



SCREENING FOR GENDER-BASED VIOLENCE IN PRIMARY HEALTH FACILITIES IN HUMANITARIAN SETTINGS;

IMPLEMENTATION GUIDELINES AND RECOMMENDATIONS FOR IRC PROGRAMS

BACKGROUND

Gender-based violence (GBV) against women and girls includes sexual violence, sexual exploitation and abuse, intimate partner violence (including sexual, emotional, physical and economic violence), forced, child and early marriage, and denial of access to services, resources and opportunities. The majority of this violence is perpetrated by male intimate partners or males within the wider family or community. In conflict-affected areas, it is an epidemic. Recent research suggests that **at least 1 in 5 refugee or displaced women in humanitarian settings have experienced sexual violence¹ and 2 out of 3 women reported IPV in their lifetime.² This same research showed IPV increased during conflict.** This figure is even higher when considering women who experience child, early and forced marriage, FGM, sexual exploitation and abuse, and denial of access to resources, services and opportunities. These figures are also probably an underestimate due to the significant underreporting of GBV by women and girls.

In recent years there has been increased attention around the need for GBV programming in humanitarian settings that has resulted in numerous publications of GBV guidelines, toolkits and protocols that aim to improve the quality of care provided to survivors and to increase the utilization of GBV services. Despite these efforts, an Inter-Agency Working Group (IAWG) Global Evaluation found that medical care for survivors remains one of the most neglected health interventions during humanitarian emergencies.³

While lack of available services is one of the biggest barriers to women and girls seeking help when they experience gender based violence, factors such as the lack of knowledge about

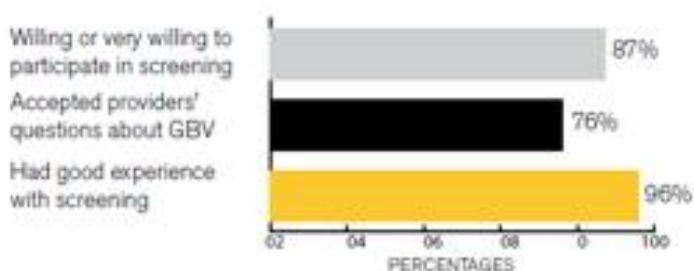
the services and the importance of timely care as well as uncertainty in health providers' capacity to provide confidential, competent and compassionate care keeps survivors from seeking help. As a result there are thousands of women and girls who could benefit from clinical care and psychosocial support, protection and other services. Instead, they face increased risk of ongoing injury/infections as well as the long-term consequences of isolation, untreated trauma, including depression, suicide, and barriers which affect their ability to fulfil their social, education, or economic potential.

Competent, confidential and compassionate care is critical for reducing the risk of ongoing injury, suffering and long-term consequences for women and adolescent girl survivors of GBV. International standards for humanitarian interventions recognize this need, noting the right of survivors to access care and to be treated with dignity and respect and free from blame. These responsibilities cannot be realized, however, without addressing two key realities: survivors are often reluctant to self-report, due to the stigmatizing and sensitive nature of GBV, and health care workers are not routinely trained to care for and identify women and adolescent girls who have experienced GBV.

Enabling skilled providers to confidentially, efficiently and effectively identify women and girls who have experienced GBV and to handle disclosures of abuse using a survivor-centered approach is a crucial part of ensuring that women and girls receive care that meets their needs and promotes their safety. Skilled providers breaking the silence on GBV provides an opportunity for survivors of GBV to disclose violence and builds trust in the health system as a place of care and non-judgmental response to GBV.

KEY FINDINGS FROM THE KENYA EVALUATION

Women in general were **positive** towards the screening intervention:



- **89.3%** of women offered screening for GBV accepted the intervention.
- **2.5%** (213/8,369) of women screened were identified as a survivor of at least one type of GBV within the past 12 months during the intervention period.
- The health facilities increased GBV referrals by **241%** (58 vs. 17) compared to the same period the previous year.
- Women referred from the health facilities accounted for **25%** (58/243) of the women seen in the Support Center.
- **57%** (33/58) of those presented as a direct result of the screening intervention.

Humanitarian practitioners are interested in the practice, based on studies suggesting that screening for GBV in health care settings is acceptable to clients and providers, and can increase the identification of survivors who might need care. Despite this, the World Health Organization's recommendations around GBV screening remain weak pending additional research proving that screening reduces violence and improves health outcomes in low-resource settings.

To advance the evidence around GBV screening, the International Rescue Committee (IRC) conducted a rigorous evaluation of its feasibility and acceptability in humanitarian settings in collaborating with Johns Hopkins University (JHU). The evaluation took place in 2015 and the screening tool used for the pilot was the 'Assessment Screen to Identify Survivors Toolkit' for GBV (ASIST-GBV) developed by JHU and seeking to proactively and routinely identify women and girl survivors of different types of GBV, such as intimate partner violence, sexual violence, forced marriage, sexual exploitation, forced pregnancy and/or abortion.⁴

Sexual violence and abuse is also perpetrated against children by adults, and against men by other men. This GBV screening tool is not appropriate for use with child or adult male survivors. The tool is specifically designed and evaluated for use with women and girl survivors of GBV and addresses all types of GBV, not only sexual violence. Clinical Care for Sexual Assault Survivors must be available to all survivors of violence

213 women reported **369** different incidents of GBV, as follows:



and specific guidance on how to support child and male survivors of sexual violence is included in the CCSAS multimedia training tool.⁵

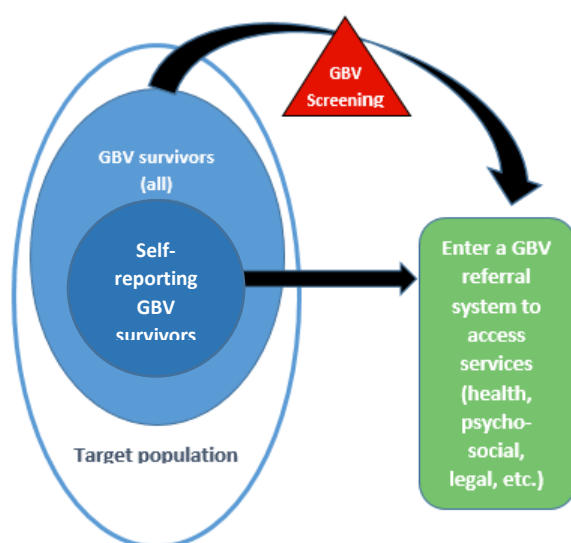
Based on these efforts and the evaluation findings, several IRC Country Programs decided to implement GBV screening following the evaluation. These guidelines build on evaluation findings followed by years of IRC GBV screening experience in several different humanitarian contexts, and aim to guide Health and WPE program coordinators and managers who wish to implement GBV screening as an intervention to ensure access to comprehensive GBV services using an integrated approach.

All tools and material presented has been adapted from the JHU 'Manual for Use of Assessment Screen to Identify Survivors of Gender Based Violence (ASIST-GBV) Among Refugee and Displaced Women and Girls'. The adaptation is based on the IRC experience from both refugee and local conflict-prone populations to make it applicable to the contexts and conditions under which the IRC works

WHAT IS SCREENING FOR GBV?

Screening as a public health approach is widely used in the medical field. WHO defines screening as 'the presumptive identification of unrecognized disease in an apparently healthy, asymptomatic population by means of tests, examinations or other procedures that can be applied rapidly and easily to the target population'.⁶

Currently, the identification and care of survivors of GBV is reliant on survivors coming forward to disclose violence and seek help from service providers. However, fear, stigma and discrimination, lack of knowledge of, or confidence in, existing services, lack of awareness of health outcomes are all significant barriers to reporting and contribute to current issues of under-reporting of GBV and low uptake of services for GBV. Obviously there is no rapid test to verify whether someone has been exposed to violence. Screening for GBV is therefore conducted through a questionnaire whereby women and older adolescent girls are exposed to questions concerning their experiences with different types of GBV within the past 12 months.



Typically, women and girl survivors of GBV are identified when a survivor self-reports to a service provider, community organization, protection entity, health provider, or community group. Many organizations have established mechanisms to encourage reporting through assurances of private and confidential reporting, sensitive and respectful approaches to victims, and linkages of reporting to services. They remain insufficient, however, because only a small percentage of women and girls who have experienced violence disclose their experience of GBV to health or other service sectors.

The screening intervention allows skilled providers to confidentially, efficiently, and effectively identify individuals who may have experienced GBV, and to improve rates of early detection and referral to health, psychosocial, and protection services.

The primary objective of GBV screening is to identify survivors of GBV AND refer to GBV services based on the needs and the willingness of the survivor. Identification alone is NOT the goal.

Secondly, screening will increase awareness about services available in the facilities and potentially reduce stigma in the affected communities.

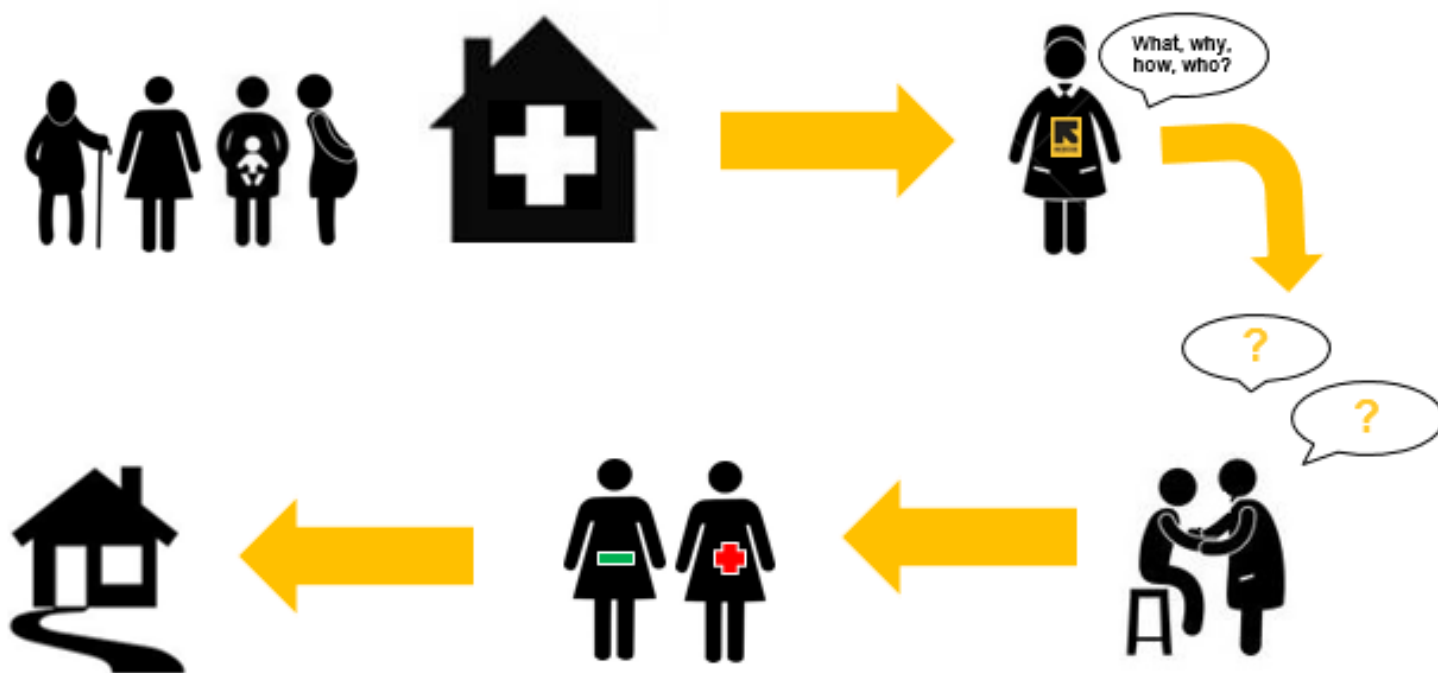
PRE-REQUISITES

GBV screening is a sensitive topic and if not implemented with caution, it could potentially put women and girls, as well as providers at risk of violence. This section describes the pre-requisite elements that need to be in place when considering implementing GBV screening. These essential elements include:

1. **Screening venue:** the intervention can be implemented in any setting (health clinic, refugee registration center, or community outreach center) where a large proportion of the population can be accessed systematically.
2. **Adaptation of the screening tool:** The questions in the questionnaire need to reflect the most common types of gender based violence perpetrated against women and older adolescent girls in the local community (see Annex 1). Language needs to be understood by providers and clients. This is easily tested with a small pilot population of women before actual implementation.
3. **Quality referral services available:** Screening should only target types of violence where quality referral options are available and accessible for both clinical care and GBV case management support. Identifying women and adolescent girl survivors of GBV without actual health and PSS services available to meet their needs is not only unethical, it also goes against the main objective of GBV screening.
4. **Training of staff:** Staff carrying out GBV screening must have gone through a 1-day training on how to apply the screening tool (see Annex 3). Furthermore, health providers should have participated in the CCSAS training or other standardized CMR/GBV training.
5. **Preparing the community and local partners for screening:** An overview and explanation of GBV screening should be provided to local organizations and leaders in a culturally appropriate manner so that the community understands the purpose of screening intervention.
6. **Ensuring universality and routine use of the GBV screening tool:** The target population needs to be clearly defined and screening applied to all women who meet eligibility criteria (see below). The screening will need to be conducted on a routine basis, such that the target population is made aware of the screening services and can inform others.

PATIENT/CLIENT FLOW DURING GBV SCREENING

The flow during GBV screening should be adapted to the patient/client flow in the facility. While GBV screening can take place in various types of facilities (transit centers, health facilities, women and girl safe spaces, outreach), the process and the steps to follow are basically identical. Within the IRC, the GBV screening intervention has primarily been implemented within health facilities and therefore this will be used as an example.



As illustrated above, screening takes place before the actual consultation. In the waiting area the targeted population will be provided with information about GBV screening in a group by a trained health provider. This information includes; What is GBV? Why is it important for survivors to receive assistance? What are the consequences of GBV? How can one be screened? Patients are also informed that their participation is confidential, voluntary and that there will be no consequences should they not wish to be screened.

In most of the IRC locations, the target population has been defined as women and older adolescent girls attending Ante Natal Care (ANC), Post Natal Care (PNC), contraception services and gynecological consultations. This is mainly to account for the increased workload at GBV referral points, such as case management and psychosocial activities, but also to ensure staff capacity at the screening point.

Once the group information is transmitted and potential questions answered, the patients will be called in one by one by the health provider as usual. Before attending to the patient's primary request (purpose of their visit), the patient will be asked if she wants to participate in the GBV screening. If yes, she will be exposed to the screening questions one by one. If she answers 'yes' to even one single question, she is per definition categorized as 'positive'. If she answers 'no' to ALL questions, she is 'negative'.

Women and older adolescent girls who screen 'positive' will be informed about the different services available to her and those found 'negative' will be given the same information in case it should ever happen to her or someone she knows (or in case they for some reason didn't answer the questions truthfully).

Remember: It is not for the provider to decide what services the woman needs. Some GBV survivors will not necessarily need or want further assistance.

ELIGIBILITY CRITERIA FOR SCREENING

Even with the target population clearly defined, there are certain situations where screening should not be carried out. This is referred to as screening eligibility criteria and is different from the screening pre-requisites which determine whether or not a facility should be considered for the GBV screening intervention.

Informed Consent: Women and older adolescent girls who participate in the screening intervention will be requested to give oral consent directly to the provider carrying out the screening once they've received clear information from the service provider (during the group session). The service provider needs to give women and older adolescent girls the opportunity to ask questions about GBV screening. Patients/clients have the right to accept or decline screening and have a right to informed consent before being exposed to the questions. Written consent is not required and therefore no consent forms should be signed or kept in the facility.

Age and intellectual capacity: In most countries the legal age for consent is 18 years. However, older adolescent girls are able to make decisions concerning their lives based on their maturity. This is known as emancipation and applies to girls under the age of 18 if, for example, she is already married, has children or has the responsibilities of an adult lifestyle. In such cases girls as young as 15 can be included in GBV screening. On the other hand, if an adult women doesn't have the intellectual capacity to understand the information or the

potential consequences of the screening, then she shouldn't be offered screening.

Sex: This tool has been designed and tested for use with women and older adolescent girls to screen for GBV and increase their access to GBV response services, it is therefore not suitable for use with male or child survivors.

Privacy and confidentiality: In order to keep survivors safe, confidentiality and privacy must be ensured at all times. This means having a private area where screening can take place undisturbed, that providers are aware of the importance of confidentiality and that only unaccompanied women and older adolescent girls are considered eligible for screening. Respecting privacy, confidentiality in order to keep patients/safe are absolute requirements.

REFERRALS

Survivor centered care is based on the needs and the wishes of the survivor, which means referral services are simply explained in an understandable way and a referral offered. Whether referrals are actually executed will depend on the survivor's decision and them giving their informed consent.

As mentioned above, referral should be of acceptable quality and the types of questions included in the screening should carefully reflect the actual services available and accessible. For example, screening questions concerning intimate partner violence should not be included unless there are case management and psychosocial support services immediately available.

Many survivors will need time to re-think their options and may not wish to be referred directly. This should be fully respected by service providers. Experience shows however, that more survivors accept referrals if the services are immediately accessible. This should be taken into consideration when designing the project.

Women and older adolescent girls who screen 'positive' as well as those who screen 'negative' should receive information about the different referral options and the importance of timely assistance. Partly because some may experience violence later or know others in need, but also because there is a risk that the woman didn't feel comfortable disclosing GBV in her answers to the questions during the screening. Given the risks and taboos, this is understandable and making sure she still knows where to go for help is essential.

DATA COLLECTION

The objective of GBV screening is to increase access to services and therefore very little data is collected in relation to the actual screening. The number of women and older adolescent girls offered screening, the number who accepted to be screened, and finally the number who screened positive is recorded anonymously in a tally sheet (Annex 2) which should

be used for M&E purposes. Under NO circumstance should sensitive information concerning the screening be recorded in the patient file or in the facility register. Nor should screening data be used to establish prevalence among the target population as this goes against international best practices for GBV data collection.

Survivors who are found 'positive' and wish to receive care will be provided with support by health providers or case managers, who will follow best practice protocols to appropriately document the case with the informed consent of the survivor.⁷

BUDGETING The screening intervention itself is not particularly resource demanding. The workload that follows caused by the increased numbers of women and girl survivors of GBV who will need clinical care and GBV case management however, does significantly increase the workload across sectors. Based on IRC experiences⁸ from Kenya and South Sudan (refugee settings), the increase in survivors referred for WPE and/or health services ranged between 241-262%. This needs to be accounted for before the intervention is implemented with all referral services in order to meet the needs of identified survivors.

Furthermore the health teams need to budget for the actual screening process. This is typically done by the nurses/midwives/clinical officers who conduct the consultation, but could also be done by midwife assistants,



VCT counselors or other non-clinical staff. Asking the questions should not take more than 3-4 minutes per patient and depending on the answers the referral process could take a little longer. It is important to keep in mind that screening is a rapid process to determine the need for further referral. It is not a counselling session and if such an activity is needed, the survivor should be referred to the GBV case managers.

In order to save time in the often crowded health facilities, the information session is given in the waiting areas to larger groups of patients. This approach is also in line with how HIV counselling and testing is conducted whereby general information is given to a large group and actual consent is obtained individually by the clinical provider in a private confidential space.

ADVANTAGES OF GBV SCREENING

The IRC projects have produced several positive outcomes as evidenced by an increase in GBV cases identified and referred, as well as favorable feedback from clients and providers.

In Kenya and South Sudan, refugee camps as well as local communities, the number of referred cases of GBV to the WPE support center/safe spaces rose significantly (2-3 fold) during the intervention period. This increase was partly due to women and older adolescent girls who presented as a direct result of the GBV screening as well as a general increase in referrals from health facilities. In Eastern DRC no baseline data was available but for two years in a row, 100% of women and girl survivors of sexual assault presented within 72 hours which speaks to the awareness and accessibility of services in the intervention area.

In addition to improved access to comprehensive GBV care, survivors also demonstrated greater willingness to report GBV cases and began speaking openly about GBV with providers and referring cases involving acquaintances, such as family members and neighbors. This increased comfort was also shared by providers, who not only felt that they could speak more freely with patients about different forms of GBV, but expressed a desire to take on more responsibility for providing care for GBV. This change in attitude was supported — and facilitated — by greater collaboration and communication between different program sectors, improving the overall referral pathway. Though screening was initially time-consuming, it was decreased to two to three minutes by conducting group sessions on general GBV awareness — which women and older adolescent girls deemed acceptable — prior to obtaining individual consent as mentioned above.

Furthermore, initial assumptions about the individuals best placed to carry out the screening were proven wrong. We initially hypothesized that nurses, midwives and clinical officers should carry out the screening but found that, in spite of concerns raised by some providers, women and older adolescent girls trusted refugee staff members, local staff and

non-clinical staff who spoke the local language and had received additional training on the importance of confidentiality and privacy. It is therefore to be decided on a case to case basis, who is best placed to carry out the screening.

CHALLENGES OF GBV SCREENING

While GBV screening resulted in encouraging trends, the full potential of the intervention is challenged in some locations by limitations concerning staff, confidential structure and immediate availability of follow-up GBV response services. It was found that health facilities (especially in refugee settings) were often ill-equipped to provide private spaces where the screening could take place, which is one of the prerequisites for GBV screening. Options were often limited to shared consultation rooms or open-air consultations due to uncomfortably hot climates indoor, resulting in fewer women and older adolescent girls being screened.

Conducting the screening also resulted in an increased workload for staff operating in an already overworked environment, such as in Dadaab, where the provider-to-patient ratio more than doubles the standards set by the Sphere guidelines. As a result, though the numbers of women and older adolescent girls screened increased every month, it still reflected a lower percentage of women and older adolescent girls screened than expected. The high workload continued to negatively impact providers' ability to respond to the needs of survivors even after the initial screening.

A considerable number of women and older adolescent girls who did not screen positive for GBV within the past 12 months still expressed a need for psychosocial support. For some survivors, the assault(s) may have happened prior to that period, or have included types of assault that are not based on gender. GBV case managers struggled to meet the needs and expectations of these clients due to their already overstretched capacity.

Even after the screening, operational barriers limited the ability to fully meet the needs of survivors. Psychosocial support and GBV case management was not immediately available in the health facilities and GBV survivors either had to walk to the support center or wait for ambulance referral. As a result, women and older adolescent girls often chose to postpone referrals due to other responsibilities, such as childcare and household chores.

Providers need to be equipped to deal with the reactions from women and older adolescent girls during and after the screening. For a woman to be screened positive doesn't necessarily mean that she identifies herself as a survivor. She could have sufficient support and coping mechanisms in place to deal with the situation and in some cases, such as marital rape and forced pregnancy, the types of GBV that were

screened for may not have been considered abusive according to cultural/religious perceptions.

Providers need to address this in a respectful manner but nonetheless challenge harmful stereotypes or cultural/social norms which affect women and girl's health and safety.

INTEGRATED PROGRAMMING AT IRC

Identifying areas of complementarity between different sectors and realizing the advantages for women and girls and implementers are the building blocks of the integrated approach. Programming can potentially be more cost-effective and reach a greater portion of women and girls in the affected population. By using an integrated approach, with staff and various sectors working in partnership, programs can be better equipped to mitigate risks and fully meet the needs of women and girls.

Although there is no agreed upon definition for integrated programming, there is common understanding around the approach with different sectors or teams joining forces and taking collaboration to the next level while acknowledging the advantages and the challenges this brings.

In the IRC2020 strategy this is clearly demonstrated in the shift to outcome-driven programming. Achieving outcomes for women and girls can only happen through combined and coordinated efforts and in the case of GBV programming, making sure that GBV services are available, of good quality and that survivors have the knowledge, power and support to seek services. Integrated SRH and WPE programming should be the ideal at all times if we want to see improvements in safety and health outcomes for women and girls in humanitarian settings.

RECOMMENDATIONS

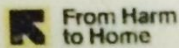
- **Establish plans for addressing increased staff workload.** As mentioned in ASIST-GBV guidelines, screening will lead to an increase of survivors reporting for GBV response services, which will impact not only the health sector carrying out the intervention, but the GBV response sector who should budget for an increased number of GBV case managers.
- **Select locations according to predefined eligibility criteria.** The criteria that must be considered include availability of staff members trained in clinical care for sexual assault survivors (CCSAS), the availability of private consultation rooms, quality referral services and the ability to ensure confidentiality according the ASIST-GBV guidelines.
- **Conduct community sensitization prior to implementing screening for GBV.** These activities should provide information about the intervention, to raise awareness about the importance of timely reporting and confront taboos. These efforts are more effective by involving women's and men's groups and community and religious leaders and can be included within ongoing health and GBV community education activities.

- **Carefully adapt the screening tool to take into account local cultural and religious considerations.** It is essential to pilot the tool among providers and patients prior to implementation. Harmful stereotypes or cultural/religious norms/behaviors which affect women and girl's health and safety in the specific context will need to be challenged, respectfully. Making sure key terms have been appropriately translated into local languages will also increase the impact of this intervention.
- **Properly assess clinic staff in order to identify who is best placed to screen prior to implementation.** Considerations may include language, sex, workload and role.
- **Allocate resources specifically to the screening intervention.** While it is important to integrate screening into the health facility visit, it is critical that providers take ownership. Responsibilities should be integrated into job descriptions and project outputs.
- **Provide technical support in the initial phase for training and evaluation.** A dedicated technical support person needs to be appointed to continuously support screening activities, do follow-up trainings, ensure cross-sector communication and address challenges.
- **Position GBV officers and psychosocial counselors in the health posts or in the immediate vicinity.** Women and older adolescent girls shoulder many family and community responsibilities and often don't have the option of taking more time out of their day to follow up on referrals after being screened.

Based on evaluation findings⁸ and experiences from our GBV screening interventions, the IRC strongly believes that GBV screening is an effective way for health providers in humanitarian settings to assist survivors of GBV. We find that, with the appropriate measures taken and prerequisites met, GBV screening by health providers has the potential to 1) create a confidential environment where survivors can speak openly about their experiences with GBV, 2) ensure competent care and referrals based on individual needs and wishes of survivors, and 3) increase community awareness about GBV issues, thereby reducing stigma and improving attitudes.

Our experience also highlights that, like any other program that involves women and girls' sexual and reproductive health and rights, screening for GBV needs to be addressed appropriately. The design and implementation should be based on proper assessments in terms of culture, religion, gender norms and attitudes of clients, as well as providers.

Documenting direct links between improved health outcomes, reduced violence against women and girls and screening for GBV is challenging. We recommend that future research efforts and resources be focused on measuring whether screening for GBV leads to increased knowledge of available resources/services and that women and older adolescent girls who screen positive and receive comprehensive services feel supported, empowered and safe.



COUNSELLING IN PROGRESS

KINDLY

DO NOT INTERRUPT

International Rescue Committee (IRC) responds to the world's worst humanitarian crises and helps people whose lives and livelihoods are shattered by conflict and disaster to survive, recover, and gain control of their future. The IRC responds to the world's worst humanitarian crises and helps people to survive and rebuild their lives. Founded in 1933 at the request of Albert Einstein, the IRC offers lifesaving care and life changing assistance to refugees forced to flee from war, persecution or natural disaster. At work today in over 40 countries and 22 U.S. cities, we restore safety, dignity and hope to millions who are uprooted and struggling to endure. For more than 20 years, the IRC has been breaking down barriers that prevent survivors from disclosing violence and seeking services. We continue to work in areas characterized by insecurity, displacement and a collapse of health services. The IRC is providing clinical care for gender-based violence in 19 countries and psychosocial and women's empowerment support in over 33 countries.

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Annex 1 ASIST-GBV Screening Tool for Women

Introduction: Violence is a traumatic experience for both men and women. When we ask women about “gender based violence”, we are asking about different types of violence that women/girls may experience. This could include physical violence (hitting, punching, kicked, slapped, choked, hurt with a weapon, or otherwise physically hurt), sexual violence, psychological harm (threats, insults, talk down to you), including threats of violence and/or coercion by members of their own family, acquaintances, and/or strangers in the home, community and/or during armed conflict. Gender based violence can also lead to health problems (physical and mental) for some women. The purpose of these questions is to assess your experiences of gender based violence. Your responses can help us identify with you the most appropriate health and protection services. We are asking all clients who come to IRC health facilities these same questions. Your responses to these questions are confidential and will not be shared with anyone without your permission.

Is it okay for us to ask you questions on gender based violence? Yes_____ No_____ *IF no, ask if she would like additional resources for health or safety.*

Screening questions:
1.1 In the past 12 month, have you been threatened with physical or sexual violence by someone in your home or outside of your home?
1.2 In the past 12 month, have you been hit, punched, kicked, slapped, choked, hurt with a weapon, or otherwise physically hurt by someone in your house or outside of your house?
1.3 In the past 12 month, have you been forced to have sex against your will?
1.4 In the past 12 month, were you ever forced to have sex to be able to eat, have shelter, or have sex for essential services [such as protection or school] because you or someone in your family would be in physical danger if you refused?
1.5 In the past 12 month, were you ever physically forced or made to feel that you had to become pregnant against your will?
1.5a If yes, are you currently pregnant because of that?
1.6 In the past 12 month, has anyone ever forced you to lose a pregnancy? By this, I mean forced you to take a medication, go to a clinic, or physically hurt you to end your pregnancy.
1.7 In the past 12 month, were you coerced or forced into marriage (or to partner with someone)?
END OF SCREENING: If the participant responded ‘yes’ to experiencing any of the violence in questions from 1.1 to 1.7, she has screened positive for GBV.
1.8 REFERRAL: [Interviewer: Ask all who screen positive] Would you like to be referred to service for your experience of gender-based violence? These could include health, psychosocial, and protection services.



Reporting form for GBV Screening in Health Facilities

Data collection for _____

Period: _____ Collected by: _____ Location: _____

Indicator	Data collected
Total # of Women >15 presented for RH services in the health posts	
Total # of women offered screening for GBV	
Total # of women accepted screening for GBV	
Total # of women screened positive for GBV	
Total # of GBV survivors receiving clinical care	
Total # of GBV survivors referred for WPE services	

Annex 3

GBV SCREENING TRAINING AGENDA

Time	Topic	Notes
8.30 - 9.00	Introduction	Introduction of facilitator & participants (icebreaker) Contextualize GBV in humanitarian settings; Why is it so important?
9.00 – 10.30	Short recap of GBV terms	Difference between Sex and Gender : - What is the difference - 2 groups (each group gives 3 examples of male/female tasks that are sex/gender related) Different types of GBV: - Mention all the different kinds and give examples (one small case pr. type) Power dynamics and violence: - Who has power, who has less power in the society? - Power, violence and consent Negative impact and consequences of violence: - List negative consequences of GBV according to individual, family and community - Distribute handout - How can health providers/health facilities prevent and respond to the consequences?
10.30 – 10.45	Tea break	
10.45 – 12.15	What is GBV screening?	What do we mean by Universal screening? - Who is eligible? (screening venue, selection and training of staff, Informed consent, preparing the community, ensuring routine use, security, comprehensive referral pathway) - What does the evidence say? - Official objectives - How does it happen (show slide)? - Why do survivors not report? -> brainstorm - Distribute the tool and read through in pairs. - What are the advantages/concerns of screening? (2 groups)
12.15 – 13.00	Practicing #1	Group exercise #1: - 3 people per group (patient, provider and observer)
13.00 – 14.00	Lunch	
14.00 – 14.45	Consent	What is important in the consent section? - What is GBV? - Who can be victims of GBV? - What are the consequences of GBV? - What is the purpose of screening? ! we screen everybody! ! we keep confidentiality! ! you can always refuse or say no! Group exercise #2: - All participants should stand up (one by one) and present the consent section to the group as they would like to with their own words (split into 2 groups if necessary).
14.45 – 15.30	Practicing #2	Group exercise #4: - 3 people per. group (patient, provider and observer)
15.30 – 16.00	Finishing ceremony	How do we feel? Plan for supervision Signing of confidential poster and certificate

Annex 4: GBV SCREENING CLIENT EXIT INTERVIEW FORM



JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Participant Information:

Date of interview: _____ Location of interview: _____ Interviewer: _____

Verbal Consent Given? Yes _____ No _____

If consent has not been given, do not continue with the interview.

Introduction:

Earlier in your clinic visit, one of our staff members asked you to participate in screening for gender-based violence, in which they asked you seven questions about any recent case of violence you may have experienced. We would like to hear about your experience and hope you will please help us improve our program by answering some questions about the screening you participated in. We are interested in your honest opinions, whether they are positive or negative. There is no right or wrong answer. We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Questions:	Response options:	Enter number of response
2. When the staff initially asked you to participate in screening (being asked these seven questions) for gender-based violence, how willing were you to participate in the screening?	1. Very willing 2. Willing 3. Not very willing 4. Not at all willing to participate 88. Don't know 99. No response	
7. When you were asked the questions about gender-based violence, did you feel it is acceptable for providers/staff to ask about recent experiences of violence?	0. No 1. Yes (Skip to 9) 88. Don't know 99. No response	
12. Did you feel safe responding to these questions about gender-based violence?	0. No 1. Yes 88. Don't know 99. No response	
13. To what degree to you think asking these questions will generally help women who experienced gender-based violence to access services?	1. It is very helpful to them 2. Somewhat helpful 3. Not very helpful 4. Not at all helpful 88. Don't know 99. No response	
14. In general, how would you rate your experience being screened/asked these questions about gender-based violence?	1. Very good 2. Pretty good 3. Pretty bad 4. Terrible 88. Don't know 99. No response	

Thank you for participating in our brief interview. Is there anything else you would like to tell us?
