

Caring for women subjected to violence: A WHO curriculum for training health-care providers



**World Health
Organization**

Caring for women subjected to violence: a WHO curriculum for training health-care providers

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Facilitator's Guide



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Purpose and overview

Violence against women, including intimate partner violence and sexual violence, is pervasive globally and leads to significant physical and mental health problems. Thus, it is a public health issue that demands a concerted response from health-care providers and health systems worldwide. The World Health Organization (WHO) has developed guidelines for the health-care sector: *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (2013) and an accompanying clinical handbook *Health care for women subjected to intimate partner violence or sexual violence: clinical handbook* (2014). This in-service curriculum, based on these documents, aims to provide health-care providers with the knowledge and basic skills to implement the WHO recommendations in their clinical practice. Training providers is key to improving the health system's response to violence against women.

First-line support

L Listen,
I Inquire
V Validate
E Enhance safety
S Support

This curriculum is designed to provide health-care providers, particularly in low- and middle-income countries, with a foundation for responding to domestic/ intimate partner violence and sexual violence

against women. The curriculum seeks to build skills and to address providers' attitudes towards survivors of violence. Participants will learn how to provide women-centred clinical care, including identifying women experiencing violence, providing first-line support through the LIVES approach (Listen, Inquire, Validate, Enhance safety and Support), providing essential clinical care for survivors, and identifying local support resources. They will learn to reflect on their own attitudes and understand survivors' experience. The curriculum emphasizes compassionate, empathic provider–patient communication.

This curriculum is based on WHO's clinical handbook. Participants and facilitators are advised to keep the handbook handy for reference throughout the training.

Training is an important component of an overarching health system response to violence against women. Health services managers and health policy-makers

also have responsibility for strengthening planning, coordination and human resource management; establishing policies and protocols; and monitoring and evaluating the provision of care to survivors of violence. Managers and policy-makers are advised to consult *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers* (WHO, 2017) for comprehensive guidance on improving health system readiness.

The clinical guidelines on which this training is based do not specifically address children, adolescent girls (under age 18) or men. Nonetheless, actions described may also be valuable for these population. They also apply to domestic violence more broadly – that is, violence by family members other than an intimate partner. Facilitators are encouraged to review *Responding to children and adolescents who have been sexually abused: WHO clinical guidelines* (WHO, 2017) for recommendations for a child- and adolescent-centred response.

Who is this training for?

This training curriculum is primarily designed for practising health-care providers, particularly doctors, nurses and midwives. Parts of it may also be useful to other cadres of health-care providers, including psychologists, social workers, nurse assistants, community health workers and lay counsellors.

Participant-centred learning

This curriculum uses a participant-centred approach to learning – an active, collaborative, inquiry-based approach to teaching and training. Also known as learner-centred education, participant-centred learning emphasizes that the trainee is an active participant. Participant-centred learning actively engages the trainee wherever possible, rather than relying only on facilitators. Learners actively participate in knowledge and skills development through case studies, guided discussions, participatory reflection exercises, videos and readings. This process supports critical reflection, emotional engagement, skills development and the ability to put knowledge into practice.

Aim of this training

To foster understanding of and develop the basic skills to implement the recommendations of the WHO clinical and policy guidelines and clinical handbook on responding to intimate partner violence and sexual violence against women.

The four objectives of the training

1. Demonstrate **general knowledge** of violence against women as a public health problem.
2. Demonstrate behaviours and understand values contributing to **safe and supportive services for survivors**.
3. Demonstrate **clinical skills** appropriate to one's profession and specialty to respond to violence against women.
4. Demonstrate knowledge of how to **access resources and support** for patients and for oneself.

Competency-based training

This competency-based curriculum enables development of the knowledge and skills to provide comprehensive, high-quality care to women who are subjected to intimate partner violence or sexual violence. Each session supports one of four objectives (see box) while fostering unique competencies. Table 1 presents the titles and competencies of the training sessions. The objectives and capacities for this training were defined through an expert review process.

Table 1. Sessions, objectives and competencies

No.	Session, objective, competencies
1	Understanding violence against women as a public health problem <i>Objective 1.</i> Demonstrate general knowledge of violence against women as a public health problem <i>Competencies:</i> ■ Know the epidemiology of the different forms of violence against women at global and local levels. ■ Know the health consequences of violence against women. ■ Understand the role and limitations of health-care providers in responding to violence against women. ■ Know about the WHO clinical and policy guidelines and clinical handbook on responding to intimate partner violence and sexual violence against women.
2	Understanding the survivor's experience and how providers' values and beliefs affect the care they give <i>Objective 2.</i> Demonstrate behaviours and understand values contributing to safe and supportive services <i>Competencies:</i> ■ Demonstrate self-awareness of one's beliefs, assumptions, potential biases and emotional responses that can affect interactions with survivors of violence against women. ■ Understand the circumstances and the barriers that women experiencing violence face when seeking support. ■ Recognize the importance of having empathy with survivors.
3	Guiding principles and overview of the health response to violence against women <i>Objective 2:</i> Demonstrate behaviours and understand values contributing to safe and supportive services <i>Competencies:</i> ■ Know the guiding principles of providing woman-centred care in a culturally appropriate way. ■ Understand how to apply the guiding principles for women-centred care in your practice.

No.	Session, objective, competencies
4	Provider–survivor communication skills <i>Objective 2:</i> Demonstrate behaviours and understand values contributing to safe and supportive services <i>Competency:</i> ■ Communicate empathically and effectively with patients/survivors.
5	When and how to identify intimate partner violence <i>Objective 3:</i> Demonstrate clinical skills appropriate to one’s profession and specialty to respond to violence against women <i>Competencies:</i> ■ Understand the minimum standards that need to be met to enquire about and respond appropriately to violence against women. ■ Recognize the signs and symptoms that suggest intimate partner violence. ■ Understand when and how to ask about intimate partner violence. ■ Demonstrate appropriate ways to ask about intimate partner violence.
6	First-line support using LIV(ES), part 1: <u>L</u>isten, <u>I</u>nquire, <u>V</u>alidate <i>Objective 3:</i> Demonstrate clinical skills appropriate to one’s profession and specialty to respond to violence against women <i>Competencies:</i> ■ Know the content of first-line support (LIVES). ■ Demonstrate skills in offering the first three elements (listening, inquiring and validating) of first-line support to survivors who disclose abuse.
7	Know your setting: identify referral networks and understand the legal and policy context <i>Objective 4:</i> Demonstrate knowledge of how to access resources and support for patients and for oneself <i>Competencies:</i> ■ Understand the role of other services in caring for survivors of violence against women. ■ Know what resources are available in the community. ■ Know the legal and policy context, including health-care providers’ legal obligations, with regards to the local and national response to violence against women.
8	First-line support using (LIV)ES, part 2: <u>E</u>nhancing safety and providing <u>S</u>upport <i>Objective 3:</i> Demonstrate clinical skills appropriate to one’s profession and specialty to respond to violence against women <i>Objective 4:</i> Demonstrate knowledge of how to access resources and support for patients and for oneself <i>Competencies:</i> ■ Demonstrate the skills to assess immediate risk/safety and to support safety planning. ■ Know what resources are available in the community. ■ Know how to collaborate with partners to help survivors access other services and to provide referrals. ■ Demonstrate skills to provide warm referrals.

No.	Session, objective, competencies
9	Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination <i>Objective 3:</i> Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women <i>Competencies:</i> ■ Demonstrate skills to take a clinical history. ■ Know how to conduct an examination of a survivor of sexual assault, including rape and abuse. ■ Know when to collect forensic evidence and how to support or facilitate such evidence collection.
9a	Forensic examination (supplemental) <i>Objective 3:</i> Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women <i>Competency:</i> ■ Know when and how to collect forensic evidence.
10	Clinical care for survivors of sexual assault/rape, part 2: treatment and care <i>Objective 3:</i> Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women <i>Competency:</i> ■ Know how to provide appropriate treatment/care to survivors of sexual assault, including rape and abuse.
11	Documenting intimate partner violence and sexual violence <i>Objective 3:</i> Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women <i>Competency:</i> ■ Know how to document violence against women in a safe and confidential manner.
12	Care for mental health and self-care for providers <i>Objective 3:</i> Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women <i>Objective 4:</i> Demonstrate knowledge of how to access resources and support for patients and for oneself <i>Competencies:</i> ■ Know how to provide basic mental health care. ■ Know how to access and practise self-care.
13	Addressing family planning and HIV disclosure for women subjected to violence (supplemental) <i>Objective 3:</i> Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women <i>Competency:</i> ■ Demonstrate skills in identifying and caring for women experiencing violence who present to either family planning or HIV services.

Time requirements

The curriculum is designed for flexible implementation. The full 13 sessions are usually delivered in two and a half days, and experience suggests that this is the minimum required. However, if necessary you can cover sessions 1–12 in two days. To cover the core content adequately, a minimum of two continuous days is needed. However, additional time to practise skills is desirable, particularly for participants who are learning about this issue for the first time. If less than two days are available, you will need to adjust the content to fit the time available. We suggest covering sessions 1 through 8 to ensure that LIVES is fully covered. Additional skills-building exercises are provided in case more time is available. If the time is available, it would be best devoted to practising skills in first-line support, which is central to survivor-centred clinical care.

Alternatively, the core content can be covered by half-day sessions scheduled at regular intervals over several weeks or months. This low-dose, high-frequency approach has proved effective for training. While we recommend a minimum of 12–14 hours, if there is less time available, much can still be accomplished by keeping the focus on skills in offering first-line support. Some settings have come back for remaining or repeated sessions six months later as part of a refresher. If necessary, some skills-building can also happen within half- or one-day sessions.

Annex 1 shows the time suggested for each session, with and without supplemental content. This schedule may vary according to context and local preferences. If preferable, more time can be devoted to sessions that involve role play, including sessions 6 and 8. Care should be given to the spacing and delivery of content to ensure that participants practise and master new skills before learning more skills.

Learning is a continuous process. Refresher sessions at regular intervals (for example, annually) will help providers to consolidate and update their knowledge and skills.

Who should be trained?

The training is designed for a group setting, to harness the group experience for critical reflection and support for adaptation and implementation of content to the

Need to take this training alone?

This facilitator's guide is best used in a classroom or group setting. If you are alone, identify at least one additional trainee to do the training with you. Be sure to think through the reflection questions, either alone or with a training partner, to obtain the most from your training experience. An e-learning version will be available in mid-2020 and is meant to be self-guided.

local context and service delivery structure. Ideally, this training should be implemented with groups of different types of health-care providers from the same facility – doctors, nurses/midwives, those with administrative/supervisory responsibilities). Different providers have different roles and responsibilities in providing care and, hence, need to learn to communicate and work as a team to deliver quality care. Some trainings have also included police and other sectors.

Participatory training is more effective with small groups of participants. Ideally, 20–30 participants would be trained at a time to allow adequate time for discussions and interactive activities. However, the same content can be delivered with a larger group.

Participants from other sectors

While a large part of this training is designed specifically for health-care providers, there are sessions where it may be particularly useful to invite participants from other sectors, such as the police, judicial and social services, and organizations that work with communities. A multisectoral training can help ensure that all participants share a common understanding of what is required to meet the health-care needs of survivors in a timely way, what health-care providers can and cannot do with respect to medico-legal care, how to strengthen coordination and referrals and how to mobilize communities to support survivors.

In Annex 1 the symbol # indicates a session where participants from other sectors can be especially helpful. Plan the training venue in a way that allows space for additional participants.

This facilitator's guide

This document is a facilitator's guide to the curriculum. It provides directions on how to implement this training for maximum learning.

- Follow the facilitator's guide. This curriculum was developed with input from experts and trainers and underwent several pilot tests. It was developed keeping in mind facilitators with variable knowledge of violence against women and violence against women experts with variable knowledge of facilitation. Please follow the facilitator's guide to ensure that the main points are learned, and the recommendations are followed. Those with long experience facilitating training on the health response to violence against women will be able to use their experience to provide additional examples and insights for the learners.
- Implementation notes and tips on facilitation for trainers are included in each session. They are intended to foster active, participant-centred learning.
- Notes accompany many of the slides and provide additional information for facilitators to communicate content.
- The sessions are ordered to move systematically from building an understanding of the problem and women's context through cumulative skills-building. This structure makes depth possible and reinforces the application of knowledge and skills learned in earlier sessions.
- The sessions are structured so that facilitators can:
 - deliver key content and information clearly and concisely
 - facilitate participatory learning through a range of interactive methods (for example, role plays, video demonstrations, group discussions, brainstorming)
 - facilitate participants' critical reflections on key learnings through guided discussions
 - summarize key messages for each session.

Getting started

Who should facilitate?

The best facilitators for this training will have a combination of the following:

- a clinical background (doctor, nurse, psychologist, counsellor)
- experience providing health care to women survivors of violence
- experience in training, including leading interactive discussions.

Two facilitators are recommended.

- Facilitators should alternate the lead and support roles described below to minimize fatigue and provide participants with variety in presentation styles.
- If possible, at least one co-facilitator should represent a relevant local health facility to support institutional buy-in and allow setting-specific discussion of material, concepts and resources.
- In some cases a single experienced facilitator can lead the entire training. If there are other experienced people in the group, they could be invited to play the support role.

Lead facilitator's role

- Lead presentations of content and discussion
- Circulate through the room during group work to monitor and provide feedback.

Support facilitator's role

- Monitor time
- Circulate microphone to participants as needed
- Distribute case examples or written materials as needed
- Identify questions in the group
- Provide an additional perspective on questions raised in the group
- Circulate through the room during group work to monitor and provide feedback on activities.

Preparing for the training

The checklist in Table 2 can help you prepare to conduct the training.

Table 2. Preparation checklist

Know your trainees	■ Know your participants. Know the background and current job responsibilities of participants and, if they are members of a team, their roles on the team. ■ Acknowledge that some aspects of the content may be distressing for participants who have experienced violence in their own lives (see tips in Annex 3).
Space, supplies and equipment	■ Meeting space and equipment. If possible, find a space where you can use equipment such as audiovisual aids. Equipment may include: ■ computer ■ projector ■ white board ■ microphone with adequate speakers/sound system if the size of the room requires it. ■ Provide a place to go. Find an additional room or other space where participants can go if they feel uncomfortable. There may be survivors of violence participating, and they may need to excuse themselves from time to time. ■ Set up ahead. Arrange the room before the course begins, and check equipment. ■ Provide tables. Set up the room with tables in small groups (6–8 persons) to allow maximum participation and discussion. Do not set up the room in lecture style with rows of chairs.
Schedule, invite guests	■ Develop a schedule. Table 1 proposes the order of sessions, but the schedule can be modified based on available time, type and experience of participants and supplemental activities. ■ Allow time. If you need to change the suggested schedule, review the facilitator's guide to ensure that sufficient time is allotted for discussions, exercises and breaks. ■ Invite guests. Consider if, when and how guests will be included as speakers or learners. See section on invited guests, next page. ■ Award certificates? Decide whether to award completion certificates. See the section on certificate distribution or ceremony (Annex 6, p. 90).
Facilitator preparation	■ Materials. In advance, review all training materials, including facilitator's guide, slides, slide notes and handouts. For each session this facilitator's guide details key points to make. Questions and probing points for semi-structured discussion are provided. Give special attention to the step-by-step instructions for each activity. ■ Facilitators' roles. Review and agree on roles and responsibilities in each session. ■ Essential reminders and tips. Review the essential reminders, Table 3, and tips for effective training, Annex 2.
Prepare the materials and supplies	■ Prepare the participants' reading materials and handouts (Annex 3). ■ Provide the clinical handbook and other WHO resource materials ahead of time. Have other materials ready to distribute at each session. ■ Print the reading materials and handouts to be distributed in hard copy. Copy onto USB keys any files to be distributed electronically. These keys can also be used for documenting any group work assignments. ■ Gather supplies (Annex 4).

Make the training relevant to your setting	■ Adapt training materials to the local context as necessary. For example, case studies, names of characters in story cards and role plays and visuals should all be adapted to local context. ■ Review terminology in the facilitator's guide and the slides to ensure that terms suit the local context or modify as needed. ■ Consider adding a slide with country/regional data on violence against women to Session 1 (slide 10). ■ Review the legal and policy context, including laws and policies and protocols, regarding violence against women at the health setting that is hosting the training. These will be reviewed in Session 7. For example, a. Is there a protocol/standard operating procedure for service provision? b. Does the health information system have provisions for documenting violence – for example, facility registers or intake forms? c. What laws and policies affect confidentiality, reporting obligations and who can provide care or perform specific procedures? d. What, if any, are the circumstances under which abortion can be offered/provided? e. What, if any, are restrictions on providing treatment based on the age of the survivor or type of treatment? f. Which documentation form is used for cases of sexual assault including forensic examination? ■ Map support services (use the referral chart job aid in the clinical handbook as a reference). ■ Identify at least one support resource to mention at the beginning of the orientation session that participants could use if needed during training. ■ Consider showing videos and websites that take into account the safety of the participants, are culturally appropriate and do not involve inappropriate imagery.
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Guest speakers and resource persons

This training can be enhanced with additional invited guest speakers or resource persons or participants from other sectors.

Invited guest speakers can provide clarity on topics that may be beyond the expertise of the primary facilitators. Review with any guest speakers the learning objectives and competencies for the session that they will contribute to.

You can invite, for example:

- a provider or advocate who works with survivors of violence providing other types of services (for example, counselling, legal advice, shelter) to discuss what services are available and ways to strengthen referrals (see Session 7)

- a legal expert to talk about the laws pertaining to violence against women and the legal obligations of health-care providers (see Session 7)
- a representative of a non-governmental organization (NGO) or women's organization that provides information to survivors about their rights and options for legal recourse (see Session 7).

Policy-makers

Senior policy-makers or health-care managers can play an important role by demonstrating political commitment to the response to violence against women in the health sector and inspiring health-care providers.

Policy-makers can be asked to address the group about existing policies, programmes and budgets relevant to health care for survivors of violence.

Table 3. Essential reminders while training on care for violence against women

Self-determination: the choice of the survivor is central. ■ Patient/survivor preferences and needs should guide the provision of all care. Whenever possible, remind participants that we trust the survivor to know what is best for herself and her situation.
Be vigilant about identifying and responding to victim-blaming. ■ Make clear that violence is never a woman's fault.
Terminology matters. ■ This curriculum uses the term "survivor" rather than "victim" to indicate that the person who has experienced violence has agency, autonomy and choice and to mitigate stigma.
What about violence against men? ■ The issue of violence against men often comes up in discussion. Clarify that: ■ Evidence shows that the forms and nature of violence faced by women and by men are different. ■ Violence faced by women is rooted in unequal gender power relations and is more likely to come from a close male partner or other family member (or within other trusted relationships) and to be hidden. ■ Skills learned in this training – particularly survivor-centred response and first-line support – can be useful for responding to male survivors.
What about children? ■ Violence against children and adolescents may also come up in discussion. Sessions 9 and 10, on clinical care for sexual assault, cover specific considerations for children and adolescents.

Sessions

Orientation and introductions

Preparation and general information	
Session length 	60–80 minutes
Training techniques 	Exercise: Fear and Motivations in a Hat ¹ (30 minutes)
Facilitator materials 	■ Copies of pre-training survey (optional) ■ Flip chart/large pieces of paper ■ Hat, bowl or basket (for Fear and Motivations in a Hat exercise) ■ Sticky notes or note cards and tape ■ Pens
Session content	
Pre-training survey (optional) (20 minutes) 	Provide pre-training survey for participants to complete, if using survey as part of training evaluation.
Introductions (10 minutes) 	Introduce yourself and other facilitators and resource persons, and briefly describe your backgrounds. Explain that we will begin with participant introductions and a brief discussion of the learning objectives for the training. Invite participants to form pairs with their neighbours. Ask the pairs to take 2–3 minutes to introduce themselves to their partners (that is, their name, what the name means or signifies in their culture, their clinical role and institutional affiliation). In plenary, depending on the number of participants and the time available, ask 3–4 pairs to introduce their partners to the rest of the group (1 minute per pair). <i>Note: Even if participants already know each other well, this exercise to facilitate introductions is a useful icebreaker. Also, it gives the facilitator an opportunity to become</i>

Adapted from Kelsey Hegarty's "Fear in a Hat."

familiar with the participants. This is just an example, and you are encouraged to find other creative ways to facilitate participant introductions as appropriate in your context.

Present the overall learning objectives for the training (5 minutes)



As a result of this training, participants will be able to (slide 2):

- **Objective 1:** Demonstrate general knowledge of violence against women as a public health problem
- **Objective 2:** Demonstrate behaviours and understand values contributing to safe and supportive services
- **Objective 3:** Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women
- **Objective 4:** Demonstrate knowledge of how to access resources and support for patients and for oneself

Presentation of the agenda and logistics (15 minutes)



Training overview (slide 3)

Review the agenda.

Housekeeping. Orient trainees to the training space (for example, restroom location, safe/quiet space and other logistics).

Expectations. Ask participants, "What are your expectations for this training?"

Write the participants' expectations on a flip chart or large piece of paper and display it at the front of the room.

Review the list quickly so that you can refer back to it throughout the training. If any topics come up that are not covered, decide whether they can be reviewed within the planned agenda or if additional or separate training time is needed.

Explain that the training format is a blend of didactic and participatory methods.

Acknowledge the presence of survivors and encourage sensitivity.

- For example: "I want to remind everyone that some of us may be survivors of violence ourselves. There may also be those who have witnessed such violence or had it happen to someone close to them. This is a reminder to all of us to be sensitive to those experiences during our time together."

Explain that some of the material presented may be triggering to participants who have experienced violence. Tell participants that they can step out if they are uncomfortable. Encourage them to engage in self-care as needed.

Write down on a board or flip chart at least one resource that is available for survivors during the training and encourage its use should they need it.

Ground rules. Explain that it is important to establish a set of ground rules for training.

Ask people to suggest ground rules for the training. Write them on a flip chart.

Probe for and add anything missing from this list (slide 4):

- Timeliness – both in attendance and in expressing your point of view
- Learn and work together
 - Contribute to meeting the objectives – participate actively, record workshop outputs, volunteer to lead/facilitate exercises
- Respect each other
 - Listen with an open mind
 - Let everyone participate
 - Express disagreements respectfully
 - Give feedback in a constructive way (starting with the positive)
 - Do not interrupt when people are talking
- Safe space
 - Respect confidentiality. Any personal information shared stays in the room
- Be present
 - Only use electronic devices such as mobile phones or laptops for emergencies.

Explain that these ground rules will govern the training and that additional suggestions can be made as the training progresses.

Exercise: Fear and Motivations in a Hat (30 minutes)



Learning objectives for the exercise (slide 5)

- To acknowledge and understand providers' concerns about caring for survivors of intimate partner and sexual violence
- To build on providers' motivations and strengths in addressing intimate partner and sexual violence.

Instructions for facilitators (slide 6)

- **Give** each participant two pieces of paper.
- **Put out** two hats or boxes for participants to put their notes in. Label one "Fears" and the other "Motivations".
- **Ask** participants to write:
 - on one piece of paper something that motivates them to respond to intimate partner or sexual violence
 - on a second piece of paper one fear that they have about responding to intimate partner or sexual violence.
- **Ask** the participants to fold the pieces of paper and put them in the hats – fears in one, motivations in the other.
- **Randomly pick out** a response from the "fears" hat and read it to the group. Discuss the fear with the participants and ask how such a fear can be overcome.
- Do this two or three more times, depending on time.

- **Next pick out** a response from the “motivations” hat and read it to the group. Discuss the motivation with the participants and ask for suggestions of how the training can build on this.
- Do this two or three more times, depending on time.
- During a break, **stick all responses** on two separate flip charts (barriers/fears on one and motivations on the other), organized by broad themes/areas, to refer to throughout the training.

(If time permits, it is useful to include a short session towards the end of the course to revisit them, see how many were addressed throughout the training and discuss others.)

Take-away points (slide 7)

- Many providers have concerns about raising the topic of violence with their patients. They may fear that this may trigger their own memories of experiencing or witnessing abuse, or they may feel inadequate to respond to violence.
- However, data suggest that if providers raise the topic of violence with women and respond to them with empathy, this can be a source of healing for survivors.
- Many of us are passionate about providing care and ensuring health and justice for our clients. This positive energy can fuel how we apply this training in our clinical practice.

Session 1. Understanding violence against women as a public health problem

Preparation and general information

Learning objectives and competencies



Objective 1: Demonstrate general knowledge of violence against women as a public health problem.

Competencies

- Know the epidemiology of the different forms of violence against women at global and local levels.
- Know the health consequences of violence against women.
- Understand the role and limitations of health-care providers in responding to violence against women.
- Know about the WHO clinical and policy guidelines and clinical handbook on responding to intimate partner violence and sexual violence against women.

Session length



40 minutes

(Extra time may be needed for country presentations.)

Training techniques



- Video (5 minutes)
- Presentation with slides and discussion (35 minutes)

Handouts



- Violence against women: Global picture/health response
- Addressing provider barriers to responding to violence against women
- Why does the health-care provider response matter?

Session content

Background



- Violence against women is a major public health and women's health problem. It is rooted in gender inequalities. It is a human rights violation.
- Women subjected to violence have the right to the highest possible standard of health care. Health-care providers have an obligation to fulfil this right, and they are in a unique position to support women subjected to violence. They can create a safe and confidential environment for facilitating disclosure of violence and offer an empathic response, appropriate treatment and referrals to other resources and services.
- We will start by watching a short video about strengthening the health system response to violence.

**Video
(5 minutes)**



Explain that we will now present a brief (3-minute) video.

Present video from this link (slide 3):

https://www.youtube.com/watch?v=Qc_GHITvTml

**Presentation
with slides and
discussions
(35 minutes)**



Slides for Session 1 cover the following content (for details, see the slide notes in the PowerPoint file):

Definitions and forms of VAW (slides 4–6)

- Read aloud the global definition (slide 5).
- Violence against women takes many forms. Intimate partner violence (domestic violence) is the most common form worldwide (slide 6).
- Ask participants to reflect on and discuss other examples of violence not listed, and what forms of abuse are most common in their setting and recognized by their legal framework.

Prevalence of VAW (slides 7–12)

- Distribute handout *Violence against women: global picture/health response*.
- Highlight the global and regional estimates of intimate partner violence and sexual violence (slides 8–9 and handout). (Add local prevalence data, slide 10.)
- Highlight subgroups that may be at higher risk or particularly relevant to health-care providers (pregnant women, women living with HIV, women with disabilities, indigenous women and women who engage in sex work) (slide 12).

Health and socio-economic consequences of VAW (slides 13–15)

- Highlight the many short- and long-term physical and mental health consequences for women (slide 14) and for their children (slide 15).
- Describe the social and economic consequences (slide 15).

Role of health-care providers (slides 16–21)

- Providers are often seen as role models in the community and are trusted by women (slide 17).
- Women subjected to violence may have emotional needs, need for reassurance and ongoing safety concerns in addition to physical health needs (slide 18).
- The provider's role focuses on empathic support and care, and referral to other services where available (slide 19). Providers are not responsible for solving the violence or related issues or making decisions for women (slide 20).
- Ignoring violence can do harm. Thus, it is important to look at the possible consequences of provider behaviours (slide 21).

WHO tools and guidelines to assist providers (slides 22–25)

- Note WHO clinical and policy guidelines as well as clinical guidelines for responding to child and adolescent sexual abuse (slide 23),
- and two implementation tools – the clinical handbook for health-care providers (slide 24) and the health manager’s manual (slide 25).

Slides 24 and 25 on the implementation tools could be left out if time is short, as the content will be covered later.

Take-away points (slides 26–27)

- The health sector and health-care providers have a crucial role to play in identifying and supporting survivors.

Note that most topics in this session will be explored more deeply later. **Ask** if there are points that need clarification now (10 minutes).

Distribute handouts for reading after class: *Addressing provider barriers to responding to violence against women* and *Why does the health-care provider response matter?*

Wrap-up



Ask if there are any questions or concerns.

State the **key messages**:

- Violence affects women’s physical and mental health.
- Health-care providers have an important role to play in providing support and care to survivors.
- As health-care providers, we may have fears about addressing violence experienced by women who seek health services, but many of us are deeply committed to improving the health and well-being of women who seek care.
- This training is designed to build knowledge, skills and confidence to respond effectively to survivors of violence.

Session 2. Understanding the survivor's experience and how providers' values and beliefs affect the care they give

Preparation and general information

Learning objectives and competencies



Objective 2: Demonstrate behaviours and understand values contributing to safe and supportive service cultures.

Competencies

- Demonstrate self-awareness of one's beliefs, assumptions, potential biases and emotional responses that can affect interactions with survivors of violence against women.
- Understand the circumstances and the barriers that women experiencing violence face when seeking support.
- Recognize the importance of having empathy with survivors.

Session length



80–140 minutes

Training techniques



Exercise 2.1: to explore providers' values and beliefs

- Option A: Myth or Fact? (15 minutes)
- Option B: Voting with Your Feet (30 minutes)

Exercise 2.2: to understand survivors' experience

- Option A: Blanketed by Blame (45 minutes)
- Option B: In Her Shoes (75 minutes)

If 60 minutes available for the exercises, you can conduct Exercise 2.1 Option A + Exercise 2.2 Option A

If 90 minutes available for the exercises, you can conduct Exercise 2.1 Option A + Exercise 2.1 Option B + Exercise 2.2 Option A or Exercise 2.1 Option A + Exercise 2.2 Option B

If 120 minutes available for the exercises, you can conduct Exercise 2.1 Option A + Exercise 2.1 Option B + Exercise 2.2 Option B

Guided discussion (20 minutes)

- Why women do not leave (10 minutes)
- Barriers to care-seeking (10 minutes)

Facilitator materials



Exercise 2.1, Option A – Myth or Fact?

- Facilitator resource

Exercise 2.1, Option B – Voting with Your Feet

- Facilitator resource
- Two signs – one that says “agree” and another that says “disagree”

Exercise 2.2, Option A – Blanketed by Blame

- 11 shawls or newspaper sheets
- 12 character cards

Exercise 2.2, Option B – In Her Shoes (requires advance preparation)

- Facilitator instructions – also see material at: <http://raisingvoices.org/innovation/creating-methodologies/in-her-shoes/>
- 15 stations (A3 or A4 paper or coloured index cards with a destination or character written on each)
- Participant handout – story cards for each group

Handouts



- Why don't women leave?
- Barriers to seeking care

Session content

Background



Introduce the session by explaining that responding to violence against women requires understanding how, as providers, our values, beliefs and attitudes may affect how we provide care as well as our ability to empathize with survivors' experiences of seeking help. These beliefs and values are often shaped by the same societal norms that lead to stigmatizing women subjected to violence. The activities in this session help participants to critically reflect on these beliefs and values and the underlying norms that shape them by recognizing common myths and beliefs about violence against women, understanding survivors' experience of seeking help, and clarifying the way our beliefs can/may affect the care we give.

Exercise 2.1, Option A: Myth or Fact? (15 minutes)



Learning objective for the exercise

- Critically reflect on our perceptions and beliefs that affect the care we provide to survivors.

Instructions for facilitators (slide 3)

- **Explain** that you would like to spend some time exploring some common myths about violence.

- **Ask the participants** to share any local beliefs they have heard related to violence against women.
- **Read the first statement** of the facilitator's resource, "Myth or Fact?" to the group.
- **Ask the group** whether they think this is a fact or a myth. See if there is agreement within the group or not.
- **Ask one person** who believes it is a fact and one who believes it to be a myth to explain the reason for their response.
- **Provide the answer.** Note that the statement is a myth or a fact and give the reason.
- **Repeat** this for another three statements. (Select statements that seem most relevant to the group.) Spend no more than 3 minutes on each statement.

For **Guiding questions** for discussion and **Take-away points**, see the sections below under Exercise 2.1, Option B: Voting with Your Feet.

**Exercise 2.1,
Option B:
Voting with
Your Feet
(30 minutes)**



Learning objective for the exercise

- Reflect critically on our perceptions and beliefs that affect the care we provide to survivors.

Instructions for facilitators (slide 4)

- **Find a space** where participants can easily move around.
- If the group is too big, split into two or three groups and conduct the exercise in 2–3 different spaces (for example, a breakaway room or different ends of the room).
- **Ask the participants** in each group to stand in the middle of the room in a straight line.
- **Place a sign** (either on flip charts or pieces of paper in large font) with "Agree" written on one side of the space and on the opposite side a sign with "Disagree" on it.
- **Read out loud** one of the statements listed in the facilitator resource.
- **Ask participants** to respond by moving towards one of the signs – either agree or disagree – depending on whether they agree or disagree with the statement.
- **Ask the participants** to choose how close to the sign they stand based on how strongly they agree or disagree with the statement.
- After each statement **facilitate a discussion** about why people chose the places they took. This will help them to dig deeper into their underlying belief systems.
- **Ask** each side to explain its point of view to the other side. Allow some time for debate.
- After a short debate, **ask** if anyone would like to change position.
- **Repeat** this by reading 4–5 more statements, depending on how much time is available.

Note: This exercise can be intensely personal and uncomfortable for some participants. If you hear discomfort expressed, intersperse the statements on violence against women with those that are under the miscellaneous category to create a nonthreatening atmosphere.

This exercise can also result in some participants feeling isolated if their values do not align with those of other group members, or it can create feelings of negativity towards their peers. Encourage participants to maintain a non-judgemental attitude towards beliefs that are not aligned with theirs or with those of the majority of the participants. These are complicated, emotional issues, and some participants may react strongly to the statement and others' views. Remind them that everyone brings his or her own personal perspective to this exercise and that they need to be respectful of each other.

Guiding questions for discussion for Exercise 2.1, Option A or B



Guiding questions for discussion, Exercise 2.1 (Option A or B)

- After the exercise is complete, **facilitate a group discussion** using the following questions as a starting point:
 - How did it feel to confront values that you do not share?
 - What did you learn from this experience?
 - Did you change your opinion about any of the issues?
- Encourage debate within the group and be ready to spend some time discussing the issues that arise.

Take-away points for Exercise 2.1, Option A or B



Take-away points (slide 5)

The purpose of this exercise is to reflect on how our personal beliefs about violence against women and values might affect the care that we as health-care providers offer to survivors.

- Our beliefs and attitudes often reflect the norms and values of the societies we live in. It is important to reflect on these norms and whether they might harm survivors. We must challenge them in our interactions with survivors and as role models to our patients and communities.
- Women subjected to violence are often acutely aware and can sense when people have negative beliefs and opinions about them. If we are aware of our negative beliefs, we can better avoid communicating them to survivors of violence.
- Changing mindsets takes time. However, it is possible to change our beliefs and attitudes, and it is healthy to examine and adjust them if necessary.

Exercise 2.2, Option A: Blanketed by Blame (45 minutes)



Learning objectives for the exercise (slide 6)

- Increase awareness of and empathy for the difficulties that women who experience violence face when seeking support.
- Highlight how unequal gender norms and behaviours can affect women's ability to seek help and access care.
- Encourage participants to think about what they can do as providers to offer an empathic response to survivors of violence.

Instructions for facilitators (slide 7)

- **Have ready** 11 shawls or newspaper sheets.
- **Ask** 12 individuals to participate in the activity. Invite the others to observe.
- **Ask** for one volunteer to play the role of Maya (change name according to country), a woman who has experienced violence. Ask the other 11 to play the other characters written on the character cards.
- **Provide** each of the 12 participants with a character card (Handout: Blanketed by Blame).
- Instruct Maya to sit in the middle. She sits in a chair in front of and facing the other participants.
- **Instruct** the other participants to stand around Maya in a circle, facing outwards (away from Maya). Each holds a shawl or newspaper sheet.
- As facilitator, **stand outside the circle** and read the script of Maya's story (Handout: Blanketed by Blame). Then, in the order of characters listed below, explain who Maya approaches for help.
- **Ask each character** to read the statement on the character card and then step forward and place a shawl/newspaper over Maya.
 - Order of blanketing (covering Maya with shawl or newspaper): friend, HER mother, neighbour, HIS mother, community health worker (female), priest (male), daughter, police, social worker, lawyer, doctor
- After all 11 characters have placed a shawl/newspaper on Maya, **ask Maya** why did she not just leave her partner. Wait for her response.
- Next, **ask each character** to reverse this process by reading the statement on the reverse side of the character card and then remove one shawl/newspaper from Maya. This time the characters should face inwards, towards Maya.
 - Order of removing the blanket (the shawl or newspaper): doctor, lawyer, social worker, police, daughter, priest, community health worker, HIS mother, neighbour, HER mother, friend.
- Participants have 30 minutes for this exercise. After that, the facilitator should guide a 15-minute discussion in plenary.

Guiding questions for discussion (record responses on a flip chart and come back to them later in the training)

Ask:

- How did Maya feel?
- How did each of the other characters feel? (Ask for volunteers.)
- How did the observers feel? (Ask for volunteers.)

Discuss:

- How did you feel about the survivor's options for help and about the choices she was able to make?

- **Probe:** Was she always free or did she have the power to make the decision and seek help?
- How did the people that Maya approached respond to her?
- **Probe:** How could they have done this better?

Take-away points: See messages after the instructions for In Her Shoes, below.

**Exercise 2.2,
Option B:
In Her Shoes
(75 minutes)**



Learning objectives for the exercise (slide 8)

- Increase awareness of and empathy for the difficulties that women who experience violence face when seeking support.
- Highlight how unequal gender norms and behaviours can affect women's ability to seek help and obtain care.
- Encourage participants to think about what they can do as providers to offer an empathic response to survivors of violence.

Instructions for facilitators (slide 9)

- **Prepare** the 15 "stations".

Write the following words, each on one piece of paper: Religion, Friends & neighbours, Violence strikes, Police, Medical care, Family, NGO, Work, Return home, Chance, Cultural leader, Traditional healer, Carry on, Education, and Camp. (There may be other points of contact in your setting that you can add.)

Hang these papers up around the room. Spread them out to facilitate movement of the participants. If possible, add some elements to make the stations more realistic – for example, pencils and notepad at Education.

Lay down each story card of the different stories at the relevant station, ensuring that the different stories are next to each other and the same stories are layered, with the lowest number on top. (For example, one stack at the station "Violence strikes" with: Zola violence strikes 1, and below that, Zola violence strikes 2, etc. Next to that: Betty violence strikes 1, below that Betty violence strikes 2, etc.)

- **Explain:** This exercise will give us the chance to walk in the shoes of a woman who has experienced violence. We will make the kind of decisions that she faces and discuss those decisions.
- **Break the group** into small groups of 3–5 participants each.
- Explain that this is a guided experience, and each group will make decisions through discussion and consensus.
- **Hand each group** an identity card of a different character. If there are more groups than identity cards, be sure to have enough copies of identity cards to cover all the groups. Stagger the starts of the groups with the same identity by 5 minutes to avoid many groups being at the same station at the same time. (See character cards and situation cards for "In Her Shoes").
- **Ask participants** in each group to follow the instructions at the bottom of the cards. At each station participants will find a card that is relevant to their character. Ask the participants to read that card and make decisions on the basis of the card.

- Participants have **45 minutes** for this exercise. After that the facilitator should guide a 30-minute discussion in plenary.

Guiding questions for discussion (record inputs on a flip chart and refer to the responses later as needed)

Ask:

- How did it feel to walk through the story of this woman? Were you able to put yourselves “in her shoes”?
- How do you feel about the woman’s options for help and about the choices she was able to make?
 - **Probe:** Was she always free or did she have the power to make the decision and seek help?
- How did the people that she approached respond to the survivor?
 - **Probe:** How could they have done this better?

Take-away points for Exercise 2.2, Option A or B



Take-away points for this exercise (slides 10–11)

- This exercise illustrates the challenging decisions that women face in handling violence and how people respond to them.
- Women make important safety decisions all the time, and they are the experts on their own situations. Often, however, they have few, if any, options for seeking help and support. Many factors may prevent a woman from obtaining help, including economic barriers, social stigma, legal obstacles and threats of physical violence.
- When violence against women is considered normal, survivors often feel that they must simply accept it. Many survivors are not believed or are dismissed. Hence, they may feel compelled to stay in violent situations. These situations result from unequal gender norms in our communities.
- Violence against women is never justified. It does not matter whether or not a woman is married, what she wears, how she acts, what her religion is, or any other factor. It is important to NEVER place any kind of blame on the woman.
- Health-care providers can help survivors in several ways on the path to healing. They can:
 - reach out to women who they suspect are experiencing violence and ask them about it
 - listen to survivors’ stories
 - show empathy, which can make a big difference to how a woman feels
 - believe women’s experiences and not blame them for the violence
 - ask them about their needs and concerns, and encourage them to look for options
 - support them to make decisions that are right for them, and respect the survivors’ wishes and choices.

We will come back to these themes throughout the training.

End this exercise by bringing emotional closure: Ask participants to write in their notebooks one hopeful thing that they learned from this exercise.

**Guided
discussion
(20 minutes)**



Transition to a guided discussion on understanding women's readiness for change and barriers they may face when seeking care.

Explain that we want to build on the exercise to understand women's situations and explore two questions:

Question 1: When we hear about women's experience of violence, we may wonder, "Why doesn't she just leave her partner?"

Lead a discussion.

- **Open** the discussion by asking for reasons why someone might not leave a job they hated but had worked at for a long time and had a good salary.
- **Ask participants** if they have wondered why women do not leave violent situations. If so, what are their reflections about why they do not leave? Draw on the participant handout "Why don't women leave?"
 - **Probe** for individual, social, cultural, economic and institutional barriers.
 - Are there any other reasons not listed here?
 - What might be some of the most important barriers in our specific setting?

Key points for discussion:

- Making change is a process. Women are not always ready to take action for a variety of reasons, and they may never be ready. Yet providers must always be ready to respond, so that, when she is ready, she has the support she needs. Even moving a woman along the path towards readiness to seek care or to adopt safety strategies is a valuable contribution.
- Health-care providers can be helpful in addressing women's fears and sense of isolation and in setting norms that make it clear that abuse is not part of healthy relationships.

Question 2: We may also ask, "Why do women who experience violence delay seeking care?"

Lead a discussion on what barriers either prevent or cause delays in survivors seeking care for symptoms linked to violence. Draw on the handout "Barriers in seeking care".

- Probe for individual, social, cultural, economic and institutional barriers.
- Are there any other reasons not listed here?
- What might be some of the most important barriers in our specific setting?
- Are there any other reasons why women might not seek help?
- How can we support women to obtain the help they need?

Key points for discussion:

- Some of the same reasons that women have for not leaving their relationships can also inhibit care-seeking.

- The WHO Multi-Country Study found that most women who had experienced violence by an intimate partner had not told anyone about their partner's violence (when they did it was mostly friends and family). They had not sought help from a service provider or agency either; when they did it was mostly health services.
- Some of the most common reasons for seeking help (social services) reflect "turning point" moments, including the following:
 - She could not endure any more.
 - She was badly injured or feared for her (or her children's) life.
 - Her partner had threatened or hit her children.
 - She had been encouraged by friends or family.
- While we naturally want to prevent further abuse, it is essential that women themselves remain in control of the process to determine when and how they want to create change. Being aware of the barriers helps providers counter them – for example, assuring women that they are not to blame, and helping them understand how serious violence can be and how it impacts their health.
- **Acknowledge** that achieving safety is a long-term goal for women subjected to violence and that safety differs for each person.
- **Distribute the handouts** *Why don't women leave?* and *Barriers to seeking care*.

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 12):

- The exercises in this session illustrate the challenging situations, decisions and responses that women subjected to violence face. By putting ourselves in the shoes of the survivor, we can empathize and better understand their situations.
- As providers, it is important to reflect on our own values and beliefs that are shaped by society and how we may convey these to our patients – by stigmatizing them and causing them additional trauma. It is important NEVER to place any kind of blame on the woman. We can also remind others not to blame victims for the violence they experience.
- Given the barriers to leaving relationships or even sharing abuse experiences, it is important to remember that safety is a long-term goal.
- As providers, we always encourage women to look for options in their lives and support them to choose what they believe is right for them.

Session 3. Guiding principles and overview of the health response to violence against women

Preparation and general information	
Learning objectives and competencies 	Objective 2: Demonstrate behaviours and understand values contributing to safe and supportive service cultures. Competencies ■ Know the guiding principles of providing women-centred care in a culturally appropriate way. ■ Understand how to apply the guiding principles for women-centred care in your practice.
Session length 	30 minutes
Training techniques 	■ Presentation with slides (30 minutes)
Handout 	■ Poster or small pocket card summarizing LIVES (first-line support)
Accompanying reading 	■ Clinical handbook, pages 3–5
Session content	
Background 	Introduce the session by explaining that the WHO clinical handbook, which is largely the basis for this training, was developed with woman-centred care as the basis of an appropriate and supportive response to violence against women. In this session we will better understand and learn how to apply these principles in clinical practice. We also will begin to become familiar with the overall structure and content of the clinical handbook.



Slides for Session 3 cover the following content (for details, see the slide notes in the PowerPoint file):

Guiding principles (slides 3–8)

- The two fundamental principles for woman-centred care are respect for human rights and promotion of gender equality (slides 4–6).
- Privacy, safety and confidentiality are essential for providing care to women subjected to violence (slide 7).
- There are additional considerations for children and adolescents who have been sexually abused (slide 8). These are based on the principles of best interest of the child and evolving capacities.

Contents of clinical handbook (slides 9–10)

- The rest of this session presents an overview of the clinical handbook.

Clinical handbook part 1: Identifying women subjected to violence
(slides 11–13)

- Discuss entry points for health care for women subjected to violence in their settings (slide 12).
- Contrast universal screening and clinical inquiry. WHO does not recommend universal screening for intimate partner violence but instead recommends **clinical inquiry** (slide 13).

Clinical handbook part 2: First-line support (slides 14–16)

LIVES job aid

- The word “**LIVES**” can help you remember the elements of first-line support (slide 15). This training will build skills for the elements in “LIVES”. (This concept is adapted from psychological first aid.)
- If you have only one hour to train health-care providers, first-line support – LIVES – is what you want to pass on. Refer them to the LIVES job aid (either page 14 of the clinical handbook, the card on the last page of the clinical handbook or the LIVES poster).
- Show the summary protocol on care for survivors of intimate partner violence (slide 16).

Clinical handbook part 3: Clinical care for sexual assault/abuse (slides 17–18)

- Show the summary protocol on how to care for survivors of sexual assault/abuse (slide 18).
- The training will follow the steps outlined in the summary protocols.

Clinical handbook part 4: Mental health care (slides 19–20)

- Even if not trained as a mental health specialist, you can offer basic psychosocial support, assess mental health status for moderate to severe depression, suicidality or post-traumatic stress disorder (PTSD) and refer to a specialist if needed. The training will cover these basic steps (slide 20).

Clinical handbook addendums: Considerations for family planning and HIV settings (slides 21–22)

- Women seeking family planning or HIV testing services may experience violence as an underlying situation and face specific challenges to the uptake of contraceptives or disclosing HIV status.
- Providers in these settings not only need training in identification of violence and first-line support; they also need to know how to offer counselling for family planning and HIV disclosure while keeping in mind women's need for safety.

Two responsibilities of managers: reporting violence and enabling health systems (slides 23–25)

- **Reporting** considerations (slide 24): WHO does not recommend mandatory reporting for women subjected to violence.
- **Enabling health systems** (slide 25): This training does not go into aspects of management, but participants with managerial responsibilities can refer to the health manager's manual for strengthening systems for guidance.

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 26):

- The health system response should be based on respect for human rights and promotion of gender equality.
- This training will cover and seek to build skills in the five parts of the WHO clinical handbook.
- An enabling health system is key to helping providers put training into practice.

Session 4. Provider–survivor communication skills

Preparation and general information	
Learning objectives and competencies 	Objective 2: Demonstrate behaviours and understand values contributing to safe and supportive service cultures. Competency Communicate empathically and effectively with patients/survivors.
Session length 	45 minutes
Training techniques 	- Discussion and presentation (15 minutes) - Exercise 4.1: Active listening (30 minutes)
Handouts 	Active listening principles
Accompanying reading 	Clinical handbook, pages 42–45, section titled “Communicate”; page 89, “Tips for talking with clients”
Session content	
Background 	Introduce the session by noting that Listening is the first element of LIVES. Listening is something we do all the time, but we do not always listen mindfully or consciously. Good listening skills can be practised. Good listening makes a big difference to what women subjected to violence will disclose, how supported they feel and how quickly they can begin healing. We will use this session to reflect on and practise the art of listening and elements of good listening skills.

**Discussion and presentation
(15 minutes)**



- **Discussion:** How do we know if someone is listening to us?

Slides for Session 4 cover the following content (for details, see the slide notes in the PowerPoint file):

Review principles of active listening

- Distribute handout *Active listening principles* and discuss active listening practices (slide 3).
- Review and demonstrate the principles of good listening posture (the mnemonic SOLER) (slide 4).

**Exercise 4.1:
Active listening
(30 minutes)**



Learning objective for the exercise

- Appreciate and practise active listening.

Instructions for facilitators (slide 5)

- **Ask participants** to form pairs with another participant.
- **Ask participants** to recall a challenging situation in any area of life and to tell their partner a story about it for about 5 minutes. NOTE: Do not use an example related to violence, as this time is too short for dealing with a disclosure of violence.
- **Ask the listener** to practise active listening, including open-ended questions, non-verbal communication and non-judgemental responses. Refer them to the handout *Active listening principles* for reminders of active listening practices.
- **After 5 minutes**, ask the participants to switch roles so that the person who first listened now tells his or her story for about 5 minutes and the other partner becomes the active listener.

Guided discussion (slide 6)

In plenary, ask the participants the following questions:

- What did your partner do to show she/he was listening attentively to you?
- What did your partner say that showed active listening?
- What did your partner NOT do or say – both good and bad?
- How did you feel afterwards?

Ask participants which communication skills are most useful to their clinical settings and appropriate in their contexts.

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 7):

- Survivors of violence are often silenced by abusers, family members, others in the community – and even health-care providers. By contrast, active and supportive listening allows survivors to feel heard – an important step towards healing and enabling disclosure of violence.
- Empathic and effective communication takes place throughout the meeting.
- Use both verbal and non-verbal skills.
- Start by asking open-ended questions.

Session 5. When and how to identify intimate partner violence

Preparation and general information	
Learning objectives and competencies 	Objective 3: Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women. Competencies ■ Understand the minimum standards that need to be met to enquire about and respond appropriately to violence against women. ■ Recognize the signs and symptoms that suggest intimate partner violence. ■ Understand when and how to ask about intimate partner violence. ■ Demonstrate appropriate ways to ask about intimate partner violence.
Session length 	40 or 70 minutes
Training techniques 	■ Presentation with slides (10 minutes) ■ Exercise 5.1, Option A: Role play on identification of intimate partner violence (60 minutes) OR (depending on amount of time available) ■ Exercise 5.1, Option B: Case reviews on identification of intimate partner violence (30 minutes)
Handout 	■ Asking about violence
Facilitator materials 	■ Role play on identification of intimate partner violence (Exercise 5.1, Option A) ■ Case reviews on identification of intimate partner violence (Exercise 5.1, Option B)
Accompanying reading 	■ Clinical handbook, pages 8–11

Session content

Background



Remind participants that health-care providers are in a unique position to help survivors of intimate partner violence. Survivors can often seek health care without coming in specifically to discuss violence. Health-care providers tend to be the first point of professional contact for survivors.

As a health-care provider, you may suspect violence and identify survivors (refer to page 8 of the clinical handbook).

Presentation with slides (10 minutes)



Slides for Session 5 cover the following content (for details, see the slide notes in the PowerPoint file):

- Minimum requirements need to be in place before asking about violence. These are protocols, training, privacy, confidentiality and a referral system (slide 4).
- **Privacy:** Never discuss violence if anyone else – even a friend – is present or may be able to overhear. You may need to think of a strategy to be able to see the woman alone, such as sending the person to do an errand or to fill out a form.
- **Reminder:** WHO recommends clinical inquiry. Universal screening is not recommended (slide 5). (Refer to page 17 of the WHO clinical and policy guidelines for more information.)
- Women subjected to intimate partner violence often seek health care for related emotional or physical conditions. (When to suspect that a woman is experiencing violence and make an enquiry is covered in slides 6–7 and in the clinical handbook, page 9.)
- When asking about violence, raise the topic indirectly first (slide 8), then more directly if appropriate (slide 9). Sample statements are provided in the job aid on asking about violence on page 11 of the clinical handbook. Other statements can be used, as appropriate, and they do not all need to be used.
- Often, women will not tell you about violence (slide 10). See also page 12 of the clinical handbook.

Emphasize the following:

- Remember the principles of women-centred care.
- Your verbal and non-verbal communication skills are important for building trust when and if a woman is ready to disclose abuse and obtain help.
- She may not disclose to you the first time that you ask – or ever – and you need to respect her decision.

Conduct the exercise. See instructions below.

- Questions that providers may have (slides 16–17), with responses, are covered in pages 34–37 in the handbook and in a living annex on the WHO website.

**Exercise 5.1,
Option A:
Role play on
identification
of intimate
partner violence
(60 minutes)**



Note: Choose Exercise 5.1, Option A (60 minutes) or 5.1, Option B (30 minutes) depending on the amount of time available.

Note to facilitator: Refer to the instructions for role plays in Annex 5 for a reminder on how to provide feedback to role play participants.

Learning objective for the exercise (slide 11)

- Practise appropriate ways in which to raise the topic of violence and to ask about violence.

Instructions for facilitators (slide 12)

Show a video demonstrating providers asking about violence. If a video is not available, a pair of facilitators can demonstrate the role play.

For the role plays:

- **Divide** the participants into groups of three.
- **Ask** one person in each group to volunteer to play the role of a patient/survivor, another to play the role of a health-care provider, and the third to be the observer who will provide feedback to the other two.
- **Hand out** the scenarios (Participant handout – Identification of intimate partner violence). Give the patient scenario to the survivor and the observer but not to the provider.

Explain the following:

- **The patients** read the scenario. They play the role of the survivor and describe their symptoms or conditions to the health-care provider. They do not share information regarding the violence unless they are asked by the health-care provider and feel comfortable sharing.
- **The health-care providers' job** is to provide care and ask relevant questions. If necessary, they raise the topic of violence and/or ask about violence.
- **The observers' role** is to read the guidance in the clinical handbook (page 11) and provide feedback to the health-care worker on her or his approach to asking the woman about violence. The observer should pay attention to the questions asked as well as the overall verbal and non-verbal communication.

Suggestion to facilitator: *Walk around the room and ask at least one client NOT to disclose violence (discreetly). This would enable the health-care worker to practise skills in providing support to the patient even if she does not disclose.*

After 10 minutes of doing the role play or after disclosure of violence if earlier, the observer should stop them and discuss for 5 minutes:

- How did the participant playing the role of the survivor feel talking to the provider?
- Ask the observer to provide feedback on how the health-care worker asked questions, how he/she responded to the survivor, and how the non-verbal communication was.
- Ask the health-care worker to reflect on what other actions could help the woman.

If there is time, ask the participants to switch roles and do another role play.

After the role play, facilitate a discussion with the whole group to debrief their experiences (30 minutes). The questions below can be used as a guide.

- For those playing the role of patients, how did you feel about being asked about violence?
 - **Probe:** Did you disclose abuse? Why or why not?
 - **Probe:** How did you feel when you disclosed?
- For those playing the role of health-care providers, how did you feel about asking about violence?
 - **Probe:** What made you suspicious about the possibility of violence?
 - **Probe:** Did you hesitate to ask? If so, why?
 - **Probe:** How did you feel when she disclosed her experience of violence, or if she did not disclose?
- For those playing the role of observers, how did you feel about what was going on?
 - **Probe:** How was the verbal and non-verbal communication? How did health-care providers communicate or not communicate support?
- What did you notice about the woman's willingness to disclose her experience of violence? Did she hesitate or not?
- What could the health-care provider have done better in the situation?

**Exercise 5.1,
Option B: Case
reviews on
identification
of intimate
partner violence
(30 minutes)**



Note: Choose Exercise 5.1, Option A (60 minutes) or 5.1, Option B (30 minutes) depending on the amount of time available.

Learning objectives for the exercise (slide 13)

- Recognize signs and symptoms that suggest violence.
- Practise appropriate ways to raise the topic of violence and to ask about violence.

Instructions for facilitators (slides 14–15)

- **Ask** participants to work in groups of 4–5 and review what is presented in the handout Case reviews on identification of intimate partner violence.
- The groups will have **10 minutes** to read the cases and discuss and agree on answers to the following questions:
 - Do you think this person may have experienced violence? What makes you think this?
 - How would you raise the topic? What are the questions you would ask? Please write them down.
- After the participants have reviewed the cases, **discuss** them in plenary using the exercise below.

Plenary exercise

- As facilitator, take the role of the survivor in the cases provided. All participants take the role of the provider. (If there are several facilitators, this exercise is best done in small groups.)

- **State, as the patient**, why you are there and ask all participants (the providers) to ask questions. The group work they did will help them in this exercise.
- **Encourage all participants** to ask questions and actively participate.
- In the role of the patient, **answer each question** that the “providers” ask.
- After each of the cases, ask the participants which questions worked well, and which did not. Note the type of questions that worked well (for example, open-ended, indirect to start).
 - If the questions are not sensitive, address this.
 - If the questions are not leading anywhere, address this.
 - If participants ask closed questions, only respond with “yes” or “no”, not giving any further information.
- **Ask and discuss:** What approaches worked well?

After you discuss all three cases, point out that different approaches may be necessary for each survivor depending on the responses and circumstances.

It is important to take a survivor-centred approach – ensuring that you listen well to what the survivor tells you – to hear her needs and ask about them without blaming her. In examining her, keep in mind the fears discussed in the first session.

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 18):

- Partner violence is identified by staying attentive to possible clinical cues.
- First, ask general questions about relationships, the situation at home, etc.
- Ask about violence compassionately, without judgement.
- Many survivors will not disclose. Even so, providers have an important role – providing information and building trust.
- Verbal and non-verbal communication skills are important.
- Active and empathic listening provides important support.
- Skills to identify/ask improve with practice.

Session 6. First-line support using LIVES, part 1: Listen, Inquire, Validate

Preparation and general information	
Learning objectives and competencies 	Objective 3: Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women. Competencies ■ Know the content of first-line support (LIVES). ■ Demonstrate skills in offering the first three elements (listening, inquiring and validating) of first-line support to survivors who disclose abuse.
Session length 	105 minutes
Training techniques 	■ Presentation with slides (15 minutes) ■ Video demonstrating identification of violence and LIV elements of LIVES, followed by guided discussion (https://youtu.be/Hu06nVCzih0, minutes 8:40 to 14:20 and 14:47 to 20:36) (30 minutes) ■ Exercise 6.1: Role play to practise LIV(ES), part 1 (60 minutes)
Handouts 	■ Communication skills and pathways ■ Health-care providers' common questions (pages 34–37 of the clinical handbook)
Facilitator materials 	■ Exercise 6.1: Role play scenarios on LIV(ES), part 1
Accompanying reading 	■ Clinical handbook, pages 13–24

Session content

Presentation with slides (15 minutes)



Slides for Session 6 cover the following content (for details, see the slide notes in the PowerPoint file):

What is first-line support?

- First-line support is the most important care that you can provide (slide 3).
- “LIVES” is first-line support for violence against women (slide 4). This session covers the first part – LIV – of first-line support. The second part – ES – is covered in Session 8.
- **Listening** is more than just hearing a woman’s words. It is the most important part of good communication and the basis of first-line support. It gives the woman a chance to say what she wants to a caring person who wants to help. This should be done in a safe and private place (slide 5–6).
- **Inquiring** about her needs and concerns in a caring way, putting her at the centre of decisions (slide 7).
- **Validating** what she is telling you. Showing that you understand what she is saying and that you believe what she says without judgement or conditions (slide 8).
- **Distribute handout** Communication skills and pathways.

Video and guided discussion (30 minutes)



Introduce the video (slide 9) by encouraging participants to look for the communication skills and pathways highlighted on the handout and in the specific steps of LIV.

Prompt them to think how they might communicate the same points in their own words.

Show video modelling good practice for identification of violence and the LIV elements of LIVES (15 minutes). The video is at <https://youtu.be/Hu06nVCzih0> (link to video on slide 9). Show the video from 8:40 to 14:20, then from 14:47 to 20:36.

(This video is from the Royal Australian College of General Practitioners Professional Development Program on Family Violence, <https://www.racgp.org.au/familyviolence/modules.htm>.)

Guided discussion of video (15 minutes)

Ask participants to reflect on each of the LIV elements:

- How did the provider demonstrate listening?
 - What non-verbal cues were used?
 - What else could be done?
- How did the provider demonstrate inquiring?
 - What types of questions were used?
 - How else could this be done?

Exercise 6.1: Role play to practise LIV(ES), part 1 (60 minutes)



- How did the provider demonstrate validating?
 - How else could you respond?

Note to facilitator: Refer to the annex on providing feedback to role play participants.

Learning objective for the exercise

- Develop skills for the LIV elements of first-line support.

Instructions for facilitators (slide 10)

- **Divide participants** into groups of three. Ask each group to decide who will play the role of a patient, a health-care provider and an observer.
- **Hand out** the instructions and the scenarios only to the patients and observers and ask them to read and prepare.
- **Ask the *patients* and the *observers*** to read the instructions and the scenarios and to choose a scenario to play out.
- The role of the *patient* is to tell the *health-care worker* why she is there and to respond to questions asked by the *health-care provider*.
- Based on the scenario selected, the *health-care provider* should ask about violence and provide first-line support to the client using what they have learned about LIV(ES).
- The *observer's* role is to observe the verbal and non-verbal communication between the health-care provider and the patient and, at the end of the role play, to provide feedback to the health-care provider on her or his skills in providing the first three elements of first-line support.

Tell *patients* and *providers* to practise the role play for 10 minutes.

Instruct the *observer* to provide feedback to the *health-care worker* for 5 minutes.

The group should then **switch roles** within their group and repeat the exercise using the other scenario.

Option A: Facilitate a group discussion to debrief each scenario

Facilitate a group discussion to debrief their experiences (30 minutes). The questions below can be used as a guide:

- To those who played the role of the ***patients***:
 - How did you feel about the health-care worker asking about violence?
 - Did you disclose violence? Why or why not?
- To ***health-care providers***:
 - How did you ask about the patient's experience of violence?
 - How did you feel if the patient disclosed?
 - What did you say to the patient who disclosed violence?
 - If no disclosure: How did you decide to stop asking about violence? How did you leave the door open for further discussion?

■ To **observers**:

- How was the non-verbal communication?
- How forthcoming was the patient about her experience of violence? Why?

Note: Some participants may overlay the scenario or act as rushed or disinterested providers. These scenarios of “missed opportunity” can be highly instructive. In discussion highlight the barriers to discussion of violence (time, disinterest, burnout, lack of privacy may come up). Take this opportunity to acknowledge the challenges that the system can present. Invite reflection on what can be done differently, or how a colleague could be approached for support.

Option B: Invite selected participants to role-play each scenario in front of the group

Note: Do this only if you are sure these participants will demonstrate quality care and will feel comfortable receiving feedback from the entire group.

Thank participants for volunteering; it is brave to do this in front of an audience.

Invite feedback from the broader group.

- Begin with positive feedback: What was done well?
- What are opportunities for improvement?

Distribute handout on *Health-care providers’ common questions* or refer to pages 34–37 of the clinical handbook.

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 11):

- As we have noted throughout the training, effective listening and LIVES can be a powerful healing tool for survivors. For some, first-line response alone can be what they need to move forward.
- Remember to minimize distractions and focus on your patient for most effective communication.
- Take the time to continue practising the LIV portions of LIVES, and think about how you can provide first-line support using your own words.

Session 7. Know your setting: identify referral networks and understand the legal and policy context

Preparation and general information	
Learning objectives and competencies 	Objective 4: Demonstrate knowledge of how to access resources and support for patients and for oneself. Competencies ■ Understand the role of other services in caring for survivors of violence against women. ■ Know what resources are available in the community. ■ Know the legal and policy context, including health-care providers' legal obligations, with regards to the local and national response to violence against women.
Session length 	70 minutes (without additional below) Additional 30 minutes for optional exercise Additional 30 minutes for optional invited guest
Training techniques 	■ Presentation with slides and guided discussion (20 minutes) ■ Guided discussion on policy context (20 minutes) ■ Exercise 7.1: The Web of Referrals (30 minutes) ■ Exercise 7.2 (optional): Drawing the ideal referral pathway (if participants have managerial responsibilities) (30 minutes) ■ Optional/encouraged: Invited guest to present on legal/policy context or on referral services available locally (30 minutes)
Facilitator materials 	■ Exercise 7.1: The Web of Referrals – character cards ■ Exercise 7.2: Drawing the ideal referral pathway – template (job aid 8.1 in the health manager's manual, page 91)
Accompanying reading 	■ Clinical handbook, pages 29–32 (section on social support and job aid referral chart) ■ Health manager's manual, Annex 6 (sample referral directory form), chapter 3 pages 33–36, chapter 6 page 65 and chapter 8 pages 82–93

Invited guest



Guest speakers to consider (see section in the introduction on Guest speakers and resource persons)

- Referral portion: Invite a health-care provider who cares for women subjected to intimate partner or sexual violence or an advocate to discuss the services available, referral pathways and ways to strengthen ties.
- Policy portion: Invite a Ministry of Health official or other person knowledgeable about national, subnational and institutional policy to present on the local policy environment.

Session content

Presentation with slides and guided discussion (20 minutes)



Slides for Session 7 cover the following content (for details, see the slide notes in the PowerPoint file):

Discuss what needs women may have that the health system cannot meet. Explain that helping women access these services is essential for their health and safety.

Establishing referral pathways

- Indicate the principles for referrals, always respecting and following the survivor's choice (slide 3).
- Highlight how to establish referral pathways (slide 4), including identifying and mapping available services, making referral agreements with known resources and making a referral directory (refer to the job aid – slide 5). Discuss what it means to “know a resource” (slide 6).
- Explain how to provide “warm referrals” (slides 7–8). Warm referrals help reduce barriers.
- *If participants have managerial responsibilities:* Highlight the steps of developing referral pathways through the handout of job aid 8.1 from the health systems manual (slides 15–17). See optional exercise 7.2, below.

Legal and policy context

- Describe the legal and policy context or ask someone to describe it (slides 9–11).
- Specifically, for example, what laws apply to or have implications for health-care providers' response to sexual violence, intimate partner violence and child sexual abuse? Specifically, what do laws and policies say about abortion services, access to abortion and emergency contraception, age of sexual consent, age of parental consent for adolescents' access to care, mandatory reporting, who is authorized to perform forensic examinations and testify in court if applicable, and what are the legal and policy obligations or limitations to confidentiality of information and sharing data?

Exercise 7.1: The Web of Referrals (30 minutes)



Learning objective for the exercise (slide 12)

- Appreciate how a lack of coordination and too much specialization can make referrals burdensome for the survivor.

Instructions for facilitators (slide 13)

- Ten volunteers are needed.

TIP: If the group is very large, it can be split into two.

- **Ask 9 volunteers** to come to the front and form a circle. Ask for a 10th volunteer to stand in the centre to play the role of Rose, a violence survivor. Ask the rest of the participants to be outside the circle and to observe the situation.
- **Give each volunteer** in the circle a character card with instructions. *TIP: Mix the order of the cards before handing them out.* Give Rose the description of her situation (participant handout for Web of Referrals exercise) and a ball of coloured thread or yarn.
- **Read Rose's story** to the group: Rose is a 28-year-old woman who has been experiencing physical and sexual abuse from her boyfriend for the last six months. She does not know what to do, and so she first approaches her sister for help.
- **Ask Rose** to play her character and approach her sister. Ask Rose to take the ball of thread with her wherever she goes but to give the end of the string to her sister and unwind the string from the ball as she goes.
- **Ask the sister** to respond to Rose as per her card instructs and to take the end of the thread. Thereafter, each character that Rose visits should play their role as instructed on their card. Rose gives the thread to each person she meets. Then she unwinds more thread from the ball as she goes to the next person.

By the end of the exercise, Rose has re-told her story to multiple people and is standing in the midst of a tangled web of thread.

Group discussion

- Ask the observers: How often did Rose have to repeat her story?
- Ask Rose how she felt repeating her story so many times?
- Ask those who played the other characters: Did you feel that you could be helpful to Rose?
- Ask the whole group:
 - Is this situation realistic? Is this what happens in your setting?
 - What could have been done to avoid this web of string?
 - What could be done to minimize the need for Rose to repeat her story?

**Exercise 7.2
(optional):
Drawing the
ideal referral
pathway (for
health managers
or providers with
managerial roles)
(30 minutes)**



Learning objective for the exercise (slide 14)

- Think through how to draw a referral pathway for your locality.

Instructions for facilitator (slide 14)

Give each participant a template for developing an ideal referral pathway. (Participants from the same facility or region can work together.) Ask the participants to draw out a referral pathway for their health facility/region. Designate whether the pathway is for sexual assault or intimate partner violence. The pathway should include connections both within and between facilities, and the information flow among these in both directions.

In developing the ideal referral pathway, participants should use, as a model, job aid 8.1 in the health manager's manual, page 91 (also available as a handout), especially Step 5, page 93, and follow these instructions:

- To draw the ideal referral pathway, think what it means to put the woman's needs at the centre, protecting her privacy and confidentiality and minimizing the need for her to repeat her story.
- Identify and write down the formal supports for which she may need referrals (for example, police, health-care provider, social worker, legal services), as well as the informal supports that may be useful (for example, family and friends, social networks, village elders, religious and traditional leaders).
- Specify sequences or paths that the survivor could follow, taking into account her wishes and preferences.

Group discussion

After the exercise reconvene all the participants. Ask the groups (or individuals) to present their referral pathways.

Facilitate discussion of the following themes:

- Referrals in accordance with her wishes and needs (self-determination principle)
- Confidentiality and safety in referral process
- Identifying and overcoming barriers to referrals (for example, transportation)
- The provider's role is to connect women with care – not to provide all aspects of necessary support (for example, legal aid).

This discussion may identify new resources, which can be shared with the group.

Invited guest



Introduce guest speaker to present on either the legal and policy context or on available referral resources in the community.

- Facilitate discussion depending on the speaker's focus.

Wrap-up



Ask if there are **questions or concerns**.

State the **key messages** (slide 18):

- Active and up-to-date referral networks and warm referral practices can help women more easily access the care that is available.
- Make referral agreements with known resources.
- Remember, self-determination is at the core of the referral process.
- Providers are responsible for knowing the legal and policy context that affects the care they provide.

Session 8. First-line support using (LIV)ES, part 2: Enhancing safety and providing Support

Preparation and general information	
Learning objectives and competencies 	Objective 4: Demonstrate knowledge of how to access resources and support for patients and for oneself. Competencies ■ Demonstrate the skills to assess immediate risk/safety and to support safety planning. ■ Know what resources are available in the community. ■ Know how to collaborate with partners to help survivors access other services and to provide referrals. ■ Demonstrate skills to provide warm referrals.
Session length 	95 minutes
Training techniques 	■ Presentation with slides (5 minutes) ■ Demonstration role play with discussion (30 minutes) ■ Exercise 8.1: Role play to practise (LIV)ES, part 2 (60 minutes)
Facilitator materials 	■ Exercise 8.1: Role play scenarios on (LIV)ES, part 2
Accompanying reading 	■ Clinical handbook, pages 25–33

Session content

Background



Introduce the session by reminding participants that in Session 6 they learned skills for the first three elements of LIVES (Listen, Inquire, Validate). In Session 7, participants learned how to establish survivor-centred referrals, identify resources in the community and maintain a referral directory.

This session will cover skills and practice for the last two elements of LIVES (Enhancing safety and providing Support). Empathic, active communication throughout will make the conversation more effective and comfortable for both you and your client.

Presentation with slides (5 minutes)



The slides for Session 8 cover the following content: (for detail, see the slide notes in the PowerPoint file):

Enhancing safety

- When assessing safety after sexual assault or partner violence, discuss whether or not it is safe for the woman to go home (slide 4). Partner violence is not likely to stop on its own. Safety concerns should be taken seriously, and women should be helped with safety assessment and plans.
- Review the risk assessment job aid in the clinical handbook on page 26 and the safety planning job aid on page 27 (slide 5).
- If the woman is not safe, help her to make a safety plan and make the necessary referrals (slide 6).
- Safety is a long-term goal. A woman may not be ready to take action now, but she needs to know what to do.
- To avoid putting her at risk, be sure to maintain privacy and confidentiality (slide 7).

Facilitating social support (slide 8)

- Discuss with her what is most important to her, and help her identify and consider her options.
- Providers should use and update the referral directory job aid as the basis for facilitating access to formal social support based on her needs. Also, or instead, women may prefer to rely on their informal networks.
- Health-care providers play an important role by connecting women to needed resources and, through warm referrals, encouraging them to seek support.

Demonstration role play (30 minutes)



Demonstrate a role play with your co-facilitator to show how to assess and support the safety of a survivor and to facilitate social support (the E and S elements of LIVES). Use one of the scenarios in the LIVES role play handout (10 minutes).

Ask participants to reflect on each element of the ES phase, and **lead a discussion** on the following questions (20 minutes):

- How did the provider raise the topic of safety?
- How did the provider show respect for the woman's decisions?

Exercise 8.1: Role play to practise (LIV)ES, part two, and discussion (60 minutes)



- How did the provider facilitate access to social support – informal and formal?
- How else could this be handled? What would you do differently? Similarly?

Note to facilitator: Refer to the annex on providing feedback to role play participants.

Learning objective for the exercise (slide 9)

- Practise skills in how to assess and help with safety and to link or connect a woman to both informal and formal social support.

Instructions for facilitators (slide 10)

- **Divide participants** into groups of three. Ask each group to decide who will play the roles of a patient, a health-care provider and an observer.
- **Hand out** the instructions and the scenarios only to the patients and observers and ask them to read and prepare.
- **Ask the patients and the observers** to read the instructions and the scenarios and to choose a scenario to play out.
- **Ask the patient:** Read the scenario but do not initially share the details with the others. When instructed by the facilitator, **only read out loud the information in items 1 and 2 to your health-care provider.**
- **Ask the health-care provider:** Listen to the patient's disclosure of abuse and provide first-line support with a focus on assessing and facilitating safety and facilitating access to social support (steps E and S from LIV)ES) as instructed in the clinical handbook, pages 25–33.
- **Ask the observer:** Note the verbal and non-verbal communication between health-care provider and patient. Provide feedback at the end of the role play to the provider. Remind observers of the tips for providing feedback on role plays (Annex 5, p. 88).
- The group should then **switch roles** within their group and repeat the exercise using the other scenario.
- Each role play should take about 10 minutes. The observer should take no more than 5 minutes to provide feedback.

Guided plenary discussion

Ask groups to discuss their role plays. You can use the following questions:

- To **patients**:
 - How did you feel about the way the health-care provider responded to your situation and needs? Did you feel that you were listened to? Why or why not?
 - How appropriate to your situation and priorities were the safety tips and recommendations for accessing social support?
- To **health-care providers**:
 - How comfortable were you in assessing and helping the patient with safety and facilitating social support?
 - Tell us about what you struggled with in your discussions with her about safety and social support.

■ To **observers**:

- What did the health-care provider do well in their interaction?
- What could they have done differently or better?

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 11):

- Risk assessment can help understand women's immediate safety needs.
- Trust your patient when she tells you she is in severe danger.
- Providing linkages to support services is a core activity in the response to violence.
- Always provide referrals that respond to her stated needs.
- As much as possible, make warm referrals.
- Empathic, active communication is most effective and comfortable for both of you.

Session 9. Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination

Preparation and general information	
Learning objectives and competencies 	Objective 3: Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women. Competencies ■ Demonstrate skills to take a clinical history. ■ Know how to conduct an examination of a survivor of sexual assault, including rape and abuse. ■ Know when to collect forensic evidence and how to support or facilitate such evidence collection.
Session length 	75 minutes
Training techniques 	■ Presentation with slides and with e-learning animation and guided discussion (30 minutes) ■ Exercise 9.1: Role play on history-taking (45 minutes)
Handouts 	■ Responding to children and adolescents who have been sexually abused: WHO clinical guidelines (pages 20–22) ■ Preparing to gather the story ■ Special considerations for medico-legal services for child victims ■ Forensic medical examination ■ Medico-legal evidence in sexual violence
Facilitator materials 	■ USB key or download: clinical management of rape – e-learning (http://apps.who.int/iris/bitstream/handle/10665/44190/CMoR_CDDownloadMultilingualVersion.zip?sequence=2&isAllowed=y) ■ Exercise 9.1: Role play on history-taking scenarios ■ Exercise 9.1: History-taking form (Section 3 of the form for documenting history, pages 91–92 of the clinical handbook – description of the incident)

Accompanying reading



- Clinical handbook: Part 3 pages 39–48, Sample history and exam form (pages 89–98)

Session content

Background



This is the first of two sessions covering quality care for survivors of sexual assault, including rape and abuse.

A woman may find it more difficult to disclose rape, sexual assault or abuse if she knows or has trusted the perpetrator (for example, husband, boyfriend, family member, other relative, acquaintance, school teacher) than if it is a stranger. Providers need to be sensitive to this when asking questions.

Also, there are specific considerations in dealing with child or adolescent survivors of rape, sexual assault or abuse.

A good history and examination are the basis for providing quality clinical care and psychological support, and also for medico-legal evidence, when relevant and needed.

Providers should be familiar with national laws and policies on rape/sexual assault or abuse, including laws and policies related to medico-legal evidence. Also, they need to be familiar with any protocols/standard operating procedures.

In some settings forensic examinations of survivors of sexual abuse may be carried out only by designated health-care providers (for example, a sexual assault forensic nurse–examiner, forensic doctor, or providers designated to issue medico-legal certificates).

Remind participants that the guiding principle for history-taking and examination is to minimize trauma and stress and avoid re-victimizing the survivor. Also, clinical care should be prioritized.

Presentation with slides + e-learning animation (15 minutes) with discussion (15 minutes)



The slides for Session 9 cover the following content: (or details, see the slide notes in the PowerPoint file):

■ Pathway and steps in history-taking and examination, and general tips (slides 3–5)

■ Clinical/medical history

- The emphasis is on taking the history of the assault (slides 6–7) and assessing her emotional state (slide 8).
- Point out that the clinical/medical history is the most important aspect of care. It guides the examination and what care needs to be offered, as well as collection of forensic evidence.

- Emphasize the importance of talking to the woman, before taking the history, about any obligation you have to report to the police (slide 9) and the limits of confidentiality.
- Show e-learning clip on clinical management of rape, demonstrating history-taking (slide 10). Click on step 3, history-taking case study.

■ Examination

- It is important to communicate and to ask for consent with each step of the examination (slides 11–12).
- The primary purpose of examination is to provide clinical care and psychological support. At the same time, providers should know when forensic evidence should be collected and some general principles of forensic examination (slides 13–14).

Note: Additional details for forensic examination are covered in Session 9a (supplemental session).

Discussion: Ask participants if they have any questions and respond to them.

Distribute the handouts and refer participants to the additional reading.

Exercise 9.1: Role play on history-taking with guided discussion (45 minutes)



Learning objectives for the exercise (slide 15)

- Practise skills in how to take a history with a focus on asking about the sexual assault incident in a sensitive way.
- Document the history on a structured form.

Instructions for facilitators (slide 15)

- Divide participants into groups of three. Ask each group to decide who will play the roles of the patient, the patient's mother and the health-care provider.
- **Separate** the three character descriptions on the handout and give one description to each participant according to their roles.
- **Ask the "providers"** to listen to the patient's account and then ask about the history of the sexual assault (clinical handbook pages 40–43), record findings on section 3 of the form on pages 91–92 of the clinical handbook (handout), then prepare the survivor for an examination (clinical handbook, pages 43–45).
- Each role play should take about 10 minutes. Then ask the participants to switch roles within their group and repeat the role play one or two more times.

Guided plenary discussion

- Ask the patients how they felt telling their stories and about the health-care provider's response.
- Ask the health-care providers what difficulties they experienced in the history-taking.
- Ask the entire group for suggestions about how the provider could best deal with the mother.

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 16):

- The history of the rape/sexual assault/abuse determines the examination, forensic evidence collection and treatment.
- Before taking the history, providers should explain any obligations to report the incident to authorities and the limits of confidentiality.
- Obtain consent separately for the history-taking, the examination and forensic evidence collection, and for reporting/sharing evidence.
- Whether to collect forensic evidence is determined by whether the survivor wants legal redress, whether there is a legal obligation to report, whether the survivor presents within five days of sexual assault and whether staff specifically trained to do this are available.

Session 9a: Forensic examination (supplemental)

Preparation and general information	
Learning objectives and competencies 	Objective 3: Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women. Competencies ■ Know when and how to collect forensic evidence.
Session length 	60 minutes
Training techniques 	■ Presentation with slides and with e-learning animation and guided discussion (30 minutes) ■ Exercise 9a.1: Decision-making on forensic evidence collection (30 minutes)
Facilitator materials 	■ USB key or download: Clinical management of rape survivors – e-learning – Step 4 (Collecting forensic evidence) https://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/ Tip: Check this link before your presentation. If it is working, the link on the web page will download a .zip file that you will need to un-zip in advance. ■ Exercise 9a.1: Scenarios and a table for recording responses
Accompanying reading 	■ Strengthening the medico-legal response to sexual violence (WHO, UNODC, 2015) https://www.who.int/reproductivehealth/publications/violence/medico-legal-response/en/ ■ Summary of local laws and policies to prepare for context
Advance preparation for the local context 	■ Prepare in advance by reviewing the following aspects of the legal and policy context so that they can be discussed in the session. ■ Who can examine? (Any physician, nurse, forensic specialist?) - What is the minimum training required? - Who can act as an expert witness in court? ■ What forms are required to document forensic evidence? - Who has these, or where are they kept? - Who can issue/sign a medico-legal certificate? - Who receives a copy of the certificate, and where are copies kept?

- Reporting

For whom/when is it mandatory to report violence?

- Storing and laboratory facilities

What samples and evidence can be stored and analysed and in what time frame?

What are the laws/policies regarding chain of custody of the samples?

Session content

Background



This session covers the collection of forensic evidence after sexual assault/rape.

Health-care providers often consider the collection of forensic evidence to be their main role post-rape. However, their main role is, in fact, the provision of first-line support and physical and psychological care.

Providers should be familiar with national laws and policies on sexual violence/assault/abuse/rape, including laws and policies related to forensics, as well as any protocols or standard operating procedures.

Who can perform the forensic examination and what training they should have received varies by country, depending on the law. Therefore, understanding the local legal context is crucial.

e-learning animation + presentation with slides (20 minutes) with discussion (10 minutes)



Before starting the presentation, show the case study of Step 4 from the e-learning animation on the clinical management of rape survivors (see link above).

The slides for Session 9a cover the following content:

- **Review the legal and policy context** (slides 4–5)

- Discuss the local circumstances regarding the roles, specific forms, reporting requirements and the storage and laboratory facilities available.

- **When can forensic examination be conducted?** (slide 6)

- If a woman chooses to go to the police or seek legal redress or may want to do this in the future, it can be important to collect forensic evidence. Also, the law may require it.
- The survivor's health and emotional well-being and safety should be the primary consideration.

- **Overview – history-taking and examination** (slides 7–8)

- A good medical history and detailed description of the sexual assault will guide the physical and forensic examination and evidence collection.
- Maximize efforts to have only one examination by combining the physical exam and evidence collection to minimize distress and trauma.

- **Forensic examination: general tips and job aids for physical examination** (slides 9–12)

- The head-to-toe physical exam is primarily for medical care, but it is also useful for forensic documentation.
- Digital vaginal exam, including the “two-finger test”, SHOULD NOT be carried out to assess if rape occurred. It has no scientific validity and is a human rights violation (slide 13).

■ **Forensic specimen collection, storage, documentation of findings** (slides 14–18)

- The account of the assault and the activities and time elapsed since then will determine the specimens to collect.
- Careful labelling, documentation and storage (to avoid contamination) are essential for medico-legal evidence.
- The absence of injuries does not mean that there was no sexual activity.
- It is important NOT to conclude whether evidence of sexual activity indicates rape or not. That is for courts to establish (slides 19–20).

Discussion

- Ask participants if they have any questions and respond to them.
- Refer participants to the additional reading and resources.

Exercise 9a.1: Decision-making on forensic evidence collection (15 minutes) with guided discussion (15 minutes)



Learning objectives for the exercise (slides 21)

- Understand how to establish whether and when forensic evidence should be collected and what evidence should be collected.

Instructions for facilitators (slide 22)

- **Divide participants** into small groups of 6–8. Depending on the number of groups, assign one scenario to each group.
- **Instruct** the participants to read the scenario.
- **Based on the scenario**, the group should discuss the following:
 - What questions would you need to ask or what information would you need to determine how to proceed with the examination? Explain why.
 - What forensic evidence would you collect? Explain why.
- Document the responses to the questions, including the “why” in the table provided in the handout.

Guided plenary discussion

- Ask the group:
 - Was the exercise easy to do? What was difficult?
 - What type of examination would they do, based on the scenario?
 - What would they do if the survivor did not want to go to the police?
- Ask each group to explain their decisions and responses and the forensic evidence samples they would collect.

Wrap-up



State the **key messages** (slide 23):

- Collect forensic evidence only when all 4 conditions are met: 1. Woman wants to go to police or it is mandatory. 2. Within seven days after assault. 3. Provider trained in forensic examination. 4. Forensic science lab available.
- Separate consent is needed for a forensic examination.
- Head-to-toe examination, but NO vaginal/"two-finger test".
- Assault history should guide forensic evidence collection.
- The time elapsed and the activities after the incident will determine whether evidence can be found.
- Storage that avoids contamination, labelling and detailed documentation are essential.
- Health-care providers may need to provide testimony. They cannot conclude whether evidence points to rape. That is for the courts to establish.

Session 10. Clinical care for survivors of sexual assault/rape, part 2: treatment and care

Preparation and general information	
Learning objectives and competencies 	Objective 3: Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women. Competencies ■ Know how to provide appropriate treatment/care to survivors of sexual assault, including rape and abuse.
Session length 	30–60 minutes
Training techniques 	■ Presentation with slides and guided discussion (30 minutes) ■ Exercise 10.1 (optional): Case studies on treatment for sexual assault (30 minutes)
Facilitator materials 	■ Exercise 10.1 (optional): Case studies on treatment for sexual assault (includes template with blank tables)
Accompanying reading 	■ Clinical handbook: Part 3 pages 39–59, Part 4 pages 67–80, Sample history and exam form pages 89–98
Session content	
Background 	■ This session covers immediate clinical care needs of survivors of sexual assault/rape. ■ While first-line support is not discussed here, note that it is part of essential care for survivors of any form of sexual violence/abuse, including rape/sexual assault. First-line support must be offered immediately in response to a disclosure of rape/sexual assault/abuse unless there is a need to triage for more urgent and life-threatening conditions.

- Providers should be familiar with national protocols, dosage, regimens and availability of emergency contraception, STI prophylaxis and HIV post-exposure prophylaxis (PEP) for both adult and child survivors of sexual assault or abuse. They should also be familiar with national laws and policy requirements related to abortion.

Presentation with slides and guided discussion (30 minutes)



The slides for Session 10 cover the following content (for details, see the slide notes in the PowerPoint file):

- Conditions/symptoms that may require urgent hospitalization (slide 3)

Prevention of pregnancy (emergency contraception) for women and girls who present within 120 hours (five days) (slides 4–6)

- Pregnancy resulting from rape is a big worry for many women and girls. Providers can help them by offering emergency contraception (EC).

Prevention of HIV for women and girls who present within 72 hours (slides 7–10)

- Emphasize the time-sensitive nature of HIV post-exposure prophylaxis (PEP) – as soon as possible and no later than 72 hours.
- Remind providers that adherence to PEP (taking one tablet each day) can face several barriers, including side-effects such as nausea and vomiting. For survivors of violence, taking PEP can trigger painful reminders of the assault.

Prevention of sexually transmitted infections (slides 11–12)

- A job aid (clinical manual, page 53) is provided to fill out with information on medication, dosage and schedule, based on national guidelines, for some of the common sexually transmitted infections (STIs) for which treatment should be offered.

Self-care and follow-up visits for longer-term care (slide 13)

- Refer to the job aids in the clinical handbook, pages 59–63, as a tool to schedule follow-up visits and communicate what signs and symptoms should be the basis for returning earlier to the clinic.

Ask if there are any **questions or concerns**.

Facilitate discussion by asking:

- What is the current practice with respect to safe abortion for survivors of rape/sexual assault?
- **If participants are familiar with the law on provision of abortion, including in cases of rape:** What are the barriers (for example, policy requirements) that may delay women and girls from accessing abortion services?

**Exercise 10.1
(optional):
Case studies on
treatment for
sexual assault
(30 minutes)**



Learning objective for the exercise (slide 14)

- Improve clinical decision-making on treatments for rape/sexual assault survivors.

Instructions for facilitators (slide 14)

- **Divide** into groups of no more than eight participants each.
- **Each group selects** a rapporteur to present back to plenary.
- There are four case studies (handout: *Sexual assault treatment decisions*). Depending on the number of groups, assign one or two case studies per group.
- **Give each group** 7 minutes per case study to discuss and fill out the tables describing which treatments they would prescribe, which tests they would do and which referrals they would do, and to explain why.
- **After 15 minutes** (assuming two case studies per group), ask them to reconvene in plenary.
- **Ask the rapporteur** from each group to present (in 3–4 minutes) one of their case studies and explain their treatment and care decisions.

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 15):

- Immediate treatment includes first-line support and, as needed, treatment of injuries, EC, HIV PEP, STI prophylaxis and hepatitis B prevention.
- Treatment for rape/sexual assault really depends on whether the survivor presents within the first 72–120 hours. Most survivors do not do so.
- However, even beyond this time frame, all survivors will benefit from first-line support (LIVES), and some may need additional mental health or psychological care depending on their symptoms.
- Providers need to determine the history of the assault and what has happened since to arrive at a decision about which tests to run and treatments to offer.

Session 11. Documenting intimate partner violence and sexual violence

Preparation and general information	
Learning objectives and competencies 	Objective 3: Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women. Competencies ■ Know how to document violence against women in a safe and confidential manner.
Session length 	30 minutes
Training techniques 	■ Presentation with slides and guided discussion (30 minutes)
Accompanying reading 	■ Clinical handbook, page 12 ■ Health systems manual, page 108, pages 147–156
Session content	
Background 	Introduce this session by highlighting the importance of documentation to providing care and to following up. There can be adverse impacts on safety, health and justice when the provider does not adequately document the clinical management of violence or breaches the confidentiality of the survivor. In some cases, documentation can also be important as evidence if the survivor wishes to pursue a legal case. That should not be the only focus, however. Additionally, good documentation by health-care providers can help managers and policy-makers to monitor programme quality and, therefore, can be the basis for improving service delivery.

**Presentation with
slides and guided
discussions
(30 minutes)**



The slides for Session 11 cover the following content (for details, see the slide notes in the PowerPoint file):

- **Discussion** of how violence against women is documented and what is documented at the participants' facilities (see slide 2 notes).

- The importance of **confidentiality** in documentation.

Group brainstorm: What does confidentiality mean to you? (There can be different understandings of what confidentiality entails.) What can be the adverse consequences of breaches of confidentiality for the woman and for the provider?

Discussion: How is the confidentiality of records assured in the participants' facilities? (See slide 3 notes.)

- Ensuring confidentiality of documents and records requires **standard operating procedures** (SOPs) (slide 3).

- Managers and providers have different roles and responsibilities in ensuring confidentiality in documentation, but both are crucial (slides 4–6).

Discussion of responsibility for records in the participants' facilities (see slide 6 notes)

- Structured forms for documentation (slides 7–9)

Discussion: What should be documented? (See slide 7 notes.)

The sample forms in the clinical handbook and the health systems manual are used for patient follow-up, for evidence and for programme monitoring. Refer to the following job aids:

- Clinical handbook: physical exam checklist, page 47, and sample history and examination form, pages 89–98
- Health systems manual: sample intake/record form, pages 147–149, and sample facility register, page 153.

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 10):

- Safety, confidentiality and privacy are essential.
- Good documentation is key to providing quality care and also for legal proceedings.
- Health managers need to establish SOPs and facilitate providers' documentation.
- Complete and easy-to-use forms improve documentation.

Session 12. Care for mental health and self-care for providers

Preparation and general information	
Learning objectives and competencies 	Objectives ■ Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women. ■ Demonstrate knowledge of how to access resources and support for patients and selves. Competencies ■ Know how to provide basic mental health care. ■ Know how to access and practise self-care.
Session length 	55 minutes
Training techniques 	■ Presentation with slides and video, and guided discussion (25 minutes) ■ Exercise 12.1, Options A and B: Stress reduction exercises (15 minutes) ■ Exercise 12.2: Role play on problem-solving skills (15 minutes)
Accompanying reading 	■ Clinical handbook: Part 4 (pages 67–84) ■ Responding to child and adolescent sexual abuse: WHO clinical guidelines, pages 33–38 ■ mhGAP, version 2.0.
Session content	
Background 	This session will help build on the skills developed in delivering first-line support to provide basic psychosocial support and to assess or identify those with mental health symptoms/conditions that need to be referred for specialized mental health care. In many settings specialized mental health services are not available. Yet there are ways that front-line workers can help survivors with their mental health in such settings. The content covered in this session is for all front-line providers, not for mental health specialists. It has been developed keeping in mind that even in low-resource settings without mental health specialists, there are some counselling, psychoeducation and interpersonal communication skills that can be strengthened among first-line

providers – be they doctors, nurses, midwives or counsellors – to offer basic psychosocial support. This session recognizes that, for more advanced mental health conditions, such as moderate to severe depression or PTSD, referrals to specialists (for example, psychiatrists or clinical psychologists) may be needed.

This session also helps providers become aware of their own symptoms of vicarious trauma, burnout and stress that may be brought on by caring for survivors of violence. It provides tips on self-care, including stress reduction exercises.

**Presentation
with slides and
guided discussion
(15 minutes)**



The slides for Session 12 cover the following content (for details, see the slide notes in the PowerPoint file):

Basic understanding about mental health care (slide 3)

- All women who disclose violence must receive first-line support (LIVES), as well as psychosocial support.
- Most women can be supported by strengthening basic coping skills, including stress management. A few women may need further assessment and treatment by a specialist for mental health conditions.

Offering psychosocial support (slides 4–6)

- Front-line providers can provide basic psychosocial support, which includes positive coping methods, social support and stress reduction.
- When a patient identifies a problem, giving advice is not the best solution. Instead, the provider should help the woman to identify problems and find her own solutions.

Assess for moderate to severe mental health conditions (slides 7–12)

- See pages 72–84 of the clinical handbook. For providers interested in learning more about managing depression, PTSD and other mental health conditions, see the mhGAP Intervention Guide at https://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/.
- Time permitting, show a video clip by clicking on the first blue link on slide 13, under “Depression”. This video shows how a provider assesses risk for depression in a patient (7 minutes 40 seconds). Invite and answer questions. Point out that the health-care provider in the video misses the opportunity to ask about violence.

Self-care for providers (slide 14)

- Providers can experience symptoms of burnout, fatigue and vicarious trauma. If they feel this, they must seek support and professional help. They also can manage their own responses through stress reduction exercises (see instructions below).

**Exercise 12.1,
Options A and B:
Stress reduction
exercises
(15 minutes)**



Learning objective for the exercise (slide 15)

- Practise stress reduction exercises that providers can offer as part of basic psychosocial support and mental health care and also use themselves.

Instructions for the facilitator

- Inform participants that we will practise the stress reduction techniques recommended in the clinical handbook section on mental health care.
- Explain that these can help people to feel calm and relaxed. Survivors can do the stress reduction exercises whenever they are stressed or anxious or cannot sleep.
- There are two stress reduction exercises. If time permits, do both. If time is short, choose one of them.
- Lead participants through the instructions on slides 16–18.

Slow breathing technique (Option A) (10 minutes)

- Try to keep your eyes closed. Sit with feet flat on the floor.
- First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about 2 minutes. As you breathe, feel the tension leave your body.

Progressive muscle relaxation technique (Option B) (10 minutes)

- Curl toes and hold the muscles tightly. Breathe deeply; count to 3 while holding toe muscles tight. Relax toes and let out your breath. Breathe normally and feel the relaxation in the toes.
- Do the same for each of these parts of your body in turn. Each time, breathe in deeply as you tighten the muscles, count 1–2–3, then relax and breathe out slowly.
- Hold your leg and thigh muscles tight ... 1–2–3
- Hold your belly tight ... 1–2–3
- Make fists with your hands ... 1–2–3
- Bend your arms at the elbows and hold your arms tight ... 1–2–3
- Squeeze your shoulder blades together ... 1–2–3
- Shrug your shoulders as high as you can ... 1–2–3
- Tighten all the muscles in your face ... 1–2–3

- Drop your chin slowly towards your chest. As you breathe in, slowly and carefully move your head in a circle to the right, and then breathe out as you bring your head around to the left and back towards your chest. Do this again. And one more time. Now go the other way. Inhale to the left and back, then exhale to the right and down. Do this again. And one more time.

- Now bring your head up to the centre. Notice how calm you feel.

Discussion (5 minutes)

- Discuss how these exercises felt for the group (for example, any positive effects, challenges) and ask if there are any questions.
- Emphasize that these exercises can take some time to learn and encourage participants to practice at home.
- Remind participants that these same exercises can be helpful to them as well in their daily lives and when they themselves need to remain calm and reduce the stress from caring for patients.

Exercise 12.2: **Role play on** **problem-** **solving skills** **(15 minutes)**



Learning objective for the exercise (slide 19)

- Practise problem-solving skills as a method for offering basic psychosocial support to patients.

Instructions for facilitators (slide 20)

- **Form pairs.** One person plays someone seeking help for a worry or concern. The second person plays a health-care provider.
- **Person seeking help:** Think of a problem that you have or have had recently and are comfortable sharing with your colleague. Share your problem with the person playing the health-care provider.
- **Health-care provider:** Use the five-step problem-solving approach. Ask the patient to:
 1. name or identify the problem
 2. describe the context of the problem
 3. brainstorm solutions
 4. prioritize solutions
 5. make an action plan.

Remember: Do not give advice.

After 10 minutes, bring the group back together for discussion.

Discussion (5 minutes)

- Ask participants who played the role of the help seeker what it was like to discuss their problem with a colleague. What was especially helpful, and what could have been done differently or in addition?
- Ask participants who played the role of the health-care provider what they felt they did well. Did they experience any difficulties with any of the steps?

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 21):

- Even in low-resource settings, front-line providers can offer basic psychosocial support.
- Basic psychosocial support includes stress reduction exercises.
- Assess women with continuing mental health symptoms for moderate–severe depression and PTSD.
- Manage moderate–severe conditions or refer to mental health-care specialists.
- Be aware of your own emotional needs. Practise self-care through stress reduction exercises, and seek professional help when needed.

Session 13 (supplemental): Addressing family planning and HIV disclosure for women subjected to violence

Preparation and general information	
Learning objectives and competencies 	Objective 3: Demonstrate clinical skills appropriate to one's profession and specialty to respond to violence against women. Competency ■ Demonstrate skills in identifying and caring for women experiencing violence who present to either family planning or HIV services.
Session length 	40 minutes
Training techniques 	■ Presentation (10 minutes) ■ Exercise 13.1: Case reviews in family planning and HIV settings (30 minutes)
Handouts 	■ Pros and cons of contraceptive methods in the context of violence ■ HIV disclosure counselling in the context of violence
Facilitator materials 	■ Facilitator guide: Case reviews in family planning and HIV settings
Session content	
Background 	Intimate partner violence can be embedded in other women's health concerns – as either a cause or an effect. For example, violence can be a barrier to contraceptive use, or contraceptive use can trigger violence. Similarly, violence can be a barrier to disclosure of HIV status, or it can result from HIV disclosure. These services, therefore, are important entry points for integration of the response to intimate partner violence. Additionally, contraceptive or HIV services need to be promoted in ways that support women's autonomy and enhance their safety.

**Presentation
with slides
(10 minutes)**



The slides for Session 13 cover the following content (for details, see the slide notes in the PowerPoint file):

Why talk about IPV and family planning? (slide 3)

- Women facing intimate partner violence lack control over their reproductive decisions. Unintended pregnancies and abortions are more common than among women not facing violence.
- Family planning providers can support these women not only through first-line support but also by facilitating contraceptive choice and counselling in ways that take into account their needs for safety.

How family planning providers can help (slides 4–6)

- Family planning providers can learn signs of intimate partner violence and ask about violence, including reproductive coercion.
- They can offer first-line support using the “LIVES” job aid to support women facing intimate partner violence and counsel women about contraceptive choices based on their safety concerns.

Why talk about IPV and HIV status disclosure? (slides 7–8)

- Women facing intimate partner violence may be at increased risk of acquiring STIs and HIV and are less likely to use condoms. Pathways for this include challenges in negotiating condom use, increase in risk-taking behaviours and barriers to uptake of HIV services, including risks of disclosure of status.

Addressing safety in HIV status disclosure (slides 9–10)

- Women, especially those experiencing intimate partner violence, can benefit from a provider’s help in thinking through disclosure of HIV testing and test results.
- Providers can ask a few questions to help determine whether a woman may need a plan for safer disclosure of test results or even should not disclose.
- Providers can help plan for safe HIV disclosure where there is fear or risk of violence.

**Exercise 13.1:
Case reviews for
family planning
and HIV settings
(30 minutes)**



Learning objective for the exercise (slide 11)

- Develop clinical decision-making/case management skills to respond to survivors of violence who present in family planning or HIV testing settings.

Instructions for the facilitator (slide 11)

- **Set up** two tables with flip charts — one for each scenario. Put a print-out of a scenario and questions at each table. Station one facilitator at each table to give instructions and facilitate discussion. If the group is too large, split into four groups and have two groups work on a scenario at the same time.
- **Divide** the participants into two groups. Instruct each group to go to one of the tables. There, a participant or a facilitator will read the scenario aloud, and the group will discuss the questions. A facilitator or a volunteer member of the group will take notes on the flip chart.

- **Allow 10 minutes** for the discussion. Then the groups should discuss the other scenario.
- **Once each group** has discussed each scenario (20 minutes), reconvene the entire group for discussion (10 minutes).

Guiding questions for the plenary discussion

- What difficulties did the groups have in identifying whether a person was experiencing violence? Was it easy or difficult to think about identifying signs and symptoms, conditions or behaviours?
- What questions would you ask to determine the best course of management for that particular case?
- What treatments or care were specific to each scenario, and what treatments or care were common for both scenarios?

Wrap-up



Ask if there are any **questions or concerns**.

State the **key messages** (slide 12):

- In various settings clinicians will need to develop additional skills to manage different cases of intimate partner violence.
- Some aspects of care, such as first-line support, asking about violence and management of sexual assault, are standard in any setting.
- In addition, family planning clients may need specific advice on method choice that meets their need for safety.
- Similarly, HIV-positive women will need specific advice related to safe disclosure and negotiation of safer sex.

Conclusion

Preparation and general information	
Session length 	20–40 minutes
Training techniques 	■ Guided discussion on moving beyond training to strengthen capacity (10 minutes) ■ Post-training feedback form (10 minutes) ■ Post-training survey/assessment (optional) (20 minutes)
Facilitator materials 	■ Copies of post-training feedback form ■ Copies of post-training survey/assessment (optional) (available on request)
Session content	
Guided discussion (10 minutes) 	Thank the participants for their participation. Revisit the questions and fears raised throughout the training, including from the "Fear and Motivations in a Hat" exercise in the first session, and answer any remaining questions. Conclude the training by reminding participants of their important role in responding to violence against women. Remind them that first-line support, including active, supportive listening, is an important step in restoring self-confidence to survivors. Remind them that, while this training builds knowledge, skills and confidence, learning is an ongoing process and that after the training, to keep up with skills and knowledge, it is important to go through: ■ Refresher sessions focusing on areas/topics/skills that are the most challenging to implement ■ Case management reviews, which include discussing how difficult cases are handled and what can be done to improve care and management ■ Assessing improvements in quality. Encourage them to continue practising their skills and to turn to their colleagues in this training for support. (For example, some groups have created a WhatsApp group to keep in touch.)

Remind them to rely on the clinical handbook, handouts from this training and their colleagues for ongoing support.

Ask participants if they have any questions to conclude, or next steps that they would like to discuss to improve their own or workplace/institutional response to violence against women.

Ask participants to reflect on and write down at least three steps that each of them can take to strengthen clinical management of violence for patients who seek care in their work setting.

Remind participants that an e-learning course will be available and that they can use it to reinforce their skills or remind themselves of specific aspects.

**Post-survey
(10–20
minutes)**



Distribute the form for evaluation of the training, and ask participants to complete it. Their responses will be used to inform and improve future training.

Optional: If you are evaluating the training as part of a project, pilot or just to improve quality, you also can administer a post-training survey questionnaire (20 minutes) to assess changes in knowledge and attitudes from the baseline.

Again, thank the participants for attending and for participating.

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Annex 1. Training timings and sample agendas

Training schedule	Length	
	Core content only	Optional content
Optional: Ministry introduction	—	20–30 minutes
Orientation and introductions Optional: Pre-training assessment	60 minutes	20 minutes
Session 1. Understanding violence against women as a public health problem Optional: Country-level presentations	40 minutes	15 minutes
Session 2: Understanding the survivor's experience and how providers' values and beliefs affect the care they give Optional: Additional exercises	80 minutes	40–60 minutes
Session 3. Guiding principles and overview of the health response to violence against women	30 minutes	—
Session 4: Provider–survivor communication skills	45 minutes	—
Session 5: When and how to identify intimate partner violence Optional: Shorter or longer exercise	40 minutes	30 minutes
Session 6: First-line support using LIV(ES), part 1: <u>L</u> isten, <u>I</u> nquire, <u>V</u> alidate	105 minutes	—
Session 7: Know your setting: identify referral networks and understand the legal and policy context Optional: Additional exercise and invited guest	70 minutes	30–60 minutes
Session 8: First-line support using (LIV)ES part 2: <u>E</u> nhancing safety and providing <u>S</u> upport	95 minutes	—
Session 9: Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination	75 minutes	—
Session 9a (supplemental): Forensic examination	—	60 minutes
Session 10: Clinical care for survivors of sexual assault/rape, part 2: treatment and care Optional: Additional exercise	30 minutes	30 minutes
Session 11: Documenting intimate partner violence and sexual violence	30 minutes	—
Session 12: Care for mental health and self-care for providers	55 minutes	—
Session 13 (supplemental): Addressing family planning and HIV disclosure for women subjected to violence	—	40 minutes
Conclusion Optional: Post-training assessment	20 minutes	20 minutes
Closing and certificate ceremony (optional)	--	20–30 minutes
Total time	~13 hours	~5.5–7.5 hours

For these sessions it is useful to have the participation of other sectors (for example, police, legal, protection, social services, NGOs).

Sample agendas

The full 13 sessions are usually delivered in two and a half days, and experience suggests that this is the minimum required. However, if necessary you can cover sessions 1–12 in two days. If less than two days are available, you will need to adjust the content to fit the time available. We suggest covering sessions 1 through 8 to ensure that LIVES is fully covered. Another option is to present half-day sessions over several weeks. Some settings have come back for remaining or repeated sessions six months later as part of a refresher.

The sample agendas below give examples of 2.5-day, 2-day and 1-day agendas. You will want to adapt for local context and time considerations. Be sure to allow for time for energizers when the group needs it, especially in the afternoons.

2.5-day agenda

Day 1	
9:00–9:30	Opening ceremony Welcome and introductory remarks
9:30–10:30	Orientation and introductions
10:30–10:45	Break
10:45–11:25	Session 1: Understanding violence against women as a public health problem (additional time may be needed for country presentations)
11:25–12:45	Session 2: Understanding the survivor's experience and how providers' values and beliefs affect the care they give
12:45–1:15	Session 3: Guiding principles and overview of the health response to violence against women
1:15–2:15	Lunch
2:15–3:00	Session 4: Provider–survivor communication skills
3:00–3:40	Session 5: When and how to identify intimate partner violence (without optional exercise)
3:40–3:55	Break
3:55–5:40	Session 6: First-line support using LIV(ES), part 1: <u>L</u> isten, <u>I</u> nquire, <u>V</u> alidate
Day 2	
9:00–10:40	Session 7: Know your setting: identify referral networks and understand the legal and policy context (with optional exercise or invited guest)
10:40–10:55	Break
10:55–12:30	Session 8: First-line support using (LIV)ES, part 2: <u>E</u> nhancing safety and providing <u>S</u> upport
12:30–1:30	Lunch
1:30–2:45	Session 9: Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination
2:45–3:00	Break
3:00–4:00	Session 10: Clinical care for survivors of sexual assault/rape, part 2: treatment and care (with optional exercise)
4:00–4:30	Session 11: Documenting intimate partner violence and sexual violence

Day 3	
9:00–9:55	Session 12: Care for mental health and self-care for providers
9:55–10:35	Session 13: Responding to intimate partner violence and sexual violence in different service delivery settings: family planning and HIV (supplemental session)
10:35–10:50	Break
10:50–11:15	Conclusion
11:15–12:00	Closing certificate ceremony
12:00–1:00	Lunch (optional)

2-day agenda, core content only

Day 1	
9:00–10:00	Orientation and introductions
10:00–10:40	Session 1: Understanding violence against women as a public health problem (additional time may be needed for country presentations)
10:40–10:55	Break
10:55–12:15	Session 2: Understanding the survivor's experience and how providers' values and beliefs affect the care they give
12:15–12:45	Session 3: Guiding principles and overview of the health response to violence against women
12:45–1:45	Lunch
1:45–2:30	Session 4: Provider–survivor communication skills
2:30–3:10	Session 5: When and how to identify intimate partner violence (without optional exercise)
3:10–3:25	Break
3:25–5:10	Session 6: First-line support using LIV(ES), part 1: <u>L</u> isten, <u>I</u> nquire, <u>V</u> alidate
Day 2	
9:00–10:10	Session 7: Know your setting: identify referral networks and understand the legal and policy context (without optional exercise or invited guest)
10:10–10:45	Session 8: First-line support using (LIV)ES, part 2: <u>E</u> nhancing safety and providing <u>S</u> upport
10:45–11:00	Break
11:00–12:00	Continued: Session 8: First-line support using (LIV)ES, part 2: <u>E</u> nhancing safety and providing <u>S</u> upport
12:00– 1:15	Session 9: Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination
1:15–2:15	Lunch
2:15–2:45	Session 10: Clinical care for survivors of sexual assault/rape, part 2: treatment and care
2:45–3:00	Break
3:00–3:30	Session 11: Documenting intimate partner violence and sexual violence
3:30–4:25	Session 12: Care for mental health and self-care for providers
4:25–5:00	Conclusion and post-training assessment

1-day agenda for obstetricians and gynaecologists

Objectives:

1. Raise awareness and increase the understanding of obstetrics and gynaecology practitioners on violence against women as a women's health and public health issue.
2. Familiarize obstetricians and gynaecologists with existing tools and good practices for building clinical knowledge and skills on the response to survivors of violence, including identification of partner violence, first-line support (LIVES), principles of survivor-centred care and post-rape care.

Time	Topic	Minutes	Method
Morning session			
9:00–9:20	Welcome and brief opening remarks by the organizers Presentation of the workshop objectives	20	
9:20–10:00	Introductions Fear in a Hat exercise (participants will be asked to share one challenge/fear of addressing VAW) (from Orientation session)	40	Participatory exercises
10:00–11:00	Understanding VAW as a public health problem: definitions, prevalence, health consequences, role of the health-care provider (from Session 1)	60	Presentation, Animation video, Questions & Answers
11:00–11:15	Coffee/tea break	15	
11:15–12:00	Myths and Facts: Vote with your Feet (from Session 2)	45	Participatory exercise
12:00–12:45	■ Principles of women-centred care (from Session 3) ■ Identification of women subject to violence (from Session 5) ■ First line support (LIVES), and referral (from Sessions 6 and 8)	45	Presentations, Videos, Questions & Answers
12:45–13:45	Lunch	60	Optional: local or regional video
Afternoon session			
13:45–14:45	Responding to violence in different contexts – discussion of case scenarios (from Session 13 or others depending on audience). For example: ■ Family planning ■ Antenatal care ■ HIV ■ Emergency settings	60	Discussion of case scenarios in small groups
14:45–15:30	Post-rape care (from Sessions 9 and 10) (pick up a coffee in between)	45	Presentations, Questions & Answers
15:30–15:50	Return to the barriers/fears identified in the Fear in a Hat exercise	20	
15:50–16:00	Closing remarks	10	

Annex 2. Tips for effective training

Prepare See checklist for preparation, Table 2, page 9.
Plan for the size of your group If the group is large, facilitators may need additional help with logistics or arranging smaller groups for the role play activities.
Stay on time and on topic It is the facilitator's role to keep the training on schedule and on topic. Set expectations early for keeping discussion on task and lengthy stories to a minimum. Remember to stay within the allotted time for each session. You will need to move the discussion along and keep it focused. If off-topic questions come up, let participants know when they will be addressed or put them in a "parking lot" to return to before a break, after a break or at the end of the day.
Acknowledge that content may cause distress and manage sensitive or difficult situations Acknowledge that there may be some aspects of the content that may be disturbing for participants who have experienced violence in their own lives. Tell the participants that those who feel distressed during the training can leave the room to take a break and return when ready. Provide a list of resources in the community that could support participants who experience distress because of their own experience of violence and make these resources available to participants. If any participants disrupt the session, suggest that there will be an opportunity to address their concerns separately after the training.
"Read" the participants During introductions and over the first few sessions, study your audience: ■ Assess which participants may be comfortable in a role play in front of the group – and which ones might be shy and prefer input in a small group or a one-on-one setting. ■ Identify participants who may be more experienced in providing health care for women subjected to violence. ■ Experienced participants may be helpful in leading role plays and providing examples. ■ You may be able to call on them to start discussion if needed.
Engage participants To engage as many different participants as possible, ensure that you give different people chances to speak. Be careful not to over-rely on the experienced participants; instead, encourage everyone to participate.
Get moving! ■ Moving around the room for group activities can help energize participants and maintain momentum over a multi-day training. ■ Suggestions for movement are embedded in sessions. Use your judgement and sense of the audience to determine when and how many to incorporate. ■ Use energizers throughout when participants are low in energy, especially immediately after lunch.

Create an option for anonymous questions

Place a hat, box or bag somewhere in the room where participants can leave written questions. Address the new questions at the end of each day or the following morning. This ensures that participants can still ask questions even if they do not want to ask them in front of the group.

Keep key resources handy

The guiding documents for this training are the 2014 WHO *Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook*, the 2017 health systems manual, *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence*, and the 2017 *Responding to children and adolescents who have been sexually abused* (see Annex 3). There may also be a national version of the clinical handbook or protocols or standard operating procedures (SOP). Keep all of these close at hand for reference.

Annex 3. Reading materials and handouts

This table lists, by session, the resource materials to be printed or distributed electronically to training participants, and also the facilitator's printed instructions.

- Provide the reading materials either on paper or electronically, on a USB stick, as the table suggests. Ask participants to read the clinical handbook as well as the national protocol/guideline/SOP to prepare for the training. The other resources are for additional reference or reading.
- The handouts are designed for participants to keep as reference materials after the training. They can be distributed electronically on USB sticks for each participant. Printed copies should be made available to participants who cannot use USB sticks.
- Exercises should be printed in advance with enough copies for all participants. They may require adaptation or translation prior to the training.
- Materials designated "Facilitator's resources" should be printed for the facilitator's use but not distributed to participants.
- Be sure to leave enough time to assemble participants' materials.

Session	Materials and supplemental reading	Print or obtain print copies	Copy for facilitator only	Copy to USB stick
All	Resource: WHO clinical handbook on health care for women subjected to intimate partner violence or sexual violence (2014)	✓		✓
	Resource: Any national guideline, protocol, SOP or policy documents pertaining to the health response to violence against women	✓		✓
	Resource: Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers (2017)			✓
	Resource: Responding to children and adolescents who have been sexually abused: WHO clinical guidelines (2017)			✓
	PowerPoint materials (slides for all sessions in PDF)			✓
Orientation and introductions	Pre-training questionnaire (optional)	✓		
1	Participant handout: Violence against women: Global picture/health response	✓		✓
	Participant handout: Addressing provider barriers to responding to violence against women	✓		✓
	Video: Strengthening health systems response to violence against women (https://www.youtube.com/watch?v=Qc_GHITvTml)			✓

Session	Materials and supplemental reading	Print or obtain print copies	Copy for facilitator only	Copy to USB stick
2	Facilitator resource: Exercise 2.1, Option A: Myth or Fact?		✓	
	Facilitator resource: Exercise 2.1, Option B: Voting with Your Feet		✓	
	Exercise 2.2, Option A: Blanketed by Blame: Character cards	✓		
	Exercise 2.2, Option B: In Her Shoes Facilitator resource available at: http://raisingvoices.org/innovation/creating-methodologies/in-her-shoes/		✓	
	Exercise 2.2, Option B: In Her Shoes Story and station cards available at: http://raisingvoices.org/innovation/creating-methodologies/in-her-shoes/	✓		
	Participant handout: Why don't women leave?	✓		✓
	Participant handout: Barriers to care-seeking	✓		✓
3	Participant handout: Poster or small pocket card summarizing LIVES (first-line support)	✓		✓
4	Participant handout: Active listening principles	✓		✓
5	Exercise 5.1, Option A: Role play on identification of intimate partner violence	✓		
	Exercise 5.1, Option B: Case reviews on identification of intimate partner violence	✓		
	Participant handout: Asking about violence	✓		✓
6	Exercise 6.1: Role play to practise LIV(ES), part 1	✓		
	Video demonstrating identification of violence and LIV elements of LIVES, followed by guided discussion (https://youtu.be/Hu06nVCzih0 , minutes 8:40 to 14:20 and 14:47 to 20:36) (30 minutes)		✓	
6	Participant handout: Communication skills and pathways	✓		✓
	Participant handout: Health-care providers' common questions	✓		✓
7	Exercise 7.1: The Web of Referrals – character cards	✓		
	Exercise 7.2: Drawing the ideal referral pathway – template (job aid 8.1 in the health manager's manual, page 91)	✓		
8	Exercise 8.1: Role play scenarios (LIV)ES, part 2	✓		

Session	Materials and supplemental reading	Print or obtain print copies	Copy for facilitator only	Copy to USB stick
9	Participant handout: Responding to children and adolescents who have been sexually abused: WHO clinical guidelines	✓		
	Participant handout: Preparing to gather the story	✓		✓
	Participant handout: Special considerations for medico-legal services for child victims	✓		✓
	Participant handout: Forensic medical examination	✓		✓
	Participant handout: Medico-legal evidence in sexual violence	✓		✓
9	USB key or download: clinical management of rape – e-learning (Step 3, history-taking case study) (http://apps.who.int/iris/bitstream/handle/10665/44190/CMoR_CDDownloadMultilingualVersion.zip?sequence=2&isAllowed=y)		✓	✓
	Exercise 9.1: Role play on history-taking scenarios	✓		
	Exercise 9.1: Sample history and examination form (from clinical handbook, pages 91–92)	✓		
9a	USB key or download: Clinical management of rape survivors – e-learning – Step 4 (Collecting forensic evidence) (https://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/)			✓
	Exercise 9a.1: Scenarios and a table for recording responses	✓		
10	Exercise 10.1: Case studies on treatment for sexual assault (includes template with blank tables)	✓		
12	Video showing how to assess risk for depression (https://www.youtube.com/watch?v=hgNAySulsjY&index=2&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&t=0s)		✓	✓
13	Exercise 13.1: Case reviews in family planning and HIV settings	✓		
	Participant handout: Pros and cons of contraceptive methods in the context of violence	✓		✓
	Participant handout: HIV disclosure counselling in the context of violence	✓		✓
Conclusion	Training feedback (evaluation) form	✓		
	Post-training questionnaire (optional)	✓		

Annex 4. Supplies checklist

☐ Laptop with PowerPoint software and VLC or other media player
☐ Flip charts
☐ Markers – pens that write on flip charts
☐ Pens
☐ Notebooks for note-taking
☐ Coloured Post-it notes
☐ Coloured index cards
☐ Tape or something else to stick flip charts to the walls
☐ Hat or box or bowl (for Fear and Motivations in a Hat exercise)
☐ 11 shawls or newspaper sheets (for Blanketed by Blame exercise)
☐ 2–3 balls of coloured yarn (for referral exercise)
☐ Reading materials, handouts and other learning materials for participants (see Annex 3)

Annex 5. Providing feedback: responding to questions and role plays

Responding to questions

- Answer questions briefly and, where appropriate, turn the question to the rest of the learners for input. This works particularly well for feedback on role plays or handling difficult situations.
- Refer participants to written materials for references and/or further clarification.
- If the question will be answered in a future session, let learners know when it will come up.
- After a question has been discussed, ask the participant if the question was answered. If time is constrained, you may need to follow up with the participant during a break if they need more information or discussion.
 - Incorporate core principles in your answers where possible. Core principles are most useful for responding to questions that include trusting women's safety decisions, self-determination and listening to patients. For example, the principle of self-determination means that we let the patient determine when or how she will disclose violence.
- Ask the participants to read the frequently asked questions in the clinical handbook (pages 34–37) and see if some of their questions are answered.
- There may be participants who express helplessness or frustration about structural or systemic issues that are beyond their control, such as constraints on resources available for survivors of violence or communication systems that they feel could put survivors at risk.
 - Acknowledge the challenging systems within which participants are working.
 - Encourage them to engage their supervisors and managers and refer them to the health manager's manual on strengthening health systems as a guide for improving system-level constraints.
- Some questions may be beyond the scope of the training.
 - Remind learners that the training is focused on first-line support, clinical care, documentation and referrals.
 - Remind participants that addressing violence against women requires a multi-pronged, multisectoral approach and that the health sector has, nonetheless, an important contribution to make. It is not their responsibility to solve all the problems of the survivors.
 - Encourage participants to seek out additional information and make connections with advocates, programmers and service providers from other sectors to create a community of practice and learning.
- Some questions may indicate participants' desire to ascertain whether a survivor has indeed experienced violence as she claims.
 - Remind participants that it is for the justice system to establish, based on the evidence, whether the survivor has been subjected to violence or assault. Their role as health-care providers is to provide, without judgement, the health care and first-line support needed and to document, in as much detail as possible, the history (as told by her) and the physical examination findings.

Role plays

Role plays are an essential component of this training and represent opportunities for trainees to practise their skills. These skills are practised in groups of three, taking turns to play the role of the provider, survivor and observer.

- The observers should observe the interactions and provide constructive feedback on the role play.
- Feedback should be given in a structured manner, based on the instructions for role plays that the facilitator should provide.
- Facilitators should circulate and provide constructive suggestions where needed.
- Invite one group to demonstrate their role play in front of the entire group after determining whether they are comfortable or not.
- Ask participants to remain constructive when providing feedback and assure the people who are demonstrating the role play that this is not a judgement of their performance.
- The facilitator can also demonstrate to the entire group a role play of an effective way of practising LIVES and/or show a video that models the correct behaviours.

Note: when having participants do role plays in front of the group, choose as provider those most likely to demonstrate a comprehensive response according to the steps taught, as this will be seen as an example of how it should be done.

Providing feedback on role plays

- Remember, your participants may be new to LIVES and discussing violence against women. Your role is to encourage them and provide examples and feedback to help them improve.
- Be sure to emphasize positive feedback and point out what was done well.
- Areas that need adjustment can be referred to as “opportunities for improvement”.
- Directly correct anything that may be harmful to patients, such as victim-blaming.

Structure for providing feedback on role plays in small groups or within the large group

- Comment first on 1–2 areas that worked well (remember to include verbal and non-verbal communication; link to guiding principles if possible).
- Ask those doing the role play what areas were difficult.
- Provide suggestions for improvement.
- Invite others in the group to provide suggestions as to how the difficult area could be handled.
- Provide any last facilitator comment or recommendation.
- Thank the presenters.

Annex 6. Certificate distribution or ceremony (optional)

Signed completion certificates can be a lasting reminder of the lessons learned in the training and can be an incentive to put the learning into practice. If printed and signed completion certificates will be provided to participants, allow sufficient time to prepare and sign the certificates.

Individual recognition through a certificate ceremony can inspire training participants to become champions and affirm their important role in providing health care to survivors of violence.

Present the certificates individually, calling each participant to the front of the room for presentation by a facilitator and a photo (20–30 minutes).

If time is limited, consider distributing certificates as participants leave or mailing certificates.

Annex 7. Tools for monitoring and evaluation

Evaluation allows facilitators to understand whether the training objectives have been met. Evaluation tools can also be used to assess needs for refresher training.

The evaluation tools include:

Participant pre- and post-training questionnaires

- Evaluate trainees' knowledge, attitudes and skills/competencies pre- and post-training
- Assess demographics, practice characteristics and training background
- Can be administered:
 - immediately before and after the training (recommended) AND
 - at regular intervals (3–6 months) thereafter, to assess the durability of lessons learned and identify needs for ongoing support.

Implementation documentation

- Documents the setting, dates of implementation, number and nature of participants, length of training, adaptations to the training materials and recommendations for adaptations to the training
- Is completed by the facilitator
- Can be completed after the training as part of documentation and ongoing quality improvement for the training.

Training feedback/evaluation form

- To be administered at the end of the training.
- Provides an overall assessment of the training, identifying which sessions worked and which ones need to be improved.

Annex 8. Supplemental exercises

The following exercises are supplemental to reinforce the primary objectives of the training. Facilitators should consider time and group interests when considering where and how to incorporate these activities. Many of these activities can be useful for encouraging attitudinal change.

For example:

- When sufficient time is available, start the training with (one or more of) these supplemental sensitization activities below to allow the participants to further understand the underlying causes of violence and how response behaviour may impact survivors.
- If not possible at the start, reconvene participants 4–6 weeks after the training and complete one of the supplemental activities below.
- Incorporate a supplemental activity at a regularly scheduled meeting.

Learning objectives and competencies

Objective 1: Demonstrate general knowledge of violence against women as a public health problem.

Competencies:

- Articulate the pervasiveness and normalization of violence and how it impacts all individuals.
- Describe factors in society that contribute to the perpetuation of intimate partner and sexual violence.

Objective 2: Demonstrate values and behaviours contributing to safe and supportive services

Competency:

- Demonstrate an awareness of how power differences between people have shaped our lives and experiences.

Recommended supplemental exercises		
The Space Between Us ¹	This activity creates awareness of how power has shaped our lives and experiences and exposes participants to the terms “gender equality” and “gender equity”.	60 minutes
The Factors that Perpetuate Violence	This activity identifies the community and social norms and roles that contribute to violence.	25 minutes
Additional supplemental activities		
Personal Beliefs and Different Listening Experiences	This activity is designed for participants to understand how their own assumptions can influence listening and the response provided.	45 minutes
Persons and Things	This activity involves participants acting as persons commanding things (objects) to do things and reflecting on how it feels to be a person in charge of a thing and vice versa. It aims to increase awareness about the existence of power in relationships and its impact on individuals and relationships.	45 minutes
Violence in Our Daily Life	This activity explores the pervasiveness and normalization of violence and how it impacts all individuals.	40 minutes
Root Causes	This activity allows for participants to explore the root causes of violence against women.	70 minutes

¹ From Raising Voices Sasa!: http://raisingvoices.org/wp-content/uploads/2013/03/downloads/Sasa/SASA_Activist_Kit/START/Training/Start.Training.DeepKnowModule.pdf.

Annex 9. Overview of handouts and resources for exercises*

Overview of handouts

Session	Handout
1	Violence against women global picture health response
1	Addressing provider barriers to assessment of violence against women
1	Why does the health care provider response matter?
2	Why don't women leave
2	Barriers to seeking care
3	Poster/small pocket card summarising LIVES
4	Active listening principles
5	Asking about violence
6	Communication skills and pathway
6	Health-care providers' common questions
9	Good practice for history taking, physical examination and documentation of findings of children and adolescents who have been sexually abused
9	Preparing to gather the story
9	Special considerations for medico-legal services for child victims
9	The forensic medical examination
9	Medico-legal evidence in sexual violence
13	Pros and Cons of contraceptive methods in the context of violence
13	HIV disclosure counselling in the context of violence

Overview of resources for exercises

Session	Exercise number	Exercise	Time	Facilitator resources and participant handouts
0	1	Fear and motivations in a hat	30 min	■ See facilitator's guide: pp 15–16
2	2.1 A	Myth or Fact	15 min	■ Facilitator resource
2	2.1 B	Voting with your feet	30 min	■ Facilitator resource and 2 signs
2	2.2 A	Blanketed by blame	45 min	■ See facilitator's guide: pp 23–24 ■ Participant handout: character cards
2	2.2 B	In her shoes	75 min	■ Facilitator resource
4	4.1	Active listening	30 min	■ See facilitator's guide: pp 33–34
5	5.1 A	A Role play on identification of intimate partner violence	60 min	■ Participant handout: Role play scenarios on IPV identification

Session	Exercise number	Exercise	Time	Facilitator resources and participant handouts
5	5.1 B	Case reviews on identification of intimate partner violence	30 min	Participant handout: case reviews on IPV identification
6	6.1	Role play scenarios on LIV(ES), part one	60 min	- See facilitators' guide: pp 42–43 - Participant handout: Role play scenarios
7	7.1	The web of referrals	30 min	- See facilitator's guide: pp 46 - Participant handout: Character cards
7	7.2	Drawing the ideal referral pathway	30 min	- See facilitator's guide: pp 47 - Participant handout: template
8	8.1	Role play scenarios on (LIV)ES, part two	60 min	- Facilitator instructions: see facilitator's guide, pp 51–52 - Participant handout: Role play scenarios
9	9.1	Role play on history-taking	45 min	- Participant handout: Role play scenarios - Participant handout: Sample history and examination form
9a	9a.1	Decision-making on forensic evidence collection	30 min	Participant handout: Scenarios and table to record responses
10	10.1	Case studies on treatment after sexual assault	30 min	Participant handout: Case studies including template
12	12.1a	Stress reduction exercise: slow breathing technique	10 min	See facilitator's guide: pp 68
12	12.1b	Stress reduction exercise: Progressive muscle relaxation technique	10 min	See facilitator's guide: pp 68–69
12	12.2	Role play on problem-solving skills	15 min	See facilitator's guide: pp 69
13	13.1	Case reviews in family planning and HIV settings	30 min	Participant handout: case reviews in family planning and HIV settings

***All these materials are available from:**
www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/

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