20) • Closure and transition (5)
9:30am–10:40am	1 hour, 20 minutes	Session 5.2: Providing Referrals to Clients Experiencing Intimate Partner Violence <ul style="list-style-type: none"> • Introduction and brainstorm (30) • IPV related services available to clients in Conakry, Guinea (20) • Matching needs with resources (10) • Clinic protocol—“Confidentiality Release Form (15) • Closure and transition (5)
10:40am–11:00am	20 minutes	Tea Break
11:00am–12:10pm	1 hour, 10 minutes	Session 5.4: Action Planning <ul style="list-style-type: none"> • Introduction (5) • Small group work (60) • Large group share and discussion (45)
12:10pm–1:10pm	1 hour	Lunch
1:10pm–2:50pm	1 hour, 50 minutes	Session 5.5: Action Planning <ul style="list-style-type: none"> • Introduction (5) • Small groups work on action plan worksheet (60) • Large group sharing and discussion (45)



SESSION X.X: PROVIDING ADDITIONAL REPRODUCTIVE HEALTH SERVICES TO CLIENTS EXPERIENCING IPV²⁰

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Explore additional reproductive health services that may be required for clients experiencing IPV.
2. Deliver additional reproductive health services that may be required for clients experiencing IPV.

TIME

1 hour , 15 minutes

MATERIALS

- Flipchart paper
- Markers
- Tape
- Pen for participants
- Watch or clock to keep track of time
- Trainers' Tool X.1: Family Planning and Reproductive Health Services Large Group Example*
- Trainers' Tool X.2: Wall Signs—Intimate Partner Violence and Considerations for Reproductive Health Services*
- Handout X.1: Intimate Partner Violence and Considerations for Reproductive Health Services*

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Print and post wall signs from *Trainers' Tool X.2: Wall Signs—Intimate Partner Violence and Considerations for Reproductive Health Services* (or copy the information from the tool onto paper).
- Print *Trainers' Tool X.1: Family Planning and Reproductive Health Services Large Group Example*.
- Print four copies of *Handout X.1: Intimate Partner Violence and Considerations for Reproductive Health Services* for each participant.

²⁰ This module was included in the piloted training in Conakry, Guinea in order to make additional space for participants to practice safety planning with a client. It is suggested that this session be incorporated on a sixth day of training.

TRAINING STEPS

Step 1: : Introduction and Brainstorm (10 minutes)

1. Explain that clients experiencing IPV often need additional reproductive health services (RHS). IPV is closely linked to STIs—including HIV—gynecological disorders and chronic pain. Part of the provider's job is to identify and provide additional reproductive health care services, beyond the family planning. (Trainers' Note: If the clinic does not test all clients for STIs, the clinic should consider referring the patient to a site that does test, if she discloses that her partner has other sexual partners.)
2. Lead a short brainstorming session by asking the following questions:
 - Generally, what types of reproductive health care services do your FP clients need?
 - Are those services offered at this clinic? If not, where can your clients obtain these services?
 - What are some factors that require FP clients to receive additional health care services? How might you explain those factors to that client?

Examples of responses:

- Treatment for a chronic or degenerative illness.
 - Mental health services.
 - Treatment of an infectious disease.
 - Acquiring prescription medication.
3. Reiterate that IPV increases a client's need for additional health care services, including reproductive health care services. Inquire about why that might be the case.

Step 2: IPV and Considerations for Reproductive Health Services (35 minutes)

1. Explain that this activity will operate in the same manner as the IPV and FP activity.
2. Direct the participants' attention to the IPV and RHS facts hanging on the wall. Explain that the participants will be working in pairs to analyze the facts related to IPV and RHS.
3. Allow the participants to choose a new partner, or work with the same partner. Try to keep the participants paired with someone of a different job function.
4. Distribute the four copies of *Handout X.1: Intimate Partner Violence and Considerations for Reproductive Health Services* to each participant (three for the exercise, one for the group example). Allow the participants to silently read through the worksheet for 30 seconds. Then ask a participant to volunteer to read-the worksheet aloud. Explain that the participants are to complete the exercise with at least three of the eight IPV-RHS facts.
5. Using five minutes of the allotted 30 minutes, complete the following IPV-RHS fact as a large group to help the participants understand the activity process: "Over 50% of clients experiencing IPV are forced to have unprotected intercourse with their abusive partner." See *Trainers' Tool X.1: Family Planning and Reproductive Health Services Large Group Example* for assistance.

6. Ask the participants if they need any additional clarification on how to complete the activity.
7. Allow the participant-pairs a few moments to leave their seats, read through each of the IPV-RHS facts and to select the first IPV-RHS fact they would like to analyze. Only one participant-pair may work on an IPV-RHS fact at a time.
8. Make note of the time on the clock, and remind the pairs that they have 30 minutes to complete three IPV-RHS fact worksheets. Instruct the pairs to work quickly, but with attention to detail; doing so will help the participants prepare for the fast-paced clinic setting.

Step 3: Debrief and Large Group Discussion (25 minutes)

1. Return the pairs to a large group after the allotted 25 minutes has passed.
2. Allow the participants to share their findings with the large group. In order to ensure equal participation, ask each pair to present on at least one IPV-RHS fact. Following each IPV-RHS fact presentation, open up the dialogue for other participants to add their insight. Spend roughly six minutes on each IPV-RHS fact.
3. Intersperse the following discussion questions throughout the presentations, as a means of linking this activity with previous activities:

- How might you explain the importance of additional RHS to a client experiencing IPV?

Examples of responses:

- Explain that IPV can take a tremendous toll on the mind and body of a survivor. Share that it is not uncommon that other ailments to be a direct result of an experience with IPV.
- Express that you want her to be as physically healthy as she can be, and in order to do so, she may need additional reproductive health services.
- Would you be able to provide additional RHS on the same day? If not, how would you ensure the client returns to the clinic for services?

Examples of responses:

- Again, express that you want her to be as physically healthy as she can be. In order to address her needs to the fullest extent, you are asking her to return to the clinic.
- Assist her in making an appointment that best fits her availability and physical ability, to return to the clinic.
- Acknowledge any disappointment or frustration for not being able to address the concern in the same day, and inform her how a return visit would benefit her overall health.
- How would you deal with the emotional impact of the IPV, and need for additional RHS services? What provider messages would you use to show empathy for the client? Remind the participants of *Handout 3.4: Messages to Convey to Clients Experiencing Intimate Partner Violence*.
- How might you handle a situation in which a client experiencing IPV receives a positive STI screening?

Examples of responses:

- Assure her that the positive screening is not her fault.
- Share that you will, together, develop a plan to address or manage the illness (curable or incurable).
- Express that you would like to discuss ways she might be able to protect herself from STIs in the future.
- How does it make you feel to know that this client will be returning home to an abusive partner? How might you deal with the emotional stress of the IPV cases you encounter and manage?

Examples of responses:

- Be aware of what makes me upset, angry or frustrated, so I can attempt to control these emotions until I am out of sight from the patient.
- Talk to a colleague when I need advice or support.
- Allow the time and space to feel, express or explore my emotions.
- Do something to—momentarily—take my mind off of my work.

Step 4: Closing and Transition (5 minutes)

1. Share the key points list below with participants.

- Show empathy for a client experiencing IPV, as well as for the provider who cares for a client experiencing IPV.
- Acknowledge the feelings or emotions that come along with providing care to an IPV client—frustration, sadness, helplessness, etc.
- The best thing to do for the client is to treat the client with dignity and respect—listen to the client, validate the client's experience, provide the client with her options and assist the client in making the best decision she can, given her circumstances and environment.
- Acknowledge that most of the clients they will care for will return home to their abusive partner following their clinic visit.
- There are tactics a client can use to increase her sense of safety and reduce the harm the IPV causes her.
- We will learn how to assist a client to identify those tactics in the Safety Planning for Harm Reduction module.

**HANDOUT X.1: INTIMATE PARTNER VIOLENCE
AND CONSIDERATIONS FOR REPRODUCTIVE HEALTH**

IPV-FP Fact:	
<p>Taking into consideration the IPV-FP fact, what two FP options do you think would be the most effective for this client?</p> <p>Option #1.</p> <p>Option #2.</p>	<p>What are the benefits, disadvantages and consequences of the options you are providing?</p> <p>Option #1.</p> <p>Option #2.</p>
<p>What two additional thoughts, questions or actions might you need to consider if you were to suggest the options you indicated above?</p> <p>1.</p> <p>2.</p>	
<p>What emotional needs might this client have?</p>	<p>What informational needs might this client have?</p>

TRAINING DAY 3

TRAINERS' TOOL X.1: FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES LARGE GROUP EXAMPLE

<p>IPV-FP Fact:</p> <p>Over 50% of clients experiencing IPV are forced to have unprotected intercourse with their abusive partner.</p>	
<p>Taking into consideration the IPV-RHS fact, list at least two RHS a client might need.</p> <p><i>Potential answers (not an exhaustive list)</i></p> <ul style="list-style-type: none"> • Emergency contraception (depending on how soon after the assault or advanced provision of EC, if possible) • An additional pack of birth control (to take if she is unable to come to the clinic for EC) • Regular screening for STIs/HIV • Treatment of bacterial infections • Prenatal care 	<p>Explain the reasons for these two RHS needs.</p> <ul style="list-style-type: none"> • EC—repeated assaults increase a client's risk of becoming pregnant • STI screening panel—Clients exposed to IPV have increased risk of acquiring STIs/HIV • Treatment of infections—more likely experience pain, infection, etc. • Prenatal care - if the client becomes pregnant as a result of the assault
<p>Could this IPV-RHS fact impact her FP options? If so, how?</p> <ul style="list-style-type: none"> • The client might opt for birth control pills if she knows she can use them as EC • The client may be faced with an unplanned pregnancy • The client may need to safety plan around a positive STI screening, which in turn increases her risk for physical and sexual violence 	
<p>Would you be able to provide the client with these two services? If not, where would you refer her?</p>	
<p>What emotional needs might this client have?</p> <ul style="list-style-type: none"> • Empathy and compassion • Validation of her feelings • Support during difficult diagnoses (positive STI/HIV screenings) • Safety planning 	<p>What information needs might this client have?</p> <ul style="list-style-type: none"> • Clear and concise information about her options • Any additional steps/tasks she might need to take as a result of her RHS need • Instructions on how to take any prescribed medications • Where to acquire the medicine or medical services if not provided at the clinic • Information about a return visit • Safety planning • Information about support services available for women experiencing IPV???

TRAINERS' TOOL X.2: WALL SIGNS—INTIMATE PARTNER VIOLENCE
AND CONSIDERATIONS FOR REPRODUCTIVE HEALTH SERVICES

**Over 50% of clients
experiencing IPV
are forced to have
unprotected intercourse
with their
abusive partner.**



**The fear of physical
violence often
inhibits the ability
to negotiate
barrier methods
and to refuse sex.**



**IPV clients living
with HIV experience
more severe IPV,
and more frequent
abuse, when compared
to IPV client living
without HIV.**



**A client's disclosure
of her STI status
to her partner can
put her at increased
risk for IPV.**



Women experiencing IPV are more likely to experience:

- **Urinary tract and vaginal infections**
- **Painful sex and vaginitis**
- **Pelvic inflammatory disease**
- **Chronic pelvic pain**
- **HIV and other STIs**
- **Decreased sexual desire**
- **Fibroids**



**Clients who have
experienced IPV
are almost 3 times
more likely to
be diagnosed with
invasive cervical cancer.**



**Clients experiencing
IPV are often
forced to cancel
or miss appointments
due to their
partner's control
over them.**



Physical violence during pregnancy is associated with:

- **Miscarriage**
- **Delayed prenatal care**
- **Stillbirth**
- **Premature labor and birth**
- **Low birth weight**



**Women experiencing
IPV are 2.5 times
more likely to have
forgone health
care within the last
12 months, compared
to clients not
experiencing IPV.**



SESSION X.X: REVIEW OF INTEGRATED IPV-FP SERVICES AND PROVIDER SKILLS²¹

LEARNING OBJECTIVES

At the completion of this session, participants will be able to:

1. Describe the process for integrating the “Five Key IPV Services” within a family planning visit.
2. Integrate the “Five Key IPV Services” within a family planning visit.

TIME

2 hours, 45 minutes

MATERIALS

- Flipchart paper
- Markers
- Computer, if possible
- LCD Projector, if possible
- Copies of the following handouts:
 - Handout X.1: PowerPoint Presentation: Integrated IPV-FP Visit—Start to Finish
 - Handout X.2: Observation Guide: Evaluation of Provider’s Skills for Integrating IPV Services
 - Handout X.3: Packet—IPV-FP Forms and Provider Tools

ADVANCE PREPARATION

- Review the training module to be certain you understand content, methodology and timing.
- Create a flipchart presentation, using *Refresher Training Handout: Review of IPV Related Services and Provider Skills*, if PowerPoint capability is not an option.
- Set up equipment necessary to project the PowerPoint presentation.
- Print one copy of *Handout X.1: PowerPoint Presentation: Integrated IPV-FP Visit—Start to Finish*.
- Print one copy of *Handout X.2: Observation Guide: Assessment of Provider Skills for Integrating IPV Services*.
- Print two copies of *Handout X.3: Packet—IPV-FP Forms and Provider Tools* for each participant.

²¹ This module was developed as per the feedback of the piloted training in Conakry, Guinea. The training participants expressed the need and desire to practice the integrated IPV-FP skills from start to finish. This session allows for 2 hours, 45 minutes of participant practice, and it is suggested that the module be used during a sixth day of training.

TRAINING STEPS

Step 1: Introduction (5 minutes)

1. Inform the participants that this session will allow them to pull together all of the information they have learned over the course of the last four days.
2. Explain that you will begin the session by providing them with overview of an integrated IPV-FP visit from start to finish.
3. Inform the participants that following the presentation, the participants will work in groups of three to practice an integrated IPV-FP visit from start to finish. Each participant will have the opportunity to play the role of a provider, client and observer.
4. Share that if time allows, participants may demonstrate their skills in front of the large group for an additional opportunity to receive feedback on their skills.
5. Ask the participants if they have any questions about the session.

Step 2: PowerPoint Presentation—Review of Integrated IPV-FP Services and Skills (40 minutes)

1. Inform the participants that you will review the process for integrated IPV-FP visits—start to finish—and the skills required to complete the process.
2. Explain to the participants that some of the slides will look familiar, as they were presented earlier in Session 2.7.
3. Distribute copies of *Handout X.1: PowerPoint Presentation: Integrated IPV-FP Visit—Start to Finish* so the participants can follow along with your presentation. Encourage the participants to write their questions and comments in the margins of the presentation, so you can address them following the presentation.
4. Deliver the PowerPoint Presentation to the participants. Do not read the slides verbatim, as the content is dense. Instead, synthesize the information into 3–5 sentences, per slide.

TRAINING TIP

- You may need to modify the PowerPoint presentation to reflect what the participants have agreed to be the IPV-FP integration process. As it currently stands, the material in the PowerPoint presentation reflects the suggested integration process.

Step 3: Large Group Debrief (25 minutes)

1. Ask the participants for their initial thoughts on the presentation.
2. Debrief the material with the participants by asking the following discussion questions:
 - Did the information presented to you help to clarify the process for integrating IPV and FP services? What has become clearer to you? What do you still need clarity on?

- Which of the steps do you feel most comfortable completing? Which steps do you feel the least comfortable completing? What do you need in order to feel comfortable?
 - Do you feel confident in your ability to use the forms associated with integrated services? Are there any forms you would like to go over as a large group now?
3. Address the participants' questions, concerns and requests as they come up during the large group discussion.

Step 4: Preparing for Participant Practice - Developing Case Profiles (10 minutes)

1. Ask the participants to convene themselves into groups of three. This small group will be the group with which they practice the process and skills from start to finish.
2. Distribute flipchart paper and markers to each of the groups. Ask each group to develop a client profile. Inform the groups that at least one other group will use the client profile during the practice session. Include in the client profile the following details:
 - Name
 - Age
 - Marital status
 - Education level
 - Economic level
 - History of pregnancy
 - Family planning need (not family planning decision)
3. Give the groups 5 minutes to develop the profile. Instruct the group to hang their client profile on the wall when they are finished.

Step 5: Explanation of Participant Practice—Reviewing IPV Services and Provider Skills (20 minutes)

1. Share with the participants that the client profiles just created will be used to facilitate the participant practice. Similar to previous role plays, one participant will play the role of the client, one will play the role of the provider, the third will observe.
2. Explain that the participant playing the role of the provider will guide the process, just as they would do in any family planning session. The provider is to integrate the five key intimate partner violence services into the session, and practice the skills necessary to carry out the steps. The participant playing the role of the client will utilize the client profile as a starting place, and develop a full client story as the discussion progresses. It will be up to the participant playing the role of the client to decide what the family planning need/desire and the forms of violence the client is experiencing.
3. Explain that this time, the participant playing the role of the observer will assess whether the provider has adequately addressed the five key services, as well as assess the provider's skill level. Distribute *Handout 0.1: Observation Guide: Assessment of Provider Skills for Integrating IPV Services*.

4. Ask the participants to take turns reading through the observation guide. Ask the participants if they have any questions related to the guide. Ease any participant anxiety related to the observer guide and the evaluation process. Remind the participants that this is an opportunity for them to practice, and to receive structured feedback from peers.
5. Distribute *Handout X.3: Packet—IPV-FP Forms and Provider Tools*. Allow the participants to browse through the forms and tools. Each participant is expected to complete the IPV Screening and Documentation Tool when they play the role of the provider. The provider tools can be referenced through the practice session.
6. Ask the participants if they have any questions about the process.
7. Allow the participants 5 minutes to—silently—brainstorm about task ahead of them.

Step 6: Participant Practice (1 hour, 45 minutes)

1. Ask the participants to decide their roles for the first role play. Allow them to get situated into a comfortable position.
2. Explain that each role play will last 30 minutes. The provider is expected to get through as much of the process as possible in the 30 minutes. If the group finishes early, as them to sit quietly while the remaining groups finish their respective role plays.
3. Following the 30-minute role play, allow the groups 10 minutes to debrief together. The observer can share highlights from the observation guide. Additionally, the client might consider sharing how the provider made them feel through the process. Debriefing the role of the provider after all three role plays have been completed.
4. After the completion of the role play and debrief, as the participants to rotate the roles. Additionally, assign each small group a different client profile.
5. Repeat the process—role play, followed by debrief, rotate roles, assign new case profile—for a total of three role plays.

Step 7: Large Group Discussion (30 minutes)

1. Allow the participants to provide their initial thoughts about the role plays.
2. Facilitate a large group discussion using the following discussion questions:
 - Describe what the process was like when you were playing the role of the provider? What was the process like when you were playing the role of the client?
 - What did you find to be the most difficult aspects to discuss with the client? As the observer, what did you witness to be the most difficult aspects of the process?
 - As the client, what were the most difficult aspects for you to discuss? How might you take that into consideration when you are working with your clients?
 - As the provider, what will you do differently next time? As the client, was there anything you wished the provider had done differently?

- As the observer, what did you notice about the non-verbal cues between the provider and the client? What did their body language look like? What would you suggest a provider need to be aware of in regards to their body language and non-verbal cues.
- What did you find to be the most rewarding aspect of the process?
- Share some of the more pointed moments of the process when the provider did something really well. Was it something the provider did or said? Was it how they explained something?

3. Ask if the participants have any concluding thoughts about the role play exercise.

Step 8: Closing and Transition (5 minutes)

1. Encourage the participants to continue to reflect on the role play experience. If they identified an aspect they need to improve on, encourage them to work with another participant that excelled in that area.
2. Encourage the participants to continue to check in with each other as they begin to implement that integration services. On-going conversations about the process, and pausing from time to time to evaluate the services, are crucial steps in ensuring proper implementation and/or to strengthen the process. Doing so results in better outcomes for the clients being served.
3. Thank the participants for engaging with the material, and congratulate the them on successfully conducting their first integrated IPV-FP visit.

HANDOUT X.1:

INTEGRATED IPV-FP VISIT—START TO FINISH *continued*

<h3 style="text-align: center;">Supportive Statements Providers Can Integrate throughout the visit:</h3> <ul style="list-style-type: none"> • I'm sorry this is happening to you. • This is not your fault. There is nothing you have done wrong to be treated in this way. • No one deserves to be treated in this way. • Violence is never justified between two people who are supposed to love one another. • If, at any point, you do not want to talk about this anymore, please do tell me. I won't be upset. I want you to help lead the direction of this conversation. • Thank you for trusting me with this information. • The information you are sharing with me is very important, and we will take that into consideration when we are addressing your FP needs and desires. • What you're experiencing is very common among women. I have worked with many clients who been in similar situations. You are not alone. <p style="font-size: small; text-align: center;">Additional statements can be found on Handout 3.4: Messages to Convey to Clients Experiencing Intimate Partner Violence.</p>	<h3 style="text-align: center;">Required Skills for Counseling</h3> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>➤ Active Listening and Paraphrasing</p> <ul style="list-style-type: none"> • <i>Definition:</i> Listening closely in order to restate the client's message simply and in your own words • <i>Purpose:</i> Conveys a vested interest in, and comprehension of, what the other person is saying. Summarizes or clarifies what that person is trying to say. </td> <td style="width: 50%; vertical-align: top;"> <p>➤ Validating and Educating</p> <ul style="list-style-type: none"> • <i>Definition:</i> Acknowledging and confirming what was said, followed by additional information that supports what is said, or corrects any misinformation that was shared. • <i>Purpose:</i> Conveys non-judgmental support, provokes thought and attempts to spark additional conversation. Seeks to eliminate any perception that IPV is justified or that it should be condoned. </td> </tr> </table>	<p>➤ Active Listening and Paraphrasing</p> <ul style="list-style-type: none"> • <i>Definition:</i> Listening closely in order to restate the client's message simply and in your own words • <i>Purpose:</i> Conveys a vested interest in, and comprehension of, what the other person is saying. Summarizes or clarifies what that person is trying to say. 	<p>➤ Validating and Educating</p> <ul style="list-style-type: none"> • <i>Definition:</i> Acknowledging and confirming what was said, followed by additional information that supports what is said, or corrects any misinformation that was shared. • <i>Purpose:</i> Conveys non-judgmental support, provokes thought and attempts to spark additional conversation. Seeks to eliminate any perception that IPV is justified or that it should be condoned.
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<p>3. Explore FP options and deliver reproductive health services that take into consideration the IPV the client is experiencing.</p> <p>“Exploring options and delivering services”: To <u>engage</u> in a conversation about the FP needs and desires, to <u>offer information</u> about the available resources that <u>address</u> the expressed need and desire and providing care to <u>meet</u> the expressed need and desire.</p> <p>How it applies to the clinic setting:</p> <p>Depending on the client's expressed need and desire, a provider will <u>offer additional information</u> about how IPV can impact her need and desire. The <u>resources available to her will remain the same, but in order to address and meet her need, the resources may have to be tailored to take into consideration the IPV she is experiencing.</u></p>	<p style="text-align: center;">Informing a client of her options, exploring those options and counseling and educating go hand-in-hand.</p> <p style="text-align: center;">These steps do not need to be separated from one another, as each step impacts one another.</p>		
<p>INTEGRATE: Informing the Client of Available Services, Exploring FP Options, IPV Counseling and Educating</p> <p>Because of the documented impact IPV can have on the sexual and reproductive health care of a client, it is important that a provider take into consideration the IPV a client may be experiencing when exploring FP options. <u>When informing the client about her FP options options, the provider can infuse the conversation with information about the dynamics of IPV and inquire about the client's ability to negotiate FP methods with her partner.</u> While doing this, the provider can also share with the client that she is not to blame for the abuse, that many other clients experience this same thing.</p>	<p>4. Assist in developing a “Safety Plan” to safe guard the client's family planning decision, increase the client's sense of safety and reduce the harm she is experiencing.</p> <p>“Safety Plan”: Steps and/or suggestions to follow in order to avoid a dangerous situation, reduce the harm experienced and increase an individual's sense of safety.</p> <p>How it applies to the clinic setting:</p> <p>Providers will engage in a conversation with the client about measures she might take should be experiencing physical or sexual violence, or in the even that the her partner is attempting to control her reproductive health.</p>		

HANDOUT X.1: INTEGRATED IPV-FP VISIT—START TO FINISH *continued*

INTEGRATE: Assisting the client in making a decision about her family planning and safety planning (as it pertains to her family planning decision).

A client may feel obligated to base her family planning decision on the violence she is experiencing. Exploring family planning options and counseling and educating can be effective in helping a client to understand that she *does not* need to base her FP decision on the IPV she is experiencing.

When assisting the client in the decision making process, a provider can help the client identify **safety measures she may take in order to protect her family planning decision as best as she can**.

Job Aid: “Provider Tool for Safety Planning With Clients Experiencing IPV”

Provider Tool for Safety Planning with Clients Experiencing Intimate Partner Violence

Safety planning is a tool that can be used with clients experiencing intimate partner violence. While safety planning will not prevent the violence that is being perpetrated against the client, safety planning can increase the sense of control a client has over her life by helping her to identify ways to potentially avoid harm and/or what to do during an act of violence.

Understanding the level of danger in which the client is living, will help the provider and client think through what her options may be. The danger measures listed below align with the screening questions pertaining to sexual and physical violence, and tactics used to control a client's sexual and reproductive health. If the client has confirmed her experience with the indicated danger measures, the provider can offer to safety plan with the client using the suggested talking points.

1. Has the violence perpetrated against the client increased over the last 12 months?	NO	YES	If yes, then offer to safety plan.
2. Does the abusive partner deny the client her right to control her sexual and reproductive health (i.e. Deny or sabotage family planning methods, deny her access to care and treatment, force pregnancy and/or termination, etc)?			
3. Does the abusive partner force the client to perform sexual acts against her will?			
4. Does the abusive partner use physical force to cause pain and/or injury?			

Each measure indicates a high risk for danger. The more measures the client confirms, the higher her risk of danger.

TALKING POINTS FOR PROVIDERS

- Would you like to discuss how you might safe guard your family planning desire? (Examples: Choosing a method that is not easily detectable, hiding the chosen method, etc.)
- Should your partner threaten your physical safety, might you be able to move the argument to an area in your home that may be safer than other areas? (Avoid: bathrooms, small spaces, standing next to a window, the kitchen or other areas with potential weapons, attempt to put a large object between abuser and self.)
- If you are concerned that you are pregnant and don't want to be, you can come here for assistance. We can help you assess what your options are.
- Have you confided in anyone about what you have been experiencing? Is there anyone you would feel comfortable speaking to about this? You deserve the support.
- If you need to leave your home, can you identify at least two locations where you might go?
- If you do leave your home, what important items will you need to take with you?
- You may always come to the clinic if you need assistance dealing with this. We will help you to the best of our ability and/or find a referral for someone who can assist you.

5. Provide referrals to other medical, psychosocial and legal services that can further assist the client in addressing the IPV that is being perpetrated against her.

“Referral”: To direct someone to an outside resource for further evaluation, consultation or assistance.

How it applies to the clinic setting:

Should the client so choose, a provider may refer a client to an outside agency with expertise in addressing IPV.

INTEGRATE: Referrals and Safety Planning for Sexual and Physical Violence

Referrals generally happen at the end of a clinic visit, as does safety planning. However, a provider can introduce the idea of safety planning at any point during the visit and return to it later. It is particularly helpful to introduce safety planning during counseling and education.

It would behoove the provider to address safety measures needed to protect the FP decision, while assisting the client in the decision making process.

Because safety planning is considered an additional support services, it goes hand-in-hand with also suggesting outside services that may be available to assist the client in addressing the IPV she is experiencing.

Again, this is the Job Aid for Safety Planning: “Provider Tool for Safety Planning With Clients Experiencing IPV”

Provider Tool for Safety Planning with Clients Experiencing Intimate Partner Violence

Safety planning is a tool that can be used with clients experiencing intimate partner violence. While safety planning will not prevent the violence that is being perpetrated against the client, safety planning can increase the sense of control a client has over her life by helping her to identify ways to potentially avoid harm and/or what to do during an act of violence.

Understanding the level of danger in which the client is living, will help the provider and client think through what her options may be. The danger measures listed below align with the screening questions pertaining to sexual and physical violence, and tactics used to control a client's sexual and reproductive health. If the client has confirmed her experience with the indicated danger measures, the provider can offer to safety plan with the client using the suggested talking points.

1. Has the violence perpetrated against the client increased over the last 12 months?	NO	YES	If yes, then offer to safety plan.
2. Does the abusive partner deny the client her right to control her sexual and reproductive health (i.e. Deny or sabotage family planning methods, deny her access to care and treatment, force pregnancy and/or termination, etc)?			
3. Does the abusive partner force the client to perform sexual acts against her will?			
4. Does the abusive partner use physical force to cause pain and/or injury?			

Each measure indicates a high risk for danger. The more measures the client confirms, the higher her risk of danger.

TALKING POINTS FOR PROVIDERS

- Would you like to discuss how you might safe guard your family planning desire? (Examples: Choosing a method that is not easily detectable, hiding the chosen method, etc.)
- Should your partner threaten your physical safety, might you be able to move the argument to an area in your home that may be safer than other areas? (Avoid: bathrooms, small spaces, standing next to a window, the kitchen or other areas with potential weapons, attempt to put a large object between abuser and self.)
- If you are concerned that you are pregnant and don't want to be, you can come here for assistance. We can help you assess what your options are.
- Have you confided in anyone about what you have been experiencing? Is there anyone you would feel comfortable speaking to about this? You deserve the support.
- If you need to leave your home, can you identify at least two locations where you might go?
- If you do leave your home, what important items will you need to take with you?
- You may always come to the clinic if you need assistance dealing with this. We will help you to the best of our ability and/or find a referral for someone who can assist you.

Provider Talking Points for Safety Planning

- Would you like to discuss how you might safe guard your family planning desire? (Examples: Choosing a method that is not easily detectable, hiding the chosen method, etc.)
- Should your partner threaten your physical safety, might you be able to move the argument to an area in your home that may be safer than other areas? (Avoid: bathrooms, small spaces, standing next to a window, the kitchen or other areas with potential weapons, attempt to put a large object between abuser and self.)
- If you are concerned that you are pregnant and don't want to be, you can come here for assistance. We can help you assess what your options are.
- Have you confided in anyone about what you have been experiencing? Is there anyone you would feel comfortable speaking to about this? You deserve the support.
- If you need to leave your home, can you identify at least two locations where you might go?
- If you do leave your home, what important items will you need to take with you?
- You may always come to the clinic if you need assistance dealing with this. We will help you to the best of our ability and/or find a referral for someone who can assist you.

HANDOUT X.1:

INTEGRATED IPV-FP VISIT—START TO FINISH *continued*

Making Referrals: Internal and External Confidentiality Release Form

Page 1:

Internal and External Confidentiality Release Form

This form defines the release parameters for which a client's confidential health information, including a disclosure of intimate partner violence, may be shared internally within the clinic and externally (external agencies). This form may be revised as your clinic, but will remain in effect until the released expiration date. This form must be signed by the client receiving services (additional signatures required for releases, see back).

I (the client) consent to the release of the following confidential health information, internally and externally (where noted in this agency):

<p><small>Internal Release</small></p> <p>Specific release of confidential information:</p> <p>My health information (medical records): <small>Name (if necessary):</small> _____</p> <p>My disclosure of intimate partner violence: <small>Name (if necessary):</small> _____</p> <p>Both my health information and disclosure of intimate partner violence: <small>Name (if necessary):</small> _____</p> <p>I want to release both the following information: <small>Name:</small> _____</p>	<p><small>External Release</small></p> <p>Specific release of confidential information:</p> <p>My health information (medical records): <small>Name (if necessary):</small> _____</p> <p>My disclosure of intimate partner violence: <small>Name (if necessary):</small> _____</p> <p>Both my health information and disclosure of intimate partner violence: <small>Name (if necessary):</small> _____</p> <p>I want to release both the following information: <small>Name:</small> _____</p>
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Name and title of provider completing this form: _____

These periods during which release of information allows is authorized:

From: _____ To: _____

Signature of provider: _____ Date: _____

Signature of client: _____ Date: _____

See Office Use Only

Date in which this release was completed: _____

Date in which this release was completed: _____

(COMPLETE BACK FOR REFERRAL TO EXTERNAL AGENCY)

Page 2:

Complete the following sections if making a client referral to an external agency.

Name and contact information of agency receiving the client referral:

Name (if known): _____ Address (if known): _____

If information to be released to this agency is 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:** _____

Provider Tools for Making Referrals

Community Resource Chart

Consider developing a resource list specific to the region. The document should have the following details for each resource listed:

- Name of the organization;
- Address and telephone number for the organization;
- Type of services provided;
- Cost associated with services provided; and,
- If possible, contact information for an individual within the organization.

Community Resource Guide						
Type of Service	Name of Organization or Services Offered	Cost of Services	Service Days & Hours	Obtaining Services	Location of Service	Policy on Confidentiality
Legal Services	National Council on Crime and Delinquency 1000 17th Street, NW Washington, DC 20036-1001	Free	Monday-Friday, 9:00 AM-5:00 PM	Call to schedule an appointment	National	Confidentiality
Example						

Provider Tools for Making Referrals

Consider also developing a resource and service map. This way, you can give the client some perspective on where the referral agency is located.



Example

LAST STEP:

Schedule a Follow-up Visit for the Client

A proper “goodbye” is just as important as a proper “hello.” Schedule a follow-up visit with the client.

Ask the client if they have any final questions for you.

Thank the client for coming to the clinic, and for being investing in their own health care. Share that you enjoyed your time together and that you look forward to seeing them at their next visit.

HANDOUT X.2: OBSERVATION GUIDE: EVALUATION OF PROVIDER'S SKILLS FOR INTEGRATING IPV SERVICES

Instructions: Evaluate the performance of the providing in implementing each task or activity, using the following codes:

1 = Need improvement 2 = Adequate 3 = Competent 4 = Not applicable

Name of Provider: _____ Date: _____

Name of Observer: _____ Site: _____

TASK/ACTIVITY	1 NEED IMPROVE.	2 ADEQUATE	3 COMPETENT	4 NOT APPLICABLE
General skills and establishment of positive client-provider interaction				
Demonstrate respect for the client; does not judge the client				
Shows friendliness by smiling and introducing themselves				
Ensures privacy within the interview room				
Explain client-provider confidentiality				
Uses simple and clear language				
Encourages the client to ask questions and express concerns				
Answers all of the client's questions				
Does not interrupt the client unless absolutely necessary				

TASK/ACTIVITY	1 NEED IMPROVE.	2 ADEQUATE	3 COMPETENT	4 NOT APPLICABLE
Integrating IPV services during family planning interview				
Explains the purpose for screening clients for IPV (impact of IPV of FP decisions)				
Conducts the screening using the screening questions				
Assists the client in making a family planning decision that takes into consideration the IPV the client is experiencing				
Explains the concept of a safety plan (cannot prevent violence, but can reduce the harm)				
Offers to assist the client in developing a personalized safety plan				
Explains the community based referral services to the client				
Offers to provide the client with a referral to a community based organization for follow up services related to IPV				

TASK/ACTIVITY	1 NEED IMPROVE.	2 ADEQUATE	3 COMPETENT	4 NOT APPLICABLE
Provider skill: Counseling				
Practices active listening and paraphrasing				
Validates and educates the client on IPV				
Responds to clients emotions with compassion and conveys empathy				
Provider conveys that IPV is not the fault of the client				
Provider uses simple and clear language when talking about IPV				
Explain to client the impact IPV can have on family planning decisions				
Assists the client in choosing a family planning method that takes into consideration the IPV the client is experiencing				
Uses clear and simple language				

TASK/ACTIVITY	1 NEED IMPROVE.	2 ADEQUATE	3 COMPETENT	4 NOT APPLICABLE
Provider skill: Safety planning				
Explains the purpose of safety planning				
Engages the client in a conversation about safety planning				
Uses clear and simple language				

TASK/ACTIVITY	1 NEED IMPROVE.	2 ADEQUATE	3 COMPETENT	4 NOT APPLICABLE
Provider skill: Referrals				
Explains the community based services available to clients experiencing IPV				
Offers to make a referral to a community based organization				
Explains the need to disclose confidential information to a referral organization				
Has the client sign the confidentiality release form				

TASK/ACTIVITY	1 NEED IMPROVE.	2 ADEQUATE	3 COMPETENT	4 NOT APPLICABLE
Provider skill: Documentation				
Asks the client for permission to document their experience of IPV on the documentation form				
Explains the storing of documentation forms (in a separate place from medical file)				
Completes the form in its entirety (as allowed by the client)				
Stores the form in its appropriate, assigned location				

TRAINING DAY 5

HANDOUT X.3: PACKET—IPV-FP FORMS AND PROVIDER TOOLS

INTIMATE PARTNER VIOLENCE SCREENING AND DOCUMENTATION TOOL

Date _____ Client ID# _____ **yes** **no** IPV confirmed by patient
 Patient Name _____ **yes** **no** IPV suspected but not confirmed
 Provider Name _____

SCREENING QUESTION	TYPE OF VIOLENCE	CLIENT RESPONSE			OFFERING OF SAFETY PLANNING MEASURES
		NO	YES	<i>If yes, indicate approximate date of last incident (DoLI).</i>	
Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?	Psychological Abuse			DoLI:	At the provider's discretion.
Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimidated, embarrassed or ashamed?	Psychological Abuse			DoLI:	At the provider's discretion.
Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?	Sexual Abuse, emphasis on Sexual and Reproductive			DoLI:	Yes.
Has your partner ever made you to participate in or do things you don't want to do sexually?	Sexual Abuse			DoLI:	Yes. Especially, if incident occurred in the last 12 months.
Has your partner ever used a part of his body or another object to hurt you physically? (Examples may include: scratch, hit, slap, kick, punch, squeeze, pin down, strike with object etc.)	Physical and Psychological Abuse			DoLI:	Yes. Especially, if incident occurred in the last 12 months.

Report: With the client's permission, record notes client's account of physical, emotional or sexual abuse.

Provider Evaluation

Special Considerations for Family Planning (chosen method and reason for chosen method)

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

Physical Findings of IPV: Describe any visual injuries.

Special Considerations for Reproductive Health Services (additional services needed as a result of IPV)
 yes **no** Risk of STIs—including HIV) was explained to client
 yes **no** Screening for STIs was offered to client
 yes **no** Screening for STIs was completed

Notes: _____

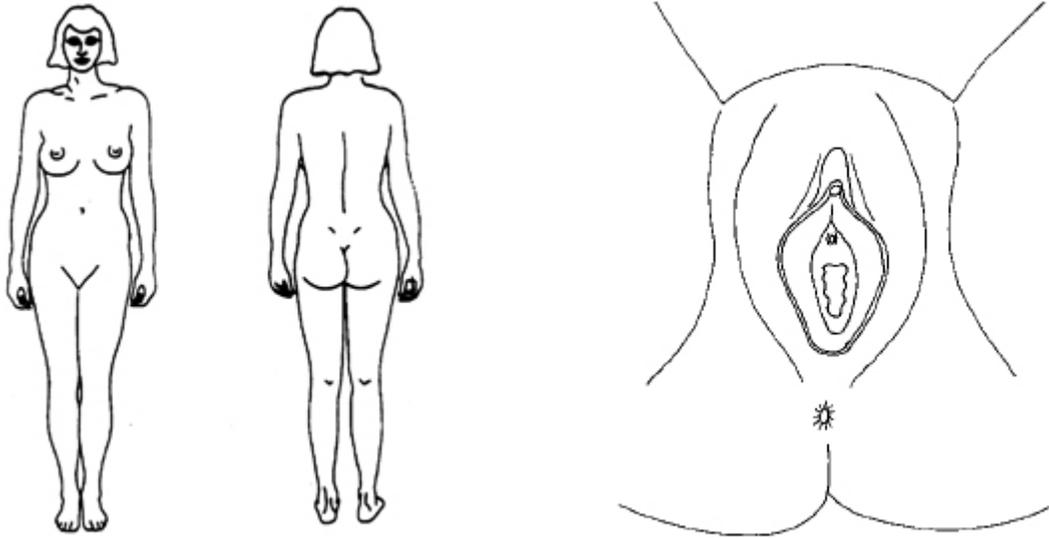
Referrals Provided to Client
 yes **no** Referred to [insert advocacy organization]
 yes **no** Referred to [insert legal organization]
 yes **no** Referred to [insert medical facility]
 yes **no** Referred to [insert internal source]
 yes **no** Referred to _____
 yes **no** Follow-up appointment scheduled for _____

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

SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS

VISUAL SCAN—Physical Finding of IPV: Ask the client if they have physical injuries that they would like the provider to record on the body map.

Note: This is not a forensic exam, rather, a visual scan of the body. Indicate in the referral section if the client requests and/or opts for a forensic exam referral.



	TENDERNESS	CONTUSION	ABRASION	LACERATION	BLEEDING
Head					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulder					
Arms					
Hands					
Chest					
Breasts					
Back					
Abdomen					
Genitals					
Anus					
Buttocks					
Legs					
Feet					

Provider Tool for Safety Planning with Clients Experiencing Intimate Partner Violence

Safety planning is a tool that can be used with clients experiencing intimate partner violence. While safety planning will not prevent the violence that is being perpetrated against the client, safety planning can increase the sense of control a client has over her life by helping her to identify ways to potentially avoid harm and/or what to do during an act of violence.

Understanding the level of danger in which the client is living, will help the provider and client think through what her options may be. The danger measures listed below align with the screening questions pertaining to sexual and physical violence, and tactics used to control a client's sexual and reproductive health. If the client has confirmed her experience with the indicated danger measures, the provider is to utilize their counseling skills to introduce the idea of safety planning to the client, then offer to help the client identify safety planning opportunities. If the client accepts the provider's offer, the provider may incorporate the suggested talking points to help guide the conversation.

The provider should infuse the safety planning conversation with supportive statements, which acknowledge client's strength and her ability to regain her sense of power and control.

DANGER MEASURE	NO	YES	If yes, then offer to safety plan.
1. Has the violence perpetrated against the client increased over the last 12 months?			
2. Does the abusive partner deny the client her the right to control her sexual and reproductive health (i.e. Deny or sabotage family planning methods, deny her access to care and treatment, force pregnancy and/or termination, etc.)?			
3. Does the abusive partner force the client to perform sexual acts against her will?			
4. Does the abusive partner use physical force to cause pain and/or injury?			
Each measure indicates a high risk for danger. The more measures the client confirms, the higher her risk of danger.			

EXAMPLES FOR INTRODUCING SAFETY PLANNING USING COUNSELING SKILLS

Counseling Skill: Active Listening And Paraphrasing	Counseling Skill: Validating And Educating
<p>Definition Listening closely in order to restate the client's message simply and in your own words</p> <p>Purpose Conveys a vested interest in, and comprehension of, what the other person is saying. Summarizes or clarifies what that person is trying to say.</p>	<p>Definition Acknowledging and confirming what was said, followed by additional information that supports what is said, or corrects any misinformation that was shared.</p> <p>Purpose Conveys nonjudgmental support, provokes thought and attempts to spark additional conversation. Seeks to eliminate any perception that IPV is justified or that it should be condoned.</p>

EXAMPLES FOR INTRODUCING SAFETY PLANNING USING COUNSELING SKILLS *continued*

Suggestions For Introducing Safety Planning To The Client	Suggestions For Introducing Safety Planning To The Client
<ul style="list-style-type: none"> • “I think I heard you say _____ is that accurate?” • “It sounds to me like you are doing _____ already, to help reduce the harm you’re experiencing. Is that accurate?” • “I’m hearing you say _____. Would it be okay if we focused on that for a moment, and look at the safety plan to see how we might address that?” 	<ul style="list-style-type: none"> • “I heard you say _____. Is it okay if I share with you what I know about this type of experience? I also think we might be able to address this in your safety plan. May I also share that information with you?” • “You share with me that you are experiencing _____. I want you to know that that particular experience is quite common among my other clients in similar situations. May I share with you some of the ways in which my other clients have safety planned around this issue?”

Suggested Talking Points For Safety Planning

- ▶ Would you like to discuss things you can do to protect yourself as much as possible? (Including discussing what you already do and what you feel you can do to be safer)
- ▶ Have you confided in anyone about what you have been experiencing? Is there anyone you would feel comfortable speaking to about this? You deserve the support.
- ▶ What do those people do to support you or what can they do to support you? Is there a way you could alert them that you are in danger if you needed to?
- ▶ Should your partner threaten your physical safety, might you be able to move the argument to an area in your home that may be safer than other areas? What might be those safer spots? (Avoid: bathrooms, small spaces, standing next to a window, the kitchen or other areas with potential weapons, attempt to put a large object between abuser and self.)
- ▶ What have you done or can you do to deescalate a situation with your partner? What have you done or can you do to protect yourself during an outburst by your partner?
- ▶ If you have children, what have you done and can you do to help keep them safer? (Examples: speak to them about your partner’s behavior, develop a signal for when you or they might be in danger, discuss where they can go for help, etc.).
- ▶ If you need to leave your home, can you identify at least two locations where you might go?
- ▶ If you do leave your home, what important items will you need to take with you? (Examples: money, identification, contact numbers/addresses, cellular phone, court/legal papers, etc.)
- ▶ Would you like to discuss how you might safe guard your family planning desire? (Examples: Choosing a method that is not easily detectable, hiding the chosen method, etc.)
- ▶ You may always come to the clinic if you need assistance dealing with this abuse and its consequences. We will help you to the best of our ability and/or find a referral for someone who can assist you.

EXAMPLES FOR INTRODUCING SAFETY PLANNING USING COUNSELING SKILLS *continued*

Supportive Statements To Be Shared With Clients

- I'm sorry this is happening to you.
- This is not your fault. There is nothing you have done wrong to be treated in this way.
- No one deserves to be treated in this way.
- Violence is never justified between two people who are supposed to love one another.
- If, at any point, you do not want to talk about this anymore, please do tell me. I won't be upset. I want you to help lead the direction of this conversation.
- Thank you for trusting me with this information.
- The information you are sharing with me is very important, and we will take that into consideration when we are addressing your FP needs and desires.
- What you're experiencing is very common among women. I have worked with many clients who been in similar situations. You are not alone.
- I want you to know that while you are here, you are in control of what happens.
- I want you to feel safe while you are here at the clinic. Is there anything we can do to help you feel more comfortable?
- You only have to share as much as you want to share.
- Your thoughts, needs and opinions matter to me.
- I want to help you do what you think is best for you.
- I think you're a strong and brave person.
- I am concerned about you, and care about what happens to you.
- If it is okay with you, I would like to discuss how these experiences might impact your FP decisions and goals.
- I want you to know that there are services available for women who are experiencing similar things as you.
- I am concerned about your safety and wellbeing. If you would like, together we can discuss how you might keep yourself safer from the harm you are experiencing.
- While my expertise is in FP, I do have knowledge and information on what you are experiencing. If you would like, we can spend a few minutes discussing your experiences.
- I trust that you know what is best for you. I will do as you would like me to do.
- What you're feeling is a normal reaction to this kind of harm. Many women have the same reaction.

INTERNAL AND EXTERNAL CONFIDENTIALITY RELEASE FORM

This form defines the release parameters for which a client's confidential health information, including a disclosure of intimate partner violence, may be shared internally (within the clinic) and externally (referral agencies). This form may be voided at any time, but will remain in effect until the indicated expiration date. This form must be signed by the client receiving services (additional signature required for referral, see back).

I (the client) consent to the release of the following confidential health information, internally and externally (please check all that apply):		
Consent to release information <i>internally</i> (within the clinic)	Consent to release information <i>externally</i> (for the purposes of a referral)	Specific element of confidential information.
		My health information (medical record). Notes (if necessary): _____ _____ _____
		My disclosure of intimate partner violence. Notes (if necessary): _____ _____ _____
		Both, my health information and disclosure of intimate partner violence. Notes (if necessary): _____ _____ _____
		I want to release <i>only the following information</i>: Notes: _____ _____ _____

Name and title of provider completing this form: _____

Name of client: _____

Time period during which release of information above is authorized: From _____ To _____

Signature of provider: _____ Date: _____

Signature of client: _____ Date: _____

(COMPLETE BACK FOR REFERRAL TO EXTERNAL AGENCY)

Complete the following sections if making a client referral to an external agency.

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 *limited* to specific individuals at the agency, please specify:

Name and title of provider completing the referral: _____

Name of client whose information is being released: _____

Reason for release of information: _____

Time period during which release of information above 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: _____

PROVIDER TOOL: MESSAGES TO CONVEY TO CLIENTS EXPERIENCING INTIMATE PARTNER VIOLENCE

1. I'm sorry this is happening to you.
2. This is not your fault. There is nothing you have done wrong to be treated in this way.
3. No one deserves to be treated in this way.
4. Violence is never justified between two people who are supposed to love one another.
5. If, at any point, you do not want to talk about this anymore, please do tell me. I won't be upset. I want you to help lead the direction of this conversation.
6. Thank you for trusting me with this information.
7. The information you are sharing with me is very important, and we will take that into consideration when we are addressing your FP needs and desires.
8. What you're experiencing is very common among women. I have worked with many clients who been in similar situations. You are not alone.
9. I want you to know that while you are here, you are in control of what happens.
10. I want you to feel safe while you are here at the clinic. Is there anything we can do to help you feel more comfortable?
11. You only have to share as much as you want to share.
12. Your thoughts, needs and opinions matter to me.
13. I want to help you do what you think is best for you.
14. I think you're a strong and brave person.
15. I am concerned about you, and care about what happens to you.
16. If it is okay with you, I would like to discuss how these experiences might impact your FP decisions and goals.
17. I want you to know that there are services available for women who are experiencing similar things as you.
18. I am concerned about your safety and wellbeing. If you would like, together we can discuss how you might keep yourself safer from the harm you are experiencing.
19. While my expertise is in FP, I do have knowledge and information on what you are experiencing. If you would like, we can spend a few minutes discussing your experiences.
20. I trust that you know what is best for you. I will do as you would like me to do.
21. What you're feeling is a normal reaction to this kind of harm. Many women have the same reactions.



PERSONALIZED SAFETY PLAN²²

1. PROTECTING MY FAMILY PLANNING My partner has put my family planning and reproductive health in danger. I will use the following tactics to increase the safety of my family planning and reproductive health.	
My chosen family planning method is _____. I chose this method because I have the power to (example: administer it without him knowing): 1. _____ 2. _____ 3. _____	
I will do the following to lessen the risk of my partner sabotaging my family planning goal (example: hiding it in a safe place): 1. _____ 2. _____ 3. _____	In the event that my partner sabotages my family planning, or compromised my reproductive health, I will do the following (example: come to the clinic for assistance): 1. _____ 2. _____ 3. _____
2. SAFETY WITHIN MY HOME There are places in my home that allow me to be safer from my partner. During an incident, I will avoid unsafe places in my home, and I will try to move myself to a safer spot.	
I will try to avoid the being cornered in the following spots (example: closets, small rooms or bathrooms, etc.). The places in my home that are safer include (example: a room with a window, door or phone) • _____ • _____ • _____	I will try to avoid areas of my home where my partner has access to weapons or potential weapons (example: tool shed, etc.). • _____ • _____ • _____
If I need to escape my home quickly, the safety route to take is: • _____ • _____ • _____	If I need to leave in an emergency, or momentarily, I can go to the following places (example: to the home of my support person and/or a public place). • _____ • _____ • _____

²² This personalized safety plan was included in the piloted training in Conakry, Guinea. Following the careful monitoring and evaluation of the participants experience with using the safety plan with clients, it was suggested that the plan be modified from document form to a conversation had with the client.

3. SAFETY AT MY JOB

My partner may choose to hurt me outside of our home. If this is ever the case, I know there are things I can do to increase my sense of safety and reduce the harm my partner causes me.

<p>The safest way for me to get to and from work is:</p> <ul style="list-style-type: none">• _____• _____• _____	<p>I can talk to (or consider talking to) the following people at my job regarding the harm I am experiencing:</p> <ul style="list-style-type: none">• _____• _____• _____
<p>I will try to avoid the being cornered in the following spots (example: closets, small rooms or bathrooms, etc.).</p> <p>The places at my job that are safer include (example: a room with a window, door or phone)</p> <ul style="list-style-type: none">• _____• _____• _____	<p>I will try to avoid areas at my job where my partner has access to weapons or potential weapons (example: tool shed, etc.).</p> <ul style="list-style-type: none">• _____• _____• _____
<p>If I need to escape my job quickly, the safety route to take is:</p> <ul style="list-style-type: none">• _____• _____• _____	<p>If I need to leave in an emergency, or momentarily, I can go to the following places (example: to the home of my support person and/or a public place).</p> <ul style="list-style-type: none">• _____• _____• _____

4. SAFETY OF MY CHILDREN

I know that I cannot prevent my partner's behavior or actions, but I will try to reduce the harm it causes my children.

<p>I can (or will plan to) talk to my children about the following aspects of my partner's behavior and/or actions:</p> <ul style="list-style-type: none">• _____• _____• _____	<p>I will create a safe space for my children to retreat to during an incident. The following places in my home would be a safe place for my children (example: bedroom, closet, just outside the home, etc.)</p> <ul style="list-style-type: none">• _____• _____• _____
<p>I can develop a "code word" (a secret word) with my children. I will use the code word to alert them that I am in danger, and that they should run for help. Our code word is (or will be):</p> <ul style="list-style-type: none">• _____	<p>I will teach my children how to escape our home quickly. The following is the safest way for them to leave is:</p> <ul style="list-style-type: none">• _____• _____• _____

<p>If my children need to escape, this is where they should go for help:</p> <ul style="list-style-type: none"> • _____ • _____ • _____ 	<p>I will tell my children that they can talk to the following people if they need support and/or help with our situation:</p> <ul style="list-style-type: none"> • _____ • _____ • _____
--	--

5. INCREASING MY PHYSICAL AND EMOTIONAL WELLBEING
 I know that I cannot prevent my partner's behavior or actions, but I will try to reduce the harm it might cause me.

<p>I know the following things cause my partner to become angry:</p> <ul style="list-style-type: none"> • _____ • _____ • _____ 	<p>I know that I cannot prevent an outburst from my partner, but I have used the following tactics in the past to de-escalate his behavior.</p> <ul style="list-style-type: none"> • _____ • _____ • _____
--	---

<p>I have done (or can do) the following things in the past to increase my physical and emotional safety during my partner's outburst.</p> <ul style="list-style-type: none"> • _____ • _____ • _____ 	<p>I have done (or can do) the following things following things to care for myself following my partner's outburst:</p> <ul style="list-style-type: none"> • _____ • _____ • _____
--	--

6. REMEMBERING MY WORTH AS A PERSON
 I recognize that my partner's behavior and actions impact the way I feel about myself. When I'm feeling badly, I will consider doing the following things:

<p>Remind myself of three things I like about myself:</p> <ul style="list-style-type: none"> • _____ • _____ • _____ 	<p>Remind myself of three things other people like about me:</p> <ul style="list-style-type: none"> • _____ • _____ • _____
---	--

<p>Engage in an activity that distracts me from my feelings, including:</p> <ul style="list-style-type: none"> • _____ • _____ • _____ 	<p>Contacting one of my support people:</p> <ul style="list-style-type: none"> • _____ • _____ • _____
---	---

6. REMEMBERING MY WORTH AS A PERSON

I recognize that my partner's behavior and actions impact the way I feel about myself. When I'm feeling badly, I will consider doing the following things:

Remind myself of three things I like about myself:

- _____
- _____
- _____

Remind myself of three things other people like about me:

- _____
- _____
- _____

Engage in an activity that distracts me from my feelings, including:

- _____
- _____
- _____

Contacting one of my support people:

- _____
- _____
- _____

7. IDENTIFYING PEOPLE WHO CARE ABOUT ME AND HOW THEY CAN HELP ME

I know there are people in my life who care about me and love me. They could help support me through this process if they knew what was happening to me.

Right now, I feel safe telling _____
_____ about my experience.

While I may not be ready to tell them about my experience yet, I feel like the following people would support me if they knew what was happening to me:

- _____
- _____
- _____

These are the things my support people can do to make me feel safer and cared for:

- _____
- _____
- _____

I can develop a "code word" (a secret word) with my support people if I need help immediately. I will use the code word to alert them that I am in danger. My code word is (or will be)

- _____

8. PLANNING TO LEAVE PERMENANTY OR FOR AN EXTENDED PERIOD OF TIME

I understand that if I decide to leave my partner, my risk of danger will increase. Therefore, I will take steps to ensure that I am adequately prepared for the time.

If I need to leave for a long period of time, this is where I might go:

- _____
- _____
- _____

If I need to leave for a long period of time, this is who I will tell:

- _____
- _____
- _____

If I need to leave for a long period of time, I will take the following items with me:

- Work ID/work permit
- Birth certificate
- Passport or ID card
- Green card, visa, or other immigration papers
- Copies of any restraining order, if you have obtained one
- Children's identification/records
- School and vaccination records (self and children)
- Marriage license or divorce papers
- Medical records
- Court documents, if any
- List of possible service organizations
- List of friends' and family's addresses and phone numbers
- Cell phone
- Money

If I need to leave for a long period of time, I will take the following additional things with me:

- _____
- _____
- _____

9. LIST OF IMPORTANT PHONE NUMBERS AND ADDRESSES

I am not alone. I understand that there are professionals, friends and family who are willing to help me.

Contact information for my support people:

Name: _____

Address: _____

Telephone #: _____

Other important contact information (example: clinic, children's school, pharmacy, etc.).

Name: _____

Address: _____

Telephone #: _____

If I need to leave for a long period of time, I will take the following items with me:

- Work ID/work permit
- Birth certificate
- Passport or ID card
- Green card, visa, or other immigration papers
- Copies of any restraining order, if you have obtained one
- Children's identification/records
- School and vaccination records (self and children)
- Marriage license or divorce papers
- Medical records
- Court documents, if any
- List of possible service organizations
- List of friends' and family's addresses and phone numbers
- Cell phone
- Money

If I need to leave for a long period of time, I will take the following additional things with me:

- _____
- _____
- _____



440 Ninth Avenue
New York, NY 10001
info@engenderhealth.org
Tel: 1-800-564-2872 or 212-561-8000
Fax: 212-561-8067

