

FACILITATOR'S GUIDE



Training curriculum for health care providers for management of intimate partner violence and sexual violence in Sierra Leone



THE WORLD BANK
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Editorial process: Benjamin James Thomas. Cover design and typesetting: Jihane El Khoury Roederer.

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Foreword

One in three women worldwide experience sexual or physical violence in their lifetime. With more than 60 per cent of women reported to have experienced physical violence at some point since age 15, and more than 60 per cent of ever married women to have experienced physical, sexual and emotional intimate partner violence, gender-based violence (GBV) is a major public health priority for the government of Sierra Leone.

Often being the first contact for GBV survivors, the health sector has a crucial role to play in providing critical care and first-line support, and linking them to essential support services in a safe manner. In fact, the Sierra Leone National Referral Protocol on Gender Based Violence mandates the Ministry of Health and Sanitation (MOHS) to provide free medical examination and treatment, and referrals to other essential services, including clinical care, psychosocial support, legal support, and access to justice and safe homes (MSWGCA-SL 2012). As pandemics such as COVID-19 can exacerbate the risk of GBV, it is even more crucial that health care providers are equipped with the knowledge and basic skills to respond to intimate partner violence and sexual violence.

The Ministry of Health and Sanitation collaborated with various actors to develop the training curriculum for health care providers for management of intimate partner violence and sexual violence in Sierra Leone as part of its efforts in strengthening the health sector response to GBV in the country. It is designed to build knowledge, skills and confidence to effectively respond to survivors of such violence. The training package, comprising a Facilitator's Guide, Participatory Exercises, Participants' Handouts, and PowerPoint slides, is intended for health care providers at all levels of the health systems. The training package is based on the Caring for Women Subjected to Violence: a WHO Curriculum for Training Health Care Providers (WHO 2019), which has been adapted for a Sierra Leonean context by integrating national guidelines, including the national clinical guidelines for management of survivors of sexual and gender-based violence, among others. It also draws on other manuals and tools in the health sector response to GBV in the region.

It is our sincere hope that this training curriculum will help increase the number of health care providers in the country with the appropriate skills and competencies to offer good quality services to survivors of violence in Sierra Leone.



A handwritten signature in black ink, which appears to read 'W. A. Wurie'.

Hon. Dr. Alpha Tejan Wurie (Ass. Prof.)
Minister for Health and Sanitation

Acknowledgements

This gender-based violence (GBV) training package is a result of collaborative efforts of various government sectors, development partners, implementing partners and GBV specialists in Sierra Leone. Recognizing the important role the health sector can play in identifying survivors of violence and responding to their needs, the Ministry of Health and Sanitation has developed this training with the aim of strengthening the national health sector response to GBV.



The preparation of these documents involved extensive discussions with government representatives, development partners, and organizations providing support services to gender-based violence survivors in Sierra Leone. The MOHS would like to thank the World Bank for its significant support in strengthening the country's health system. The development of this training package would not have been possible without the technical and financial support provided by the World Bank and the government of Japan through the Japan Policy and Human Resource Development (PHRD) grant for Advisory and Analytical Services.

Special gratitude goes to the Technical Working Group (TWG) members for their extremely valuable inputs, guidance, and practical support during the development stages of the training curriculum, as well as to the technical experts who agreed to participate in the key informant interviews and helped conceptualize the content of the resources: Dr. Sartie Kenneh (TWG Chair), Dr. Roland Williams, Dr. Abibatu Kamara, Dr. Satu Issa, Dr. Francis Moses, Mrs. Patricia Bah, Ms. Betty Korji and Ms. Sallay Carew from MOHS Mr. Charles Vandi from the Ministry of Gender and Children Affairs; Dr. Olabisi Claudius-Cole, Dr. Matilda King and Ms. Annie Mafinda from Rainbo Initiative; Ms. Baindu Massaquoi from UN Women; Dr. Kim Dickson, Dr. Stephen Mupeta and Dr. Pearl Nanka-Bruce from UNFPA; and Dr. Janet Kayita and Dr. James Bunn from WHO.

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Rev. Canon Dr. Thomas T. Samba MD, MPH, FWCP
Chief Medical Officer

Table of Contents

Foreword	1
Acknowledgements	2
Abbreviations & Acronyms	5
Purpose and Overview of the Curriculum	6
Getting Started	11
Logistics and Pre-Course Preparations	12
OPENING CEREMONIES AND INTRODUCTIONS	13
MODULE 1.	
Introduction to Gender-Based Violence	16
MODULE 2.	
Understanding Survivors' Experiences and How Providers' Values and Beliefs Affect the Care They Give	19
MODULE 3.	
Guiding Principles and Overview of the Health Response to Violence Against Women	26
MODULE 4.	
Provider–Survivor Communication Skills	28
MODULE 5.	
When and How to Identify a Woman or Girl Who May Be Subject to Violence	31
MODULE 6.	
First-Line Support Using LIVES: Listen, Inquire, Validate, Enhancing Safety and Support	35
MODULE 7.	
Know Your Setting: Identify Referral Networks and Understand the Legal and Policy Context	39
MODULE 8.	
Clinical Care for Survivors of Sexual Assault and Abuse, Part 1: History-Taking and Examination	44
MODULE 9.	
Forensic Examination	47
MODULE 10.	
Clinical Care for Survivors of Sexual Assault and Abuse, Part 2: Treatment and Care	50
MODULE 11.	
Care for Mental Health and Self-Care for Providers	53
MODULE 12.	
Documenting Intimate Partner Violence and Sexual Violence	58
MODULE 13.	
From Knowledge to Practice: Visiting a GBV Centre	61
Winding Up!	65
References	67

ANNEXES

Annex 1: Sample Training Agenda	68
Annex 2a: Training Materials Checklist	70
Annex 2b: List of Participatory Exercises and Handouts	71
Annex 3: Sample Participant Registration Form	73
Annex 4: Sample Training Database	74
Annex 5: Icebreakers and Energizers	75
Annex 6a: Pre/Post-test	76
Annex 6b: Pre/Post-test Answer Sheet	79
Annex 7a: Course Evaluation	80
Annex 7b: Course Evaluation Form	81
Annex 8: Appraisal Form for Selection of Potential Trainers	83

Abbreviations & Acronyms

DV	Domestic violence
EC	Emergency contraception
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IPV	Intimate partner violence
LIVES	Listen, Inquire, Validate, Enhance safety, and Support
MCQs	Multiple choice questions
MOHS	Ministry of Health and Sanitation
PEP	Post-exposure prophylaxis
PT	Potential trainer
PTSD	Post-traumatic stress disorder
SGBV	Sexual and gender-based violence
SOPs	Standard operating procedures
STI	Sexually transmitted infection
SV	Sexual violence
VAW	Violence against women
WHO	World Health Organization

Purpose and Overview of the Curriculum

Gender-based violence (GBV)¹ is a major public health problem and a violation of human rights with implications for the health and development outcomes of not only the survivors, but also of families, communities, and society. In Sierra Leone, the magnitude of the problem is great. According to the Sierra Leone Demographic and Health Survey 2019, 61 per cent of women age 15–49 have experienced physical violence since age 15, and 7 per cent have experienced sexual violence. When it comes to intimate partner violence (IPV), 62 per cent of ever-married women have, at least once in their lifetime, experienced physical, sexual, or emotional violence (SSL and ICF International 2020).

The Sierra Leone government has made tremendous strides towards the elimination of all forms of gender-based violence. It has signed and ratified several core international human rights treaties and enacted a range of national legislation and policies that require the state to act against sexual and gender-based violence (SGBV). Despite this strong policy and legal framework, GBV survivors remain underserved. The reasons for the inadequate services include the lack of GBV centres in some districts in the country. Currently, these services are available in ten out of the country's sixteen districts. Health care provider capacity is also highlighted as a significant gap.

Interviews conducted with GBV experts in Sierra Leone during the development of this training curriculum revealed that women and adolescent girls form the majority of the survivors of violence seen at health facilities. Despite this, the health response has focused heavily on services for children who have experienced sexual violence. Additionally, the key informants noted that service providers lack the knowledge, skills, and confidence to identify and respond to women and girls who present with other forms of violence, including physical, emotional, and intimate partner violence.

About This Training Curriculum

This curriculum is designed to provide health care providers with a minimum set of competencies for responding to domestic/intimate partner violence, and sexual violence. The curriculum seeks to build skills and to address providers' attitudes towards survivors of gender-based violence. Participants will learn how to provide survivor-centred clinical care, including identifying women and girls experiencing violence, provide first-line support through the LIVES approach (Listen, Inquire, Validate, Enhance safety and Support), provide essential clinical care for survivors, and identify local support resources. The training participants will learn to reflect on their attitudes and understand survivors' experiences. The curriculum emphasizes a survivor-centred approach, and compassionate, empathic provider-patient communication.

Although this curriculum focuses on women and girls, the content is also designed to apply when caring for boys and men, who may also be subjected to IPV and SV. This guide is based on the WHO curriculum for caring for women subjected to violence (WHO 2019), which has been adapted for a Sierra Leonean context by referring to national guidelines, including the National Clinical Guidelines for Management of Survivors of Sexual and Gender-Based Violence (MOHS-SL, forthcoming).

Target Audiences

This training curriculum is primarily designed for health care providers, such as doctors, nurses, midwives and community health officers, but the foundational sessions (modules 1–7) will also be useful to participants from other sectors, such as police, judicial and social services, and organizations that work with communities.

The Course Design

This training has been designed to start with foundational modules (1–7) scheduled for the first two days of training, where participants will be equipped with information on the magnitude and nature of

¹ In this training package, the term "gender-based violence" is often used interchangeably with the term "sexual and gender-based violence" and "violence against women". The term "sexual and gender-based violence" is often used in reports and initiatives in Sierra Leone.

GBV in Sierra Leone and taught skills for providing survivor-centred response services. The last two days (modules 8–12) are more advanced. Sessions are ordered to move systematically to help participants gain an understanding of the problem and context through cumulative skills building. This structure makes depth possible and reinforces the knowledge and skills learned in earlier sessions.

To ensure the maximal transfer of knowledge and skills from facilitators to participants, the course is designed to use a two-pronged approach in its delivery of skills and knowledge. The two-methods are participant-centred learning, and competency-based training.

Participant-Centred Learning

The curriculum relies on a participant-centred approach to learning—an active, collaborative, inquiry-based approach to teaching and training. It encourages the participants to contribute to knowledge and skills development through role-play, guided discussions, case studies, and participatory reflection exercises. This process supports critical reflection, emotional engagement, skills development, and the ability to put knowledge into practice. During each session, facilitators should encourage active participation from the participants by allowing them to share their experiences and ideas and ask questions where they need clarification. There may be questions or issues that facilitators are unable to answer immediately, or that will be covered in a later session. These questions

should be set aside and written on a flip chart titled “Parking lot”, which will be pinned up on the wall. Facilitators should ensure that they address these questions or issues before the end of the training.

Competency-Based Training

Competency-based approaches facilitate the development of knowledge and skills of health care providers in providing comprehensive, high quality care to survivors of IPV or SV. This training curriculum comprises 13 modules. Each module supports one of the six objectives outlined below while fostering unique competencies (see Table 1 below).

1. Demonstrate knowledge of the magnitude, effects, and impact of GBV globally and in Sierra Leone.
2. Demonstrate an understanding of the legal and policy frameworks in Sierra Leone.
3. Demonstrate behaviours and understand values contributing to safe and supportive services for survivors.
4. Demonstrate clinical skills to respond to survivors of IPV and SV.
5. Demonstrate knowledge of how to access resources and provide psychosocial support for patients and oneself.
6. Develop appropriate health facility protocols, referral mechanisms, and follow-up procedures for survivors of GBV.

Table 1: Summary of Training Session Themes, Learning Objectives and Learning Outcomes

Module	Theme	Learning objective	Learning outcomes
1.0	Introduction to Gender-Based Violence.	Objective 1 Demonstrate knowledge of the magnitude, effects, and impact of GBV globally and in Sierra Leone. Objective 2 Demonstrate an understanding of the legal and policy frameworks in Sierra Leone.	By the end of this module, participants should be able to: a. Understand the terminology used in GBV. b. Know the epidemiology of the different forms of violence against women and girls globally and in Sierra Leone. c. Know the risk factors for GBV in Sierra Leone. d. Know the health consequences of violence against women and girls. e. Know the legal and policy context with regards to the local and national response to gender-based violence.

Module	Theme	Learning objective	Learning outcomes
2.0	Understanding Survivor's Experiences and How Providers' Values and Beliefs Affect the Care They Give.	Objective 3 Demonstrate behaviours and understand values contributing to safe and supportive services for survivors.	By the end of this module, participants should be able to: a. Demonstrate self-awareness of their beliefs, assumptions, potential biases, and emotional responses that can affect interactions with survivors of violence. b. Understand the barriers that women and girls who experience violence face when seeking support. c. Recognize the importance of having empathy with survivors.
3.0	Guiding Principles and Overview of the Health Response to Gender-Based Violence.	Objective 3 Demonstrate behaviours and understand values contributing to safe and supportive services for survivors.	By the end of this module, participants should be able to: a. Know the guiding principles of providing survivor-centred care in a culturally appropriate way. b. Understand how to apply the guiding principles for survivor-centred care in their practice.
4.0	Provider–Survivor Communication Skills.	Objective 3 Demonstrate behaviours and understand values contributing to safe and supportive services for survivors.	By the end of this module, participants should be able to: a. Communicate empathically and effectively with patients and survivors of violence.
5.0	Identification of Intimate Partner Violence in the Clinical Setting.	Objective 4 Demonstrate clinical skills to respond to survivors of IPV and SV.	By the end of this module, participants should be able to: a. Understand the minimum standards that need to be met to inquire about and respond appropriately to violence against women and girls. b. Recognize the signs and symptoms that suggest intimate partner violence. c. Understand when and how to ask about intimate partner violence. d. Demonstrate appropriate ways to ask about intimate partner violence.
6.0	First-Line Support Using LIVES: Listen, Inquire, Validate, Enhance safety, and Support.	Objective 4 Demonstrate clinical skills to respond to survivors of IPV and SV.	By the end of this module, participants should be able to: a. Know the content of first-line support (LIVES). b. Demonstrate skills in offering LIVES to survivors who disclose abuse.
7.0	Know Your Setting: Identify Referral Networks and Understand the Legal and Policy Context.	Objective 6 Develop appropriate health facility protocols, referral mechanisms and follow-up procedures for survivors of GBV.	By the end of this module, participants should be able to: a. Understand the multisectoral nature of violence and the roles of other services in caring for survivors of IPV and SV. b. Know the role of health care providers in responding to a survivor of violence. c. Know how to collaborate with partners to help survivors to access other services and provide referrals. d. Know what resources are available in the community. e. Demonstrate skills to provide warm referrals.

Module	Theme	Learning objective	Learning outcomes
8.0	Clinical Care for Survivors of Sexual Assault and Abuse, Part 1: History-Taking and Examination.	Objective 4 Demonstrate clinical skills to respond to survivors of IPV and SV.	By the end of this module, participants should be able to: a. Demonstrate skills to take a clinical history. b. Know how to examine a survivor of sexual assault and abuse.
9.0	Forensic Examination.	Objective 4 Demonstrate clinical skills to respond to survivors of IPV and SV.	By the end of this module, participants should be able to: a. Know how to conduct a forensic examination. b. Know when to collect forensic evidence and how to support or facilitate such evidence collection.
10.0	Clinical Care for Survivors of Sexual Assault and Abuse, Part 2: Treatment and Care.	Objective 4 Demonstrate clinical skills to respond to survivors of IPV and SV.	By the end of this module, participants should be able to: a. Know how to provide appropriate treatment and care to survivors of sexual assault and abuse.
11.0	Care for Mental Health and Self-Care for Providers.	Objective 4 Demonstrate clinical skills to respond to survivors of IPV and SV. Objective 5 Demonstrate knowledge of how to access resource and provide psychosocial support for patients and for oneself.	By the end of this module, participants should be able to: a. Know how to provide basic psychosocial support to survivors of sexual violence and intimate partner violence. b. Know how to access and practice self-care.
12.0	Documenting Intimate Partner Violence and Sexual Violence.	Objective 4 Demonstrate clinical skills to respond to survivors of IPV and SV.	By the end of this module, participants should be able to: a. Know how to document intimate partner violence and sexual violence in a safe and confidential manner.
13.0	From Knowledge to Practice: Visiting a GBV Centre.	Objective 6 Develop appropriate health facility protocols, referral mechanisms and follow-up procedures for survivors of GBV.	By the end of this module, participants should be able to: a. Know the minimum standards required for quality intimate partner violence and sexual violence services. b. Understand how the GBV centres work with other stakeholders and service providers to provide comprehensive response services.

Duration of the Training

The training is designed to take four full days, which includes a field visit session to a GBV centre within the training district. While a large part of this training is designed specifically for health care providers, who must attend all the sessions, participants from other sectors, such as the police, judicial and social services, and organizations that work with communities, can attend the foundational sessions (modules 1–7) scheduled for first two days.

Course Facilitators and Composition of the Training Team

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 survivors of violence.
- Experience in training, including leading interactive discussions.

Two facilitators is the recommended number. The facilitators should alternate the lead and support roles described below to minimize fatigue and provide participants with a variety of presentation styles.

The lead facilitator's role includes:

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

The support facilitator's role includes:

- Monitoring time.
- Circulating microphone to participants as needed.
- Distributing case examples or written materials as needed.
- Identifying questions in the group.
- Providing an additional perspective on questions raised in the group.
- Circulating through the room during group work to monitor and provide feedback on activities.

The facilitators will work closely with a course coordinator from MOHS, who will be responsible for the coordination and logistical preparations for all the scheduled training sessions.

About This Facilitator's Guide

The Facilitator's Guide has been developed to support the training team to implement the training for maximum learning. The guide provides technical content and step-by-step guidance for running each of the 13 modules. In each module, you will find the learning outcomes, methods, time allocation, materials required, types of activities, and participant handouts. Within the 13 modules, you will also find instructions for the facilitators, notes to keep in mind, guiding questions, instructions for various activities, critical points for discussion, and key messages. Please follow the Facilitator's Guide to ensure that the main points are learned, and the recommendations are followed. This guide will be used alongside other facilitation materials listed below. Make sure to review these ahead of the training to familiarize yourself with their content:

- PowerPoint slides. Many of the slides have accompanying notes, which provide additional information for facilitators to use in teaching.
- Participants' handouts.
- Participatory exercises.

A Note from the Authors

Nothing is more satisfying to a facilitator than delivering well executed training that meets the expectations of participants and the expected outcomes of the training. For this to happen, preparation is the key to successful delivery. The Getting Started section of this manual will help you as a facilitator or co-facilitator to do this effectively on your journey to teaching and inspiring your learners in this interactive course. We wish you all the best in this journey to change the response in addressing IPV and SV in Sierra Leone!

"Tell me and I forget. Teach me and I remember. Involve me and I learn"

-Benjamin Franklin-

Getting Started

Your Go-To Toolkit

As you prepare to get started, the first step is for you, the facilitator, to familiarize yourself with all of the components of this training package well in advance of the training. This section will focus on what you need to do to prepare ahead of the training and during the first day of the training (we all know how nerve-racking the first day can be!). Preparation and practice will increase your confidence and will also assist in keeping sessions to the recommended time while covering the intended content.

Your Go-To Toolkit is a set of complementary materials that will help you to prepare yourself adequately before, during and after the training. The materials include the sample Training Agenda, Training Materials Checklist, examples of Icebreakers, the sample Training Database, and a set of templates to be used at different stages of the training as needed.

Training Agenda

The Training Agenda provides recommended timing for each day's activities during this course. A sample training agenda is provided in Annex 1. Note that the training team can be flexible with the plan and should be ready to change exercises or the order of the agenda to adapt to the needs of participants and the amount of time available.

Training Materials Checklist

This checklist provides a summary of the print and non-print materials required for the different activities throughout the course and a detailed list of print material required, by both facilitators and participants, in each module. During your first meeting as a training team, use this checklist to ensure that all the training materials are well prepared in advance, and will be available as required throughout the course. The checklist is also useful to help you check the materials that you need to return to the course coordinator at the end of the course. The Training Materials Checklist can be found in Annex 2b, which summarizes the materials required throughout the course. Annex 2b summarizes the print material required for each session.

Registration Form

You will use this form to record participants' attendance on each day of the course. A sample of the Registration Form is available in Annex 3.

Training Database

The Training Database is a tool that will be maintained by MOHS to keep track of the number of service providers trained using this curriculum. You will be required to fill in the details of participants and their performance by the end of the course, for submission to the course coordinator. You can find the sample template in Annex 4.

Icebreakers and Energizers

You should be attentive to the mood and energy levels of the participants throughout the training. Whenever you notice that the participants are losing concentration, you should use the icebreakers to reactivate the session. Annex 5 gives examples of energizers that you can use. It is good practice to ask one of the participants to lead this activity and use an energizer that is familiar to the participants. Use these examples only where none is offered from the participants.

Course Evaluation

Daily evaluations or reflections are important as they provide chances to learn and improve the course informally. For the participants, it allows for reflection, and for the facilitators (and course coordinator) it can provide valuable feedback. Remember the participants will have had long days of intense work. We want to make the daily evaluations as painless and as meaningful as possible for both them and the training team. In this course, participants and facilitators will have daily reflections on days 1–3, to carry out light evaluations of the course. On the last day, you will ask participants to evaluate the course. Annex 7a gives examples of end-of-day evaluations you can carry out. The formal end-of-course evaluation will be carried out on day four toward the closure of the course. A sample course evaluation form can be found in Annex 7b.

Logistics and Pre-Course Preparations

Activity: Registration of Participants (30 minutes)



- Ensure a registration desk has been set up at the entrance of the training venue.
- The table should have the Registration Form (Annex 3), participant ring binders, stationery, and name tags.
- Confirm that all participants have registered and received their folders and stationery by the end of the opening session.

Activity: Pre-Course Assessment (30 minutes)



- Distribute the paper-based pre-course test (Annex 6a) to each participant and ask them to respond to the questions individually.
- Inform participants that the purpose of the pre-course test is to aid the facilitators in gauging their current level of understanding of the content that will be taught over the next four days.
- Allow 30 minutes for participants to complete the pre-course test. Collect all pre-course assessments as soon as participants have completed them or, at the latest, by the time they are ready for their tea break.
- Mark tests and enter the marks in the Training Database. You will use this record to illustrate their progress at the end of the course.

"Before anything else, preparation is the key to success"

-Alexander Graham Bell-

OPENING CEREMONIES AND INTRODUCTIONS

Introduction

This session introduces the course and ensures that logistics have been covered to get participants well settled. Although you are encouraged to adapt this session to suit local needs, you should ensure that there is time to discuss how people will deal with sensitive issues during the course, and establish ground rules relating to sensitive issues at the beginning of the training.

Learning Outcomes

By the end of this session, it is expected:

- a. Participants will understand the aim and objectives of the course, and have received their training materials.
- b. Participants will get to know each other, share their expectations and have any concerns clarified.
- c. The group will have defined ground rules.
- d. The agenda and logistics for the course will have been agreed.

Methods

Presentation with slides.

Group discussion.

Time

90 minutes.

Materials

Copies of pre-training survey, flip chart/large pieces of paper, laptop, projector, sticky notes (or note cards), tape, and pens.

Session content

Opening session (20 minutes)



The opening session involves welcoming participants and officially opening the workshop. An official opening session can motivate participants, and is important to emphasize the benefits of the course and the agenda. Ensure that guest officials have been informed about the timing and venue at least one day before the opening ceremony.

Introduction session (20 minutes)



In this session, you should:

- Welcome the participants into the course, introduce yourself and explain your role.
- Give the housekeeping highlights and resolutions. Explain the following, as required:
 - COVID-19 preventive measures.
 - Location of washrooms.
 - Refreshments and lunch arrangements.
 - What to do if there is an emergency.
 - Any other administrative issues.
- Ask the participants to introduce themselves to the group. There are different ways to conduct the introduction session, for example:
 - The facilitator may ask participants to sit in a circle. Going around the circle, each person says their name. Then the group is made to repeat the exercise, this time saying the name of the person on their right or left. (This is an icebreaker that helps participants to interact more freely in subsequent sessions.)
 - Participants can be asked to sit in pairs, preferably with someone they have not met before the training, and then introduce each other to the rest of the group, using any of the following options or any other suitable topic. Options include, for example, name, country, one expectation the person has for the workshop, or one thing they either like or dislike.

Presentation: Training overview and learning objectives (20 minutes)



- Use slide 2 to explain to the training participants the overall objectives of the training to the training participants.
- Discuss the workshop programme with the participants, especially start and end times, and break times, and work on achieving a consensus. Refer the participants to the Training Agenda inserted in their course folders.

Activity: Expectations, hopes, and fears, and Establishing ground rules (30 minutes)



Activity: Expectations, Hopes, and Fears

You can use various methods to discuss the participant's expectation from the training and fears. For example, you could:

- Ask participants to use sticky notes or cards and write down their expectations or hopes and stick them up on a wall or board. Have different coloured stickies for the expectations or hopes, and fears.
- Ask participants to work in pairs or small groups to write their expectations/hopes and fears, on cards, one item to one card, and stick them up on a wall or board.
- Stick a large long sheet on the wall, with headings, columns, and lines, for each person to fill with their expectations or hopes and fears.

After 10 minutes, hold a plenary discussion to address the expectations or hopes and fears.

Establish ground rules

Following the plenary discussion, conduct an exercise intended to establish norms within the group. Ask participants how they can help make the learning more effective during the training and record their responses on a flip chart and give additional suggestions if needed. Paste flipchart on the wall for participants to refer to during the training. The norms may include the following but are not limited to:



DO'S

- Listen
- Ask questions
- Participate in discussions
- Respect everyone's opinion
- Share personal examples



DONT'S

- Be late for session
- Try and memorize everything
- Sleep during the training
- Talk while someone else is talking
- Receive calls on cell phones

Establish ground rules so that productive discussions do not turn into heated arguments.

- Remind the group that discussions related to IPV and SV can bring forth feelings of anger, hostility, disgust, and embarrassment for some people.
- Decide how the group can support each other: allow them to share feelings, suggest taking a break, and/or talking to you or someone else privately.
- It is important to acknowledge the range of emotional response and opinions in the room, especially because a key component of training is to engage with and transform attitudes, beliefs and behaviours that can fuel GBV.



Managing sensitive issues

Let the participants know that the training will be covering sensitive issues and that IPV and SV discussions may arouse strong emotions and feelings. You could say, 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 happened 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.

MODULE 1. Introduction to Gender-Based Violence

Introduction

This module introduces the definition, magnitude, types, risks factors, and consequences of GBV. It outlines the existing legal frameworks and guidelines that regulate a GBV response in Sierra Leone.

Learning outcomes

By the end of this module, participants should be able to:

- a. Understand the terminology used in GBV.
- b. Know the epidemiology of the different forms of violence against women and girls globally and in Sierra Leone.
- c. Know the risk factors of GBV in Sierra Leone.
- d. Know the health consequences of violence against women and girls.
- e. Know the legal and policy context with regards to the local and national response to GBV.

Methods

Presentation with slides and discussion (60 minutes).

Buzzing activities (2 x 15 minutes).

Time

90 minutes.

Materials

Laptop, projector, flip chart, marker pens, masking tape and sticky notes.

Handouts

Participant Handout 1a: GBV Terminology.

Participant Handout 1b: Violence Against Women – Global Picture/Health Response.

Participant Handout 1c: Legal and Policy Frameworks of GBV in Sierra Leone.

Session content

Activity 1: Buzzing (15 minutes)



Ask the participants to buzz in pairs for 15 minutes, discussing the meaning of the following concepts:

- Gender-based violence (GBV).
- Intimate partner violence (IPV).
- Violence against women (VAW).
- Domestic violence (DV).

Presentation with slides and discussions (10 minutes)



Definitions and forms of GBV (slides 4–5)

- **Distribute** Handout 1a: GBV Terminology.
- Show the terminologies and ask a volunteer to read out the definitions (slide 4).
- Violence against women and girls takes many forms and occurs at different stages of the survivor's life. Intimate partner violence is the most common form worldwide (slide 5).

Activity 2: Buzzing (10 minutes)



- Divide the participants into groups of three to five participants.
- Ask them to reflect on the common types of violence in their community and write on the sticky notes provided.
- Call the participants back to plenary and ask a representative from each group to summarize the types of violence discussed within their groups in 5 minutes.

Presentation with slides and discussions (55 minutes)



Prevalence of VAW (slides 7–13)

- **Distribute** Handout 1b: Violence Against Women – Global Picture/Health Response.
- Highlight (slides 7–10 and handout) the global and national estimates of intimate partner violence and sexual violence.
- Highlight subgroups that may be at higher risk or particularly relevant to health care providers such as pregnant women, adolescents, women living with HIV, women with disabilities, women of low socioeconomic status and women who engage in sex work (slide 11–13).

Emphasize the following points

- IPV and SV against women and girls in Sierra Leone is often hidden, unseen, and under-reported.
- Most women and girls do not report IPV and SV to formal services including health services.

Risk factors and causes of violence against women and girls

- Ask the participants to mention the causes of violence. This should take 5 minutes.
- Summarize the causes of violence using the Social-Ecological model (slide 15).
- Allow time for any clarifications that are needed.
- Highlight the impact of pandemics (e.g. Ebola outbreak and COVID-19) on violence against women and girls (slide 16–17).

Consequences of violence against women and girls

- Describe the health and socio-economic consequences of VAW (slides 19–20).
- Highlight the many short- and long-term physical and mental health consequences for women (slide 9) and their children (slide 20).

Legal and policy frameworks (slide 22–24)

- **Distribute** Handout 1c: Legal and Policy Frameworks of GBV in Sierra Leone.
- Summarize the National GBV laws and guidelines that address GBV in Sierra Leone.

Wrap-up



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

State the **key messages** (slides 6)

- Violence against women takes many forms.
- There can be short- and long-term consequences for health and well-being.
- While not disclosing abuse spontaneously, many women seek treatment for conditions or complications caused by violence.
- Therefore, health care providers have a central role in identifying and supporting survivors.

MODULE 2. Understanding Survivors' Experiences and How Providers' Values and Beliefs Affect the Care They Give

Introduction

Introduce the session by explaining that responding to survivors of violence requires an understanding of how our values, beliefs, and attitudes may affect how we provide care, as well as our ability to empathize with the experiences of survivors seeking help. These beliefs and values are often shaped by the same societal norms that lead to stigmatizing survivors of 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 affect the care we give.

Learning outcomes

By the end of this module, participants should be able to:

- a. Demonstrate self-awareness of their beliefs, assumptions, potential biases, and emotional responses that can affect interactions with survivors of violence.
- b. Understand the barriers that women and girls who experience violence face when seeking support.
- c. Recognize the importance of having empathy with survivors.

Methods

Experiential exercises with guiding slides (90 minutes).

Guided group discussion (30 minutes).

Time

120 minutes.

Materials

Exercise 2.1: Voting with Your Feet

- Facilitator resource.
- Two signs – one that says “Agree” and another that says “Disagree”.

Exercise 2.2: Blanketed by Blame

- 11 shawls or newspaper sheets.
- 12 Character cards.
- Facilitator's script.

Handouts

Participant Handout 2a: Why Does the Health Care Provider Response Matter?

Participant Handout 2b: Why Don't Women Leave?

Participant Handout 2c: Barriers to Seeking Care.

Session content

Exercise 2.1 Voting with Your Feet (45 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 3)

- 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 the opposite side a sign with “Disagree” on it.
- Read aloud 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 hold a discussion about why people chose the places they took. This will help them to dig deeper into their underlying belief systems.
- Ask the participants on each side to explain their 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 and girls with statements from the miscellaneous category to create a non-threatening 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 others with different beliefs. Encourage participants to maintain a non-judgmental attitude towards beliefs that are not aligned with their own, or with those of most of the participants. These are complicated, emotional issues, and some participants may react strongly to either the statement or to others’ views. Remind the group that everyone brings his or her own perspective to this exercise and that they need to be respectful of each other.

Guiding questions for discussion

- 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.

**Takeaway points
(slide 4)**

The purpose of this exercise is to reflect on how our values, and our personal beliefs about violence against women and girls, 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 and girls 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. It is healthy to self-examine and adjust our beliefs and attitudes accordingly.

**Exercise 2.2 –
Blanketed by Blame
(45 minutes)****Learning objectives for the exercise**

- Increase awareness of, and empathy for, the difficulties that women and girls who experience violence face when seeking support.
- Highlight how unequal gender norms and behaviours can affect women and girls' 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 6)

- Have ready 11 shawls (or newspaper sheets).
- Ask 12 people to participate in the activity. Invite the others to observe.
- Ask for one volunteer to play the role of Binta, a woman who has experienced violence. Ask the other 11 participants to play the other characters written on the character cards.

- Provide each of the 12 participants with a character card.
- Instruct Binta 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 Binta in a circle, facing outwards (away from Binta). Each holds a shawl (or newspaper sheet).
- As the facilitator, stand outside the circle and read the facilitator's script, which tells Binta's story. Then, in the order of characters listed below, explain who Binta approaches for help.
- Ask each character to read the statement on their character card and then step forward and place a shawl (or newspaper) over Binta.
 - Order of blanketing (covering Binta 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 Binta, ask Binta why she did not 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 or newspaper from Binta. This time the characters should face inwards, towards Binta.
 - 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 training)

Ask:

- How did Binta 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 health?
- How did the people that Binta approached respond to her?
 - Probe: How could they have done this better?

**Takeaway points
for this exercise**
(slides 7–8)



- This exercise illustrates the challenging decisions that women and girls face in handling violence and how people respond to them.
- Women and girls make important safety decisions all the time, and they are the experts in their situations.
- Often, however, they have few, if any, options for seeking help and support.
- Many factors may prevent a woman or girl from obtaining help, including economic barriers, social stigma, legal obstacles, and threats of physical violence.
- When violence against women and girls 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 and girls 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 NEVER to 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 in how a survivor feels.
 - Believe women's experiences, and not blame them for the violence.
 - Ask survivors about their needs and concerns, and encourage them to look for options.
 - Support survivors 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.

Distribute Handout 2a: Why Does the Health Care Provider Response Matter?

Guided discussion on barriers that women and girls experiencing violence face when seeking support (30 minutes)



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

Question 1: When we hear about a woman's experience of violence, we may wonder, why doesn't she just leave her partner?

Lead a discussion (15 minutes)

- 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 Handout 2b: 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 act for a variety of reasons, and they may never be ready. Providers must always be ready to respond, so that, when a survivor 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 help address survivors' fears and sense of isolation, and can help 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 (15 minutes). Draw on Handout 2c: Barriers to 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 point 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 a woman seeking help (social services) reflect "turning point" moments, including the following:
 - She could not endure any more.
 - She was severely 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, women themselves must remain in control of the process to determine when and how they want to create change. Being aware of the barriers helps providers overcome them, for example, by assuring women and girls 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 Handout: 2b: Why Don't Women Leave?, and Handout 2c: Barriers to Seeking Care.

Wrap-up



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

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

- The exercises in this session illustrate the challenging situations, decisions, and responses that women and girls subjected to violence face. By putting ourselves in the shoes of survivors, we can empathize and better understand their situations.
- As providers, it is important to reflect on our 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 survivors. 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.

MODULE 3. Guiding Principles and Overview of the Health Response to Violence Against Women

Introduction

Introduce the session by noting there are guiding principles that must be observed by health care providers when providing care to women and girls who have experienced any form of violence.

Learning outcomes

By the end of this module, participants should be able to:

- a. Know the guiding principles of providing survivor-centred care in a culturally appropriate way.
- b. Understand how to apply the guiding principles for survivor-centred care in their practice.

Training Methods

Presentation with slides (30 minutes)

Time

30 minutes.

Materials

Laptop, projector, case study handouts, flip chart, marker pens, and masking tape.

Handout

Participant Handout 3: Guiding Principles for Survivor-Centred Care.

Session content

Presentation with slides (30 minutes)



The 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 survivor-centred care are respect for human rights and the promotion of gender equality (slides 4–6).
- Privacy, safety, and confidentiality are essential for providing care to all survivors 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 the best interest of the child and evolving capacities.
- **Distribute** Handout 3: Guiding Principles for Survivor-Centred Care.

Wrap-up



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

State the **key message**:

- The health system response should be based on respect for human rights and the promotion of gender equality.

MODULE 4. Provider–Survivor Communication Skills

Introduction

Introduce the session by noting that a health care provider’s communication and attitude can influence the decisions of a survivor of violence to seek and remain in care. It is therefore important that the provider builds trust with the survivor, actively listens, and involves her in the decisions made about her care. Listening is something we do all the time, but we do not always listen to people mindfully or consciously. Good listening skills can be practiced. Good listening can make a big difference to what women and girls 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 practice the art of listening and elements of good listening skills.

Learning outcomes

By the end of this module, participants should be able to:

- a. Communicate empathically and effectively with survivors of violence.

Methods

Presentation with slides (15 minutes).

Listening exercise (30 minutes).

Time

45 minutes.

Materials

Laptop, projector, speakers, sticky notes, flip chart, and marker pens.

Handouts

Participant Handout 4: Active Listening Principles.

Preparation

For Exercise 4.1, pin up two flip charts on the wall. One should read, “Negative listening skills (-)”, and the other, “Positive listening skills (+)”.

Session content

Discussion and presentation (15 minutes)



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

Review principles of active listening

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

- **Distribute** Handout 4: Active Listening Principles and discuss active listening practices.
- Review and demonstrate the principles of good listening posture with the mnemonic SOLER (slide 4).

Active Listening Principles



Sitting Position

Sitting in an “L” or 90- degree position and at the same level.



Open Posture

Open posture shows that a counsellor is open to the client and what he/she has to say.



Lean Forward

A slight inclination toward a person may indicate “I am with you; I am interested in what you have to say .



Eye Contact

Frequently soft eye contact makes the client feel that the health care provider is being attentive.



Relaxed

Seeing the health care workers relaxed helps the survivor relax during the consultation session.

Exercise 4.1: Active listening (30 minutes)



Learning objective for the exercise

- Appreciate and practice active listening.

Instructions for facilitators (slide 4)

- Ask all participants to form a pair 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: Ask participants not use an example related to violence, as this time is too short for dealing with a disclosure of violence.
- Ask the listener to practice active listening, including open-ended questions, non-verbal communication, and non-judgmental responses. Refer them to Handout 4: Active Listening Principles for reminders of active listening practices.
- Once completed, 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 5)

In plenary, ask the participants the following questions:

- What did your partner do to show she or 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 in their clinical settings and appropriate in their contexts.

- 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.

Wrap-up



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

State the **key messages** (slide 6):

- Survivors of violence are often silenced by abusers, family members, others in the community, and even by 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 consultation.
- Use both verbal and non-verbal skills.
- Start by asking open-ended questions.
- Always ensure that you have an environment that is conducive to maintaining survivors' privacy and confidentiality.

MODULE 5. When and How to Identify a Woman or Girl Who May Be Subject to Violence

Introduction

Introduce the session by reminding participants that health care providers are in a unique position to help survivors of violence. Survivors can often seek health care without coming in specifically to discuss violence, and health care providers need to be aware that women's and girls' health problems may be caused or made worse by violence. Health care providers tend to be the first point of professional contact for survivors.

Learning outcomes

By the end of this module, participants should be able to:

- a. Understand the minimum standards that need to be met to inquire about and respond appropriately to violence against women and girls.
- b. Recognize the signs and symptoms that suggest intimate partner violence.
- c. Understand when and how to ask about intimate partner violence.
- d. Demonstrate appropriate ways to ask about intimate partner violence.

Training Methods

Presentation with slides (20 minutes).

Demonstration of role-play (10 minutes).

Exercise 5.1 Role-play on the identification of intimate partner violence (45 minutes).

Time

75 minutes.

Materials

Laptop and projector

Exercise 5.1: Role-play scripts on the identification of intimate partner violence.

Handout

Participant Handout 5a: How to Identify and Respond to a Woman or Girl Who May Be Subject to Violence.

Participant Handout 5b: Asking About Violence.

Session content

Presentation with slides (20 minutes)



The 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 3).
- **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 survivor alone, such as sending the other person to do an errand or to fill out a form.
- **Reminder: WHO recommends clinical inquiry. Universal screening is not recommended** (slide 4).
- Women and girls 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 5–6 and Handout 5a: How to Identify and Respond to a Woman or Girl Who May Be Subject to Violence.
- When asking about violence, raise the topic indirectly first (slide 7), then more directly if appropriate (slide 8). Sample statements are provided in Handout 5b: Asking About Violence. Other statements can be used, as appropriate, and they do not all need to be used.
- Often, survivors will not tell you about violence (slide 9). See also Handout 5a. Emphasize the following:
 - Remember the principles of survivor-centred care.
 - Your verbal and non-verbal communication skills are important for building trust when and if a survivor 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.

Distribute Handout 5a: How to Identify and Respond to a Woman or Girl Who May Be Subject to Violence, and Handout 5b: Asking About Violence.

Exercise 5.1 Role-play on the identification of intimate partner violence (55 minutes)



Learning objective for the exercise (slide 10)

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

Instructions for facilitators (10 minutes) (slide 11)

- Demonstrate the role-play together with your co-facilitator.

Instructions for role-plays

- Divide the participants into groups of three.

- Ask one person in each group to volunteer to play the role of a 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.
- Give the participants the role-play scenarios (Exercise 5.1 handout for participants acting as the patient). Give the patient scenario to the participant playing the survivor and to the observer, but not to the participant playing 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 violence unless they are asked by the health care provider and feel comfortable sharing.
- The health care provider's job is to provide care and ask relevant questions. If necessary, they raise the topic of violence or ask about violence.
- The observer's role is to read the guidance in Handout 5b: Asking About Violence, and give feedback to the health care provider on their approach to asking the patient 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 discreetly ask at least one survivor NOT to disclose violence in the role-play. This will allow the health care provider to practice skills in providing support to the patient even if the 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 healthcare worker asked questions, how they responded to the survivor, and how the non-verbal communication was.
- Ask the health care provider to reflect on what other actions could help the survivor.

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 patient, 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?

Continued

- For those playing the role of health care provider, 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 the survivor disclosed their experience of violence, or if it was not disclosed?
- For those playing the role of observer, how did you feel about what was going on?
 - Probe: How was the verbal and non-verbal communication? How did the health care provider communicate or not communicate support?
- What did you notice about the survivor's willingness to disclose their experience of violence? Did they hesitate or not?
- What could the health care provider have done better in the situation?

Wrap-up



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

State the **key messages** (slide 13):

- Partner violence is identified by being observant and 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 to improve with practice.

MODULE 6. First-Line Support Using LIVES: Listen, Inquire, Validate, Enhancing Safety and Support

Introduction

Introduce the session by highlighting to the participants that first-line support is often the most important care that health care providers can offer. It provides practical care and responds to a survivor's emotional, physical, safety and support needs, without intruding on her privacy.

Learning outcomes

By the end of this module, participants should be able to:

- a. Know the content of first-line support (LIVES).
- b. Demonstrate skills in offering LIVES to survivors who disclose abuse.

Training Methods

Presentation with slides (30 minutes).

Exercise 6.1: Role-play to practice LIVES (60 minutes).

Time

90 minutes.

Materials

Laptop, projector, and role-play scripts.

Handouts

Participant Handout 6a: First-Line Support.

Participant Handout 6b: Communication Skills and Pathway.

Participant Handout 6c: Enhance Safety.

Participant Handout 6d: Health Care Providers' Common Questions.

Session content

Presentation
with slides
(20 minutes)



The 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 survivors of violence (slide 4).
- **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 (slides 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 6a: First-Line Support, and Handout 6b: Communication Skills and Pathway.

Enhancing safety

- When assessing safety after a sexual assault or partner violence, discuss whether it is safe for the woman to go home (slide 9). 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 Handout 6c: Enhance Safety (slide 10).
- If the woman is not safe, help her to make a safety plan and make the necessary referrals (slide 11).
- Safety is a long-term goal. A woman may not be ready to act now, but she needs to know what to do. To avoid putting her at risk, be sure to maintain privacy and confidentiality (slide 12).

Facilitating social support (slide 13)

- Discuss with her what is most important to her and help her identify and consider her options.

**Exercise 6.1: Role-play
to practice LIVES
(60 minutes)**



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

Learning objective for the exercise

- Develop skills in providing the LIVES elements of first-line support.

Instructions for facilitators (slide 14)

- Divide participants into groups of three. Ask each group to decide who will play the roles of patient, health care provider, and observer.
- Hand out the instructions and the scenarios only to the patients and observer, 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 provider why they are 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 LIVES.
- 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 LIVES.

Tell patients and providers to practice the role-play for 10 minutes.

Instruct the observers to provide feedback to the health care providers for 5 minutes.

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

Facilitate a group discussion to debrief each scenario (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?
- How appropriate to your situation and priorities were the safety tips and recommendations for accessing social support?

■ **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?

Continued

- If no disclosure: How did you decide to stop asking about violence? How did you leave the door open for further discussion?
- 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:**

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



Note: Some participants may overplay the scenario or act as rushed or disinterested providers. These scenarios of “missed opportunity” can be highly instructive. In discussion highlight the barriers to the 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.

Distribute Handout 6d: Health Care Providers’ Common Questions.

Wrap-up



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

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

- 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 the most effective communication.
- Take the time to continue practicing LIVES, and think about how you can provide first-line support using your own words.
- Risk assessment can help you 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 response to violence.
- Always provide referrals that respond to her stated needs.
- As much as possible, make warm referrals.

MODULE 7. Know Your Setting: Identify Referral Networks and Understand the Legal and Policy Context

Introduction

This module provides an overview of all the different actors that play a role in supporting a survivor of violence. An effective referral system requires that each actor knows their role and responsibilities, and communicates clearly with other people in the referral system. A strong referral system requires that every health worker knows what support is available at different service delivery points within the health sector, and what support is available outside the health centre. A strong referral system requires clear lines of reporting and documentation to ensure that the survivor receives the necessary care.

Learning outcomes

By the end of this module, participants should be able to:

- a. Understand the multisectoral nature of violence and the role of other services in caring for survivors of IPV and SV.
- b. Know the role of health care providers in responding to a survivor of violence.
- c. Know how to collaborate with partners to help survivors' access to other services and to provide referrals.
- d. Know what resources are available in the community.
- e. Demonstrate skills to provide warm referrals.

Methods

Presentation with slides and guided discussion (30 minutes).

Exercise 7.1: The Web of Referrals (40 minutes).

Exercise 7.2: Developing facility-level service provider directories (50 minutes).

Optional/encouraged: Invite a health care provider who cares for women and girls subjected to intimate partner or sexual violence, or an advocate, to discuss the services available, referral pathways and ways to strengthen ties (30 minutes).

Time

120 minutes, or 150 minutes in sessions where a guest speaker is available.

Materials

Laptop, projector, character cards for Exercise 7.1: The Web of Referrals, Teaching Aid: Facility Service Directory Template, and ball of coloured thread or yarn.

Handouts

Participant Handout 7a: Roles and Responsibilities of Health Care Providers in IPV and SV Services.

Participant Handout 7b: Referral and Linkage.

The terminology used in referrals for GBV services

- Referral: A procedure by which a service provider sends a survivor of violence to the most appropriate service point where the survivor can receive the required service, because they cannot, at their level (of expertise, experience or responsibility) respond to the survivor's needs.
- Follow-up: Contacting the survivor at a later, specified date to check on their progress since the last appointment.
- Referral system: A system that facilitates good coordination (organization, preparation, adequate and timely support) and good collaboration between actors and service providers.
- Referral pathway: A flexible mechanism that links survivors to supportive and competent services.
- Counter-referral: The response, return action, or feedback that the referral service delivery point gives the referring facility about services that are provided to the survivor. It is initiated by the structure receiving the referred client.

Session content

Guest Speaker (30 minutes)



- Introduce guest speaker to present their topic, on either available referral resources in the community, or ways to strengthen ties with referral pathways.
- Facilitate discussion, on the speaker's topic focus.

Presentation with slides and discussion (30 minutes)



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

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

- Use slide 3 to discuss the various services that a survivor may require to ensure that they have received a comprehensive response.

Role of health care providers (slides 4–10)

Distribute Handout 7a: Roles and Responsibilities of Health Care Providers in IPV and SV Services.

- Providers are often seen as role models in the community and are trusted (slide 5).
- The health care providers involved in GBV services include but are not limited to medical doctors, nurses, midwives, and counsellors (slide 6).
- Women and girls subjected to violence may have emotional needs, a need for reassurance, and ongoing safety concerns in addition to physical health needs (slide 7).

- The provider's role focuses on empathic support, care, and referral to other services where available (slide 8).
- Providers are not responsible for solving violence or related issues or making decisions for women (slide 9).
- Ignoring violence can do harm. Thus, it is essential to look at the possible consequences of provider behaviours (slide 10).

Establishing referral pathways

- Explain that it is important for all health facilities that provide GBV services to have an effective referral process. This will enable the survivor of violence to receive comprehensive services from different people who have different skills (slide 12).
- Refer the participants to the Handout 7b: Referral and Linkage, and explain the two types of referral systems that are relevant to GBV services, intra-facility, and extra-facility (slide 13).
- Highlight how to establish referral pathways, including identifying and mapping available services, making referral agreements with known resources, and making a referral directory (slide 14).
- Show the participants a sample service referral directory (slide 15) and let them know that they will be developing their service directories using this template later in this session.
- Indicate the principles for referrals, always respecting and following the survivor's choice (slide 16).
- Discuss what it means to know a resource (slide 17).
- Explain how to provide warm referrals (slides 18–19). Warm referrals help reduce barriers.

Exercise 7.1: The Web of Referrals (40 minutes)



Learning objectives for the exercise (slide 20)

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

Instructions for facilitators (slide 21)

- Ten volunteers are needed. If the group is large, it can be split into two.
- Ask nine volunteers to come to the front and form a circle. Ask another volunteer to stand in the centre to play the role of Amina, 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. Mix the order of the cards before handing them out.

- Give Amina the description of her situation (participant handout for Web of Referrals exercise) and a ball of coloured thread or yarn.

Read Amina's story to the group

Amina 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 Amina to play her character and approach her sister. Ask Amina to take the ball of thread with her wherever she goes but to give the end of the thread to her sister and unwind the string from the ball as she goes.
- Ask the sister to respond to Amina as her card instructs, and to take the end of the thread.
- After that, each character that Amina visits should play their role as instructed on their card.
- Amina gives each person she meets a section of the thread to hold. Then she unwinds more thread from the ball as she goes to the next person.
- By the end of the exercise, Amina has re-told her story to multiple people and is standing amid a tangled web of thread.

Group discussion

- Ask the observers: How often Amina had to repeat her story?
- Ask Amina 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 Amina?
- 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 Amina to repeat her story?

Exercise 7.2: Developing facility- level service provider directories (50 minutes)



Learning objective for the exercise (slide 22)

- Develop your facility level service directory.

Instructions for the facilitator (slide 23)

- Give each participant a template for developing an ideal referral pathway (Teaching aid: Facility service directory template).
- Participants from the same facility or region can work together. Ask the participants to fill the template with the service providers that they work with closely at their facility.

Continued

- The directory should include details of a focal person in each referring and receiving service, as well as a description of the services available.
- Ask participants to use the national referral directory to identify listed service providers that are within the proximity of their health facilities.

Group discussion

After the exercise reconvene the participants and ask the groups (or individuals) to present their referral directories.

Facilitate discussion of the following themes:

- Referrals in accordance with survivors' 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 survivors with care.

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

Wrap-up



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

State the **key messages** (slide 25):

- Active and up-to-date referral networks and warm referral practices can help survivors of violence more easily access the available care.
- 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.

MODULE 8. Clinical Care for Survivors of Sexual Assault and Abuse, Part 1: History-Taking and Examination

Introduction

This is the first of two sessions covering quality care for survivors of sexual assault and abuse. A survivor may find it more difficult to disclose sexual assault or abuse if she knows or has trusted the perpetrator (for example, her husband, boyfriend, family member, another relative, acquaintance, schoolteacher) than if it is a stranger. Providers need to be sensitive to this when asking questions. There are specific considerations in dealing with a child or adolescent survivors of sexual penetration or abuse. A good history-taking and examination are the basis for providing quality clinical care and psychological support, and for medico-legal evidence when relevant and necessary. Remind participants that the guiding principle for history-taking and examination is to minimize trauma and stress and avoid revictimizing the survivor. Also, clinical care should be prioritized on the basis of assessed need.

Learning outcomes

By the end of this module, participants should be able to:

- a. Demonstrate skills to take a clinical history.
- b. Know how to examine a survivor of sexual assault and abuse.

Training Methods

Presentation with slides and guided discussion (30 minutes).

Exercise 8.1: Role-play on history-taking (45 minutes).

Time

75 minutes.

Materials

Laptop and projector.

Handouts

Participant Handout 8a: History-Taking Checklist.

Participant Handout 8b: Obtaining Consent.

Participant Handout 8c: Physical Exam Checklist.

Session content

Presentation with slides and discussion (30 minutes)



Distribute the Handout 8a: History-Taking Checklist, Handout 8b: Obtaining Consent, and Handout 8c: Physical Exam checklist.

Mention that the learning outcomes for this session are to demonstrate skills to take a clinical history and to know how to conduct a head to toe and genito-anal examination of a survivor of sexual assault and abuse (slide 2).

The slides for Session 8 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)

■ History

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

■ Examination

- It is important to communicate and to ask for consent with each step of the examination (slides 10–11). Refer to Handout 8b: Obtaining Consent.
- The primary purpose of the examination is to provide clinical care and psychological support.
- Talk the participants through the physical examination checklist. Refer to Handout 8c: Physical Exam Checklist.

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

Exercise 8.1: Role-play on history-taking with guided discussion (45 minutes)



Distribute the History-Taking Form.

Learning objectives for the exercise (slide 16)

- Practice skills in how to take a history with a focus on asking about a sexual assault incident in a sensitive way, and document the history on a structured form.

Instructions for facilitators (slide 17)

- 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.
- Give the appropriate character description to each of the participants playing the patient and the mother.
- Ask the providers to listen to the patient's account, and then ask about the history of the sexual assault (use Handout 8a: History-Taking Checklist) and record findings on the History-Taking Form.

Continued

- 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 19):

- The history of the sexual assault or abuse determines the examination, forensic evidence collection, and treatment.
- Before taking the history, providers should explain any obligations they have 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 reporting or sharing evidence.

MODULE 9. Forensic Examination

Introduction

This session covers the collection of forensic evidence after sexual assault or abuse. Health care providers often consider the collection of forensic evidence to be their main role. 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, and abuse. This includes 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 relevant law. Therefore, understanding the local legal context is crucial.

Learning outcomes

By the end of this module, participants should be able to:

- a. Know how to conduct a forensic examination.
- b. Know when to collect forensic evidence and how to support or facilitate such evidence collection.

Methods

Presentation with slides (30 minutes).

Exercise 9.1: Decision-making on forensic evidence collection (30 minutes).

Time

60 minutes.

Materials

Laptop and projector.

Exercise 9.1: Scenarios and a table for recording responses.

Handouts

Participant Handout 9a: Collecting Forensic Evidence and Maintaining a Credible Chain of Evidence.

Participant Handout 9b: Sierra Leone Medical Certificate.

Session content

Presentation with slides and discussion (30 minutes)



Distribute Handout 9a: Collecting Forensic Evidence and Maintaining a Credible Chain of Evidence, and Handout 9b: Sierra Leone Medical Certificate.

The slides for Session 9 cover the following content:

- **Recap the history-taking and examination protocol and show where forensic examination comes in** (slide 3–4).
- **Review the legal and policy context** (slides 5–6)
 - Discuss the local circumstances regarding the roles of health care providers, specific forms, reporting requirements and the storage and laboratory facilities available.
- **When can forensic examination be conducted?** (slide 7)
 - If a survivor 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.
 - The survivor's health and emotional well-being and safety should be the primary consideration.
- **General tips for a forensic exam** (slide 8)
- **Forensic specimen collection, storage, documentation of findings (slides 9–13)**
 - The account of the assault, and the activities and time elapsed since the assault, 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 14–15).

Discussion

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

Exercise 9.1: Decision-making on forensic evidence collection (15 minutes) with guided discussion (15 minutes)



Learning objectives for the exercise (slides 16)

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

Instructions for facilitators (slide 17)

- Divide participants into small groups of six to eight people. Depending on the number of groups, assign one scenario to each group.

Continued

- Instruct the participants to read the scenario.
- Based on the scenario, participants should discuss the following within their groups:
 - 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 reasons why, in the table provided in the handout.

Guided plenary discussion

- Ask the group:
 - 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



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

State the **key messages** (slide 19):

- Collect forensic evidence only when all four conditions are met:
 1. The patient wants to go to the police.
 2. It is within seven days after the assault.
 3. The provider is trained in forensic examination.
 4. A forensic science laboratory is 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, and labelling and detailed documentation, are essential.
- Health care providers may need to provide testimony. They cannot conclude whether the evidence points to rape. That is for the courts to establish.

MODULE 10. Clinical Care for Survivors of Sexual Assault and Abuse, Part 2: Treatment and Care

Introduction

This session covers the immediate clinical care needs of survivors of sexual assault and abuse. While first-line support is not discussed here, note that it is part of essential care for survivors of any form of sexual violence or abuse. First-line support must be offered immediately in response to a disclosure of sexual assault or 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.

Learning outcomes

By the end of this module, participants should be able to:

- a. Know how to provide appropriate treatment and care to survivors of sexual assault and abuse.

Methods

Presentation with slides and guided discussion (30 minutes).

Exercise 10.1: Case studies on treatment decisions for sexual assault (30 minutes).

Time

60 minutes.

Materials

Laptop and projector.

Exercise 10.1: Case studies scripts on treatment for sexual assault (includes a template with blank tables).

Handouts

Participant Handout 10a: Pathway for Initial Care After Sexual Assault or Abuse.

Participant Handout 10b: Follow-up After Sexual Assault or Abuse.

Participant Handout 10c: Testing Schedule.

Session content

Presentation with slides and discussion (30 minutes)



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

- Conditions and symptoms that may require urgent hospitalization (slide 2).

Prevention of pregnancy (emergency contraception) for women and girls who present within 120 hours (five days) (slides 3–5).

- 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 6–9).

- 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 10–11).

Self-care and follow-up visits for longer-term care (slide 12).

Ask if there are any questions or concerns.

Facilitate discussion by asking:

- What are the barriers (for example, policy requirements) that may delay women and girls from accessing timely services for sexual violence in Sierra Leone?
- What can be done to overcome these barriers?

Distribute Handout 10a: Pathway for Initial Care After Sexual Assault or Abuse, Handout 10b: Follow-up after Sexual Assault or Abuse, and Handout 10c: Testing Schedule.

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



Learning objective for the exercise (slide 14)

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

Instructions for facilitators (slide 15)

- Divide into groups of no more than eight participants each.
- Ask each group to select a rapporteur to present back to plenary.
- There are four case studies in Exercise 10.1: Case studies scripts on treatment decision for sexual assault scripts. Depending on the number of groups, assign one or two case studies per group.

Continued

- 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, which referrals they would make, and 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 17):

- Immediate treatment includes first-line support and, as needed, treatment of injuries, EC, HIV PEP, STI prophylaxis and hepatitis B prevention.
- Treatment for rape and sexual assault depends on whether the survivor presents within the first 72–120 hours. Most survivors do not do so.
- However, even beyond this timeframe, 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.

MODULE 11. Care for Mental Health and Self-Care for Providers

Introduction

This session will build on the skills developed in delivering first-line support to help provide basic psychosocial support and to assess or identify patients with mental health symptoms or 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 frontline workers can help survivors with their mental health in such settings. The content covered in this session is for all frontline providers, not for mental health specialists. 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, such as doctors, nurses, midwives or counsellors, to allow them 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.

Learning outcomes

By the end of this module, the participant should be able to:

- a. Know how to provide basic psychosocial support to survivors of sexual violence and intimate partner violence.
- b. Know how to access and practice self-care.

Methods

Presentation with slides and guided discussion (30 minutes).

Exercise 11.1: Stress reduction exercise (10 minutes).

Exercise 11.2: Role-play on problem-solving skills (20 minutes).

Time

60 minutes.

Materials

Laptop and projector.

Exercise 11.2: Role-play on problem-solving skills scripts.

Handouts

Participant Handout 11: Helping Survivors with More Severe Mental Health Problems.

Session content

Presentation with slides and discussion (30 minutes)



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

Basic understanding of mental health care (slide 3)

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

Offering psychosocial support (slides 4–6)

- Frontline 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 patient to identify problems and find her own solutions.

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

- See Handout 11: Helping Survivors with More Severe Mental Health Problems.

Self-care for providers (slide 13)

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

Exercise 11.1: Stress Reduction Exercises (10 minutes)



Learning objectives for the exercise (slide 11)

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

Instructions for the facilitator

- Inform participants that we will practice stress reduction techniques that can help people to feel calm and relaxed. Survivors can do 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 15–17.

Option A: Slow breathing technique (10 minutes)

- Try to keep your eyes closed. Sit with feet flat on the floor.
- 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.

Option B: Progressive muscle relaxation technique (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

- Discuss how these exercises felt for participants (for example, any positive effects or challenges) and ask if there are any questions.

Continued

- 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 need to remain calm and reduce stress from caring for patients.

Exercise 11.2:
Role-play on
problem-solving skills
(20 minutes)



Learning objective for the exercise

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

Instructions for facilitators (slide 19)

- **Ask the participants to form pairs.** Ask one person to play someone seeking help for worry or concern, and the second person to play 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.

Remind participants not to give advice.

After 15 minutes, bring the group back together for discussion.

Discussion (5 minutes)

- Ask participants who played the role of the person seeking help what it was like to discuss their problem with a colleague. What was especially helpful, and what could have been done differently?
- 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, frontline providers can offer basic psychosocial support.
- Basic psychosocial support includes stress reduction exercises.

Continued

- 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. Practice self-care through stress reduction exercises, and seek professional help when needed.
-

MODULE 12. Documenting Intimate Partner Violence and Sexual Violence

Introduction

Introduce this session by highlighting the importance of documentation to both 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.

Learning outcomes

By the end of this module, the participant should be able to:

- a. Know how to document intimate partner violence and sexual violence in a safe and confidential manner.

Methods

Presentation with slides and guided discussion (30 minutes).

Exercise 12.1: Documentation of IPV and SV (60 minutes).

Time

90 minutes.

Materials

Laptop and projector.

Exercise 12.1 Case study Client information.

GBV data collection forms.

Handouts

History-Taking Form (use the form in Exercise 8.1).

Participant Handout 9b: Sierra Leone Medical Certificate.

Participant Handout 12: Pictograms.

Session content

Presentation with slides and discussion (30 minutes)



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

- Discussion of how IPV and SV are documented in health facilities in Sierra Leone (see slide 2 notes).
- The importance of confidentiality in documentation (slide 3).

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 survivor and the provider?

Discussion: Ask the participants whether confidentiality of records is assured in the health facilities where they work.

- Ensuring the confidentiality of documents and records requires standard operating procedures (slide 3).
- Managers and providers have different roles and responsibilities in ensuring confidentiality in the documentation, but both roles are crucial (slides 4–6).
- Discussion of responsibility for records in the participants' facilities (see slide 4 notes).
- Structured forms for documentation (slides 9–10)

Discussion: Ask the participants what should be documented? (See slide 7 notes)

Exercise 12.1: Documentation of IPV and SV (60 minutes)



Learning objectives for the exercise (slide 11)

- Practice how to document intimate partner violence and sexual violence using the structured tools.

Distribute the handouts along with the data collection forms used in the public health facilities in Sierra Leone to document intimate partner violence and sexual violence (Handout 9b: Sierra Leone Medical Certificate and Handout 12: Pictograms).

Instructions for facilitators (slide 12)

Plenary discussion (15 minutes)

- Ask a volunteer first to explain how to fill out the medical certificate. Once explained in plenary, check that this is correct.

Group practice (45 minutes)

- Distribute the Exercise 12.1 case study with client information for this activity.

Continued

- Ask the participants to form groups of three to five people and practice as below.
 - Fill out the History-Taking Form with the necessary information (use the forms distributed in Exercise 8.1).
 - Fill out Handout 9b: Sierra Leone Medical Certificate with the necessary information.
 - Use Handout 12: Pictograms to mark specific areas of injury as per the case study.

Guided plenary discussion

- Ask the group:
 - Was the exercise easy to do? What was difficult?
 - What challenges did you face while filling the documentation tools?

Wrap-up



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

State the **key messages** (slide 14):

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

MODULE 13. From Knowledge to Practice: Visiting a GBV Centre

Introduction

This module provides a first step in linking what participants have learnt throughout the course with the current practice in providing care to the survivors of intimate partners violence and sexual violence. Participants should be reminded that this training is only the first step in improving and expanding intimate partner violence and sexual violence services. During this session, participants will have a chance to visit one of the GBV centres. This will be an opportunity to observe, assess and critique (not criticize!) the quality, availability and accessibility of the services at the centre, using a standard set of tools.



Note: The facility visit should only be conducted where the privacy of the survivors can be ascertained. You should work with the facility manager ahead of time to ensure that the participants do not interrupt the services and do not come into contact with the survivors. The facility manager may advise on the best time for a visit, based on when the centre will be less busy. The activities should be structured to minimise crowding at each service delivery point

Learning outcomes

By the end of this module, participants should be able to:

- a. Know the minimum standards required for quality intimate partner violence and sexual violence services.
- b. Understand how the GBV centres work with other stakeholders and service providers to provide comprehensive response services.

Methods

Presentation with slides (5 minutes).

Activity 13.1: Site Visit (90 minutes).

Plenary Group Feedback (25 minutes).

Time

120 minutes.

Materials

Laptop and projector.

Handouts

Participant Handout 13a: Health Facility Checklist.

Session content

Presentation with slides and discussion (10 minutes)



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

- Start by introducing the subject and the learning outcomes.
- Give an overview of different strategies used in providing GBV services (slide 3).
- Remind the participants of the different models of GBV services, and the different parts of the health system that provide services in Sierra Leone (slide 4–5).
- Remind participants on the client flow model currently in place in the GBV centres (slide 6).
- Share with the participants a snapshot of the WHO minimum standards for service delivery, and inform them that this will form the basis of their visit (slide 7).

Exercise 13.1: GBV Centre Site Visit



Learning Objectives for this exercise (slide 9)

Take the participants through the learning objectives of the GBV centre visit. Remind them that you will not be interacting with any survivors today. The purpose of the visit is to understand better how services are delivered and to assess whether they are meeting set standards.

Instructions for facilitators

- Brief the participants on the facility that they will be visiting (slide 10–11).
- Your co-facilitator can distribute copies of Handout 13: Health Facility Checklist to each participant.
- Divide the group of participants into three groups and nominate a group leader, rapporteur, and timekeeper for each group.
- Give each group leader an extra copy of Handout 13a: Health Facility Checklist that the groups will use to report back on during the debrief session (the group leaders can't keep their copies).
- Advise participants to bring stationery to take more detailed notes.
- Inform the participants that each group will cover strategic areas as follows:
 - Group 1 will cover leadership and governance, human resources, supplies, infrastructure, and finance related questions.
 - Group 2 will cover the service delivery flow, clinical examination, and data management.
 - Group 3 will cover triage, referral and linkage, and psychosocial support related questions.

Continued

- Give logistical arrangements for getting to the facility and back. For example, if transport is being provided, agree on pick up and drop off times and locations. (It may be a good idea to have the driver's number.)
- Call the head of the facility to confirm that you are on your way. Remember you will have spoken to them earlier in the week regarding today's visit.
- At the facility, ask the participants to wait in one designated area while you and the co-facilitator go for a courtesy call at the administrator's office. (It may be too overwhelming for the whole group to accompany you to the office).
- If some participants are from the facility you are visiting, you can go with the most senior of them to the administrator's office for the courtesy call.
- Introduce yourselves, and explain why you are at the facility, and your expected outcomes from the visit.
- Assure the administrator that the group does not intend to disrupt services. The privacy and confidentiality of survivors must be maintained at all times!
- Ask the administrator if one or two focal persons can be assigned to escort and answer specific questions that the group may have.
- Inform the administrator that upon completion of the exercise, the group will need to give a debrief on their observations as part of their learning outcomes.

Report back session (slide 10)



- Use slide 10 to brief participants on what will be expected of them during the debrief session.
- Because this is not an audit visit, try lightening the way in which they will give feedback.
- Once they complete the group exercise, group leaders will prepare their feedback as follows:
 - "Assume that the Minister of Health and Sanitation representative was visiting the centre and you are giving him/her a briefing on the area you will have covered."
 - What the areas that are meeting the standards?
 - What would you advocate for as considerations for improvement of standards?
 - Highlight at least three recommendations for the minister to take up that will ensure good quality and comprehensive services are offered to all survivors attending the centre.
- Site visits can be very exciting, and it is easy to lose track of time. That is why the group timekeeper has an important role.
- Agree on the timing for the visit, the report back, and departure from the facility.
- Once all three groups have given feedback, thank the facility staff on behalf of the group and return to the training venue to prepare for the afternoon session.

Wrap-up



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

State the **key messages** (slide 8):

- Setting standards for health care delivery of IPV and SV services is an important aspect of health systems strengthening.
- Applying standards is a way of enhancing quality management systems and applying continuous quality improvement measures.
- GBV centres need to work with other stakeholders in the surrounding community to provide comprehensive services.

Winding Up!

Your Go-To Toolkit

This section will focus on what you need to do to prepare as you get into the home stretch of the training. Your Go-To Toolkit remains an important reference for you as you conclude. Once again, you will refer to the Training Agenda, the Facilitator's Guide, and other relevant Annexes.

End of Training Evaluation

The training evaluation allows facilitators to understand whether the training objectives have been met. The post-evaluation tools include a post-course assessment to assess the knowledge acquired during the training, and the final course evaluation to obtain participants' feedback on the training. This evaluation will help improve future trainings.

1. The post-course assessment (30 minutes)

Ensure you have enough printed copies for each of the participants. You can find the post-test questionnaire in Annex 6a.

2. Marking and Review of Post-Course Assessment (30 minutes)

Using Annex 6b: Post-Test Answer Sheet, the participants will mark their peers' tests. Collect the results, and the co-facilitator can enter the scores into the Training Database template (Annex 4). The pass mark for the post-course examination is 50%. Participants who score 90% or more may be considered as potential trainers if additional factors are met, as described later in this section.

3. Course Evaluation (30 minutes)

Request the participants take a few minutes to evaluate the training. Encourage them to give honest feedback, both positive and negative, as this evaluation will be reviewed carefully by the organizers of the training and will help improve future trainings. The course evaluation forms can be found in Annex 7b.

4. Presentation of Certificates (30 minutes)

Certification will depend on three factors:

- 100% attendance at the training course.
- Continuous assessment of participants during the participatory exercises.
- Post-course assessment results.

Participants completing the training qualify for one of two certificates:

- **Certificate of Attendance** – This is suitable for the participants who attend the foundational sessions only (Modules 1–7) and for participants who attended the full training but did not attain the pass mark in the post-course assessment.
- **Certified GBV Service Provider** – This is a serialized certificate issued by the Ministry of Health and Sanitation of Sierra Leone. Serialized certificates are one way of ensuring the authenticity of certificates and enhancing quality assurance of training. The serialized certificate number will also appear in the training database that MOHS will build as it enhances the capacities of services providers.

Once again, congratulate participants on a job well done. Present the participants with their certificates, or invite a guest to do so.

Identification and Selection of Potential Training of Trainers

Part of your role as a facilitator is to identify potential trainers from the service providers participating in the course, to build capacity of GBV service providers as trainers and mentors in their own workplaces and districts. Doctors, nurses, midwives, and counsellors can be trainers, what matters is their ability to deliver set content as facilitators.

- Agree with the course coordinator the maximum number of potential trainers that can be selected in per course.
- Use Annex 8: Appraisal Form for Selection of Potential Trainers for the selection criteria of key qualities that the training team will use to identify potential trainers in the group.
- This competency scale will help you identify a potential trainer based on their performance in the MCQ performance, and five other core competencies. Not all participants have to be scored using this tool. A good starting point would be to select the candidates who have performed well in the MCQs and then identify potential trainers from that pool.
- Select the competency level that best describes the candidate in each section, and score according to the matrix.
- This will result in a score between 6 and 24 for each candidate.

- Agree with the course coordinator the minimum score required for a candidate to be considered. For example, you may decide only those with scores between 20 and 24 will be considered.
- Record your recommendations in the Training Database.

Closing Ceremony and Wrap-up

Thank everyone for their hard work and officially close the training. If there is a guest speaker, ask that person to say a few words to close the training. Collect and pack any non-print material that must be returned to the course coordinator.

Training Reporting

Submit training reports to the Ministry of Health and Sanitation within ten working days after the completion of the training, in the format requested by them. The lead facilitator is accountable for the submission of the training report and keeping records.

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- World Health Organization (WHO). 2017b. *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*.
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*** References include documents that are cited in accompanying notes; Participants' Handouts and Participatory Exercises.

Annex 1: Sample Training Agenda

DAY 1	
8:00 am to 8:30 am	Registration
8:30 am to 9:00 am	Pre-course assessment
9:00 am to 9:40 am	Opening Ceremonies and Introductions
9:40 am to 10:00 am	Training overview and learning objectives
10:00 am to 10:30 am	Tea Break
10:30 am to 10:50 am	Hope and Expectations Exercise
10:50 am to 11:00 am	Group norms
11:00 am to 12:30 pm	Module 1: Introduction to Gender-Based Violence
12:30 pm to 1:30 pm	Lunch
1:30 pm to 3:30 pm	Module 2: Understanding Survivors' Experiences and How Providers' Values and Beliefs Affect the Care They Give
3:30 pm to 3:45 pm	Tea Break
3:45 pm to 4:15 pm	Module 3: Guiding Principles and Overview of the Health Response to Gender-Based Violence
4:15 pm to 4:30 pm	Day evaluation and wrap up
DAY 2	
8:00 am to 8:30 am	Day 1 Recap
8:30 am to 9:15 am	Module 4: Provider–Survivor Communication Skills
9:15 am to 10:00 am	Module 5: Identification of Intimate Partner Violence in the Clinical Setting – presentation and demonstration of role play
10:00 am to 10:30 am	Tea Break
10:30 am to 11:00 am	Module 5: Identification of Intimate Partner Violence in the Clinical Setting - role-play
11:00 am to 12:30 am	Module 6: First-line support using LIVES: Listen, Inquire, Validate, Enhancing safety and Support
12:30 pm to 1:30 pm	Lunch
1:30 pm to 3:30 pm	Module 7: Know Your Setting: Identify Referral Networks and Understand the Legal and Policy Context
3:30 pm to 3:45 pm	Tea Break
3:45 pm to 4:00 pm	Day evaluation and wrap up

DAY 3	
8:00 am to 8:30 am	Day 2 Recap
8:30 am to 10:00 am	Module 8: Clinical Care for Survivors of Sexual Assault and Abuse, Part 1: History-Taking and Examination
10:00 am to 10:30 am	Tea Break
10:30 am to 11:00 am	Module 9: Forensic Examination
11:00 am to 12:30 am	Module 10: Clinical Care for Survivors of Sexual Assault and Abuse, Part 2: Treatment and Care
12:30 pm to 1:30 pm	Lunch
1:30 pm to 2:30 pm	Clinical examination practical
2:30 pm to 3:30 pm	Module 11: Care for Mental Health and Self-Care for Providers
3:30 pm to 3:45 pm	Tea Break
3:45 pm to 4:15 pm	Question and Answer session
4:15 pm to 4:30 pm	Day evaluation and wrap up
DAY 4	
8:00 am to 8:30 am	Day 3 Recap
8:30 am to 10:00 am	Module 12: Documenting Intimate Partner Violence and Sexual Violence
10:00 am to 10:30 am	Tea Break
10:30 am to 10:45 am	Pre-facility visit briefing Health System Strengthening for GBV services
10:45 am to 12:30 am	GBV Facility visit
12:30 pm to 1:30 pm	Lunch
1:30 pm to 2:00 pm	Post-Course Assessment
2:00 pm to 2:30 pm	Review of Post Course Assessment
2:30 pm to 3:00pm	Course evaluation
3:30 pm to 3:45 pm	Tea Break
3:45 pm to 4:15 pm	Certification
4:15 pm to 4:30 pm	Closing ceremony and wrap-up

Annex 2a: Training Materials Checklist

Items for requisition			
Item	Quantity	Received	Returned
A laptop loaded with module presentations, soft copies of Annexes	1		
Backup USB stick loaded with module presentations for each facilitator	2		
LCD projector (compatible with the above laptop)	1		
Connecting cables (HDMI, VGA)	1		
Flip chart rolls	6 pcs		
Flip charts stands	3		
Flip chart marker pens red, blue and black	3 packs		
Sticky notes/Post-it notes multicoloured	15 packs		
Masking tape	4 pcs		
Name tags	30 pcs		
Coloured index cards	2 packs		
Biro pens/Ball point pens	30 pcs		
A4 notebooks	30 pcs		
Participant ring binders	30 pcs		
Paper punch	2		
Stapler	2		
Staples	2 packs		
Shawls or newspaper sheets (for blanketed by blame exercise)	11 pieces		
Balls of coloured yarn / wool	2 rolls		

Items for print			
Item	Quantity	Received	Returned
Facilitator's Guide	3 copies		
Participant handouts	30 copies		
Participatory exercises handouts	30 copies		
Registration Forms (Annex 3)	4 copies		
Pre-Course Assessment MCQs (Annex 8a)	30 copies		
Post-Course Assessment MCQs (Annex 8a)	30 copies		
End-of-Course Evaluation forms (Annex 9b)	30 copies		
Pre/Post Course Answer sheets	2 copies		
Appraisal Forms for Identifying Potential Trainers (Annex 10)	6 copies		

**These are estimates for a training with 25 participants.*

Annex 2b: List of Participatory Exercises and Handouts

Module	Activity	Print Materials required	Quantity	Participant Handouts	Quantity
1.0 - Introduction to Gender-Based Violence	Buzz activities	Facilitator's Resource	2	1a: GBV Terminology	30
				1b: Violence Against Women – Global Picture/Health Response	30
				1c: Legal and Policy Frameworks of GBV in Sierra Leone	30
2.0 - Understanding the survivor's experience and how providers' values and beliefs affect the care they give	Voting with Your Feet	Facilitator's Resource	2	2b: Why Don't Women Leave?	30
	Blanketed by Blame	Facilitators script	2	2c: Barriers to Seeking Care	30
		12-character cards	1 set		30
3.0 - Guiding principles and overview of the health response to violence against women and girls		Facilitator's Resource	2	3: Guiding Principles for Survivor-Centred Care	30
4.0 - Provider-survivor communication skills	Listening exercise	Facilitator's Resource	2	4. Active Listening Principles	30
5.0 - Identification of Intimate Partner Violence or Sexual Violence in the clinical setting	Demonstration of role-playing	Demonstration scripts	2	5b: Asking About Violence	30
	Role-play	Role-play scripts	30	5a: When and How to Identify a Woman or Girl Who May Be Subject to Violence	30
6.0 - First-line support using LIVES: Listen, Inquire, Validate, Enhancing safety and providing Support	Role-play to practice LIVES	Role-play scripts	30	6a: First-Line Support	30
				6b: Communication Skills and Pathway	30
				6c: Enhance Safety	30
				6d: Health Care Providers' Common Questions	30

7.0 - Know your setting: Identify referral networks	The Web of Referrals	Character cards	1 set	7a: Roles and Responsibilities of Health Care Providers in IPV and SV Services	30
	Developing facility-level service provider directories	Facility service directory template	30	7b: Referral and Linkage	30
8.0 - Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination	Role-play on history-taking	Role-play on history-taking scenarios scripts	30	8a: History-Taking Checklist	30
		History-Taking Form	30	8b: Obtaining Consent	30
				8c: Physical Exam Checklist	30
9.0 - Forensic examination	Decision-making on forensic evidence collection	Scenarios and a table for recording responses	30	9a: Collecting Forensic Evidence and Maintaining a Credible Chain of Evidence	30
10.0 - Clinical care for survivors of sexual assault/rape, part 2: treatment and care	Case studies on treatment for sexual assault	Case studies scripts	30		
		template with blank tables	30		
11.0 - Care for mental health care and self-care for providers	Stress reduction exercises	Facilitator's Resource Pack	2	11: Helping Survivors with More Severe Mental Health Problems	30
	Role-play on problem-solving skills	Role-play scripts	30		
12.0 - Data collection and Reporting for IPV and SV services		Case study Client information	30		
		GBV data collection forms	30		
13.0 - From Knowledge to Practice - Visiting a GBV Centre		GBV Site Visit Questionnaire	30	13a: Health Facility Checklist	30

**These are estimates for a training with 25 participants.*

Annex 3: Sample Participant Registration Form

REGISTRATION FORM: National GBV Training Ministry of Health and Sanitation, Sierra Leone

District: _____ Venue: _____

Dates: _____ To: _____

Name	Designation	Workstation	Email	Phone	Signature				
						Day			
						1	2	3	4
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									

Annex 4: Sample Training Database

Potential TOT								
Post-course score								
Date trained								
Phone								
Email								
Cadre								
Name								
Workstation								
District								

Annex 5: Icebreakers and Energizers

Juggling ball game (suitable during introduction session)

Everyone stands in a close circle. (If the group is large, it may be necessary to split the group into two circles.) The facilitator starts by throwing the ball to someone in the circle, saying their name as they throw it. Continue catching and throwing the ball, establishing a pattern for the group. (Each person must remember who they receive the ball from and who they have thrown it to.) Once everyone has received the ball and a pattern is established, introduce one or two more balls, so that there are always several balls being thrown at the same time, following the set pattern.

Names and adjectives

Participants think of an adjective to describe how they are feeling or how they are. The adjective must start with the same letter as their name, for instance, “I’m Hellen, and I’m happy” or, “I’m Andrew, and I’m amazing.” As they say this, they can also mime an action that describes the adjective.

Three truths and a lie

Everyone writes their name, along with four pieces of information about themselves on a large sheet of paper. For example, “Mike likes singing, loves football, has five wives and has a pet dog”. Participants then circulate with their sheets of paper. They meet in pairs, show their paper to each other, and try to guess which of the written ‘facts’ is a lie.

Fruit salad

The facilitator divides the participants into an equal number of three to four fruits, such as oranges and bananas. Participants then sit on chairs in a circle. One person must stand in the centre of the circle of chairs. The facilitator shouts out the name of one of the fruits, such as ‘oranges’, and all of the oranges must change places with one another. The person who is standing in the middle tries to take one of their places as they move, leaving another person in the middle without a chair. The new person in the middle shouts another fruit and the game continues. A call of fruit salad’ means that everyone has to change seats.

Tide’s in/tide’s out

Draw a line representing the seashore and ask participants to stand behind the line. When the facilitator shouts “Tide’s out!” everyone jumps forwards over the line. When the leader shouts “Tide’s in!” everyone jumps back over the line. If the facilitator shouts “Tide’s out!” twice in a row, participants who move must drop out of the game.

Annex 6a: Pre/Post-test

For question 1 to 10, select one answer.

1. **“Any criminal offence arising out of physical, sexual, emotional, or psychological, social, economic abuse committed by a person against another person within a domestic relationship, e.g. between spouse, or between caregivers and children”.** This statement best fits a description of:
 - A. Intimate partner violence
 - B. Domestic Violence
 - C. Sexual Penetration
 - D. Gender-Based Violence
 - E. Sexual Violence

2. **“Behaviour by an intimate partner that causes physical, sexual, psychological, or economic harm, including acts of physical aggression, verbal abuse, sexual coercion, reproductive coercion, and other controlling behaviours. It covers violence by both current and former spouses and other intimate partners”.** This statement best fits a description of:
 - A. Intimate partner violence
 - B. Domestic Violence
 - C. Sexual Penetration
 - D. Gender-Based Violence
 - E. Sexual Violence

3. **“An act which causes the penetration of a child’s genital organs (A child is a person aged below the age of 18 years)”.** This statement best fits a description of:
 - A. Intimate partner violence
 - B. Domestic Violence
 - C. Sexual Penetration
 - D. Gender-Based Violence
 - E. Sexual Violence

4. **The following are risk factors of GBV in Sierra Leone, except?**
 - A. Gender inequality
 - B. Discriminatory gender social norms
 - C. Good communication skills
 - D. Male alcohol consumption and use of drugs
 - E. Witnessing violence in childhood

5. **The following are reasons why women do not seek help after experiencing violence, except:**
 - A. Being embarrassed or afraid to be blamed
 - B. Fear of consequences and threats after disclosing an experience of violence
 - C. Fear of bringing shame to the family
 - D. Partner threatened or hit her child
 - E. Fear of economic hardship

- 6. The following are guiding principles that should be applied by a health care provider when providing services to survivors, except:**
- A. Value her/him as a person
 - B. Respect her/his autonomy and dignity
 - C. Provide information and counselling that helps the survivor to make hers/his own decisions
 - D. Do not blame or judge
 - E. Convince her to go to any other service, such as police or courts
- 7. You should suspect a woman, or a girl has been subjected to violence if she has any of the following:**
- A. Injuries that are repeated and not well explained.
 - B. Unexplained chronic pain or conditions, including gastrointestinal, bladder infections.
 - C. Both A and B
 - D. None of the above
 - E. All the above
- 8. First-line support is the most important care, and maybe all that the survivor needs, it entails:**
- A. Listen, Inspire, Value, Enhance safety and providing Support
 - B. Listen, Inquire, Validate, Enhance safety and providing Support
 - C. Listen, Interact, Voice opinion, Emergency care and Support
 - D. Listen, Inquire, Validate, Emergency care and Solve the problem
 - E. None of the above
- 9. Which of the following health care providers can document the survivors' history, which should include the emotional state?**
- A. Doctors
 - B. Nurse
 - C. Midwife
 - D. Counsellor
 - E. All the above
- 10. The following four conditions need to be met for forensic examinations, except:**
- A. The survivor wants to go to the police
 - B. The survivor comes within seven days after the sexual assault
 - C. A health care provider who is trained in forensic examination is available
 - D. A forensic science laboratory is available
 - E. The survivor comes within 14 days of the sexual assault

Answer true or false for each of the statements below:

Question	Statement	TRUE	FALSE
11	It is the role of a GBV centre to maintain an updated referral directory with contact details of referral services		
12	Sexual violence is a crime; therefore, the health care provider is obliged to report the incident to authorities irrespective of the survivor's wish.		
13	Consent should only be taken at the first point of contact with the survivor to avoid retraumatizing them during history-taking; the examination; the forensic evidence collection, and reporting/sharing of evidence.		
14	The needs of a woman subjected to violence are complex, and the health-care provider may not be able to address them all. The health-care providers' role focuses on support and care.		
15	To ascertain whether sexual penetration/sexual violence occurred, the health service provider must conduct a virginity test in a female survivor.		
16	When offering EC, the health care provider should offer counselling and inform client on type of EC to use.		
17	Almost all women subjected to violence suffer from post-traumatic stress disorder (PTSD)		
18	The type of specimen that can be collected for forensic evidence includes survivors clothing, blood or urine; injury evidence as documented on pictograms in the medical certificate		
19	A pregnancy test must be done before giving EC. Taking EC will cause harm if the woman is already pregnant or if EC fails.		
20	In high HIV prevalence settings, it may be appropriate to offer PEP to all rape survivors coming within 72 hours		

Annex 6b: Pre/Post-test Answer Sheet

Multiple-choice questions

1. B
2. A
3. C
4. C
5. D
6. E
7. C
8. B
9. E
10. E

Answer True or False for the statements below

11. T
12. F
13. F
14. T
15. F
16. F
17. F
18. T
19. F
20. T

Annex 7a: Course Evaluation

Daily evaluation or reflections are important as they provide chances to informally learn and improve the course. For the participants, it allows for reflection and the facilitators (and course coordinator) feedback (Chambers 2002). Remember the participants will have had long days of intense work, we want to make the daily evaluations as painless and as meaningful as possible for both the participants and the training team.

In this course, participants and facilitators will have daily reflections on days 1 - 3, to carry out *light* evaluations of the course. On the last day, a formative course evaluation will be carried out.

Here are some exercises facilitators can consider for the daily reflections:

- a) **Mood Meter:** Post up a chart in the corner of the plenary room (perhaps close to the door). Each workshop day is labelled on a separate flip chart (Chart 1 – Monday, Chart 2 - Tuesday... etc.). On the extreme left margin of each flip chart to indicate Emojis showing different levels of morale (Top – Smiley Face, Middle – face with a straight line, Bottom – Sad face). At the end of each day, pose a question, e.g. how much they have learnt on that day. Participants will then mark against the emoji that represents how they feel about the day's events. This method provides a quick check and feedback, and an early warning if things are not going well.
- b) **Visualisation in Participatory Planning (VIPP) cards:** Issue blank VIPP cards or sticky notes that the participants will use to write down what they are happy about and what they aren't so happy about. Two flipcharts can be placed in the room (one with a smiling emoji and the other with a sad emoji). Participants can stick their observations or reflections in the appropriate flip chart. Alternatively, you can guide participants to use one colour or shape of VIPP cards for the positive feedback, and another colour or shape for negative feedback. The facilitators can collect these for review at the end of the day.

Tip: It may be a good idea to limit the number of cards participants get.
- c) **Stand to Score:** This is a quick, flexible, active and good when tired at the end of a day. Ask participants to stand in the centre of the room. Point out poles/corners of the room to indicate "Positive" or "Negative" evaluations. Using the programme, ask participants to evaluate by moving to the area they would rate each session. Ask people why they have chosen their position.

At the end of the evaluation and close of the day, facilitators may use what was acceptable as a norm for the group to close the day.

Annex 7b: Course Evaluation Form

COURSE EVALUATION

Training Dates _____

INSTRUCTIONS: We ask that you take a moment to provide your valuable feedback. Answers you provide are anonymous and will be used to improve future trainings.

1. Please rate the overall training by choosing the corresponding answer.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Training objectives were clear	1	2	3	4	5
The training met my expectations	1	2	3	4	5
The training will help me with my work	1	2	3	4	5
The training was clear in content	1	2	3	4	5
The content relevant to my work	1	2	3	4	5
The content was easy to understand	1	2	3	4	5
The training handouts were clear and well organized	1	2	3	4	5
The training handouts supported the training material	1	2	3	4	5
The exercises and group work activities help to strengthen my skills	1	2	3	4	5
The presentations were appropriate for learning information	1	2	3	4	5
The facilitators were knowledgeable	1	2	3	4	5
The facilitators were engaging	1	2	3	4	5
There was sufficient opportunity to ask questions	1	2	3	4	5
The training length of 4 days was	Far too short	A bit too short	Just right	A bit too long	Far too long

2. Please explain your answers above if you indicated 1, 2, or 3 or if the timing was not right:

.....

3. What is the most valuable thing you learned?

.....

4. Please rate the training elements by choosing one answer corresponding answer.

	Poor	Unsatisfactory	Fair	Satisfactory	Outstanding
Materials provided and used	1	2	3	4	5
Room set-up	1	2	3	4	5
Location	1	2	3	4	5
Support (administrative, IT, etc.)	1	2	3	4	5

5. Do you have any suggestions to improve the logistics and/or materials used?

.....

6. What sessions were most useful, and why?

.....

7. What sessions were least useful, and why?

.....

8. Is there any topic/issue related to VAW that was not dealt with in the training that you would need/want training in?

.....

9. What did you learn during the training that you will immediately use in your work?

.....

10. Any other suggestions? (e.g. additional/other exercises)

.....

Annex 8: Appraisal Form for Selection of Potential Trainers

APPRAISAL FORM FOR SELECTION OF POTENTIAL TRAINERS FOR HEALTH CARE PROVIDERS FOR MANAGEMENT OF INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE

The training for Health Service Providers for Management of Intimate Partner Violence and Sexual Violence in Sierra Leone will provide an opportunity to identify strong candidates as potential trainers. With the aid of the continuous assessments and course results, a candidate can be nominated by a facilitator, and seconded by a second facilitator as a Potential Trainer (PT), using this appraisal form.²

District		Provider Course Date	
Lead Facilitator (Name)			
Candidate Name			
Nominated by:			
Seconded by:			

To be successfully nominated as a PT, the candidate must score a minimum total of 16 points. Any score of the unacceptable automatically disqualifies the candidate from the selection. A copy of each completed form should be included in the Course Director's/Lead Facilitator's report to the Course Coordinator at the Ministry of Health and Sanitation of Sierra Leone. To be nominated as a PT, the candidate must be a registered doctor, nurse, midwife or counsellor.

Registration Number: _____

Course Certificate Serial Number: _____

² Adapted from Appraisal form for identifying ALS instructor potential, Resuscitation Council of UK, 2010

Please read the competency scale on the overleaf for further guidance then circle the appropriate number for each characteristic in the table below.

	Unacceptable	Average	Outstanding
MCQ Performance	1	2	3
Communication	1	2	3
Enthusiasm	1	2	3
Engagement in Feedback	1	2	3
Interactivity/Team working	1	2	3
Credibility	1	2	3
Total Score			
Comments			

Overall Recommendation (tick one)

Suitable PT

Not Suitable PT

Course Director's Signature	
Date	

SKILLS AND CHARACTERISTICS COMPETENCY SCALE

Score 1	Score 2	Score 3
MCQ Performance		
Candidate scores less than 50%	Candidate scores 51–89%	Candidate scores more than 90%
Communication		
Difficulty in communicating with fellow candidates/facilitators	Good communication skills with fellow candidates/facilitators including non-verbal behaviour (e.g. eye contact, body language, facial expression)	Clear and articulate communication skills with fellow candidates/facilitators and has excellent non-verbal behaviour
Enthusiasm		
Minimal interest in GBV response activities and shows little interest in learning to teach	Good interest in GBV response activities, and shows interest in teaching others	High level of interest in the subject area, has a high level of interest in learning to teach or is already a TOT
Engagement in Feedback		
Minimal engagement with the feedback process	Takes opportunities to join in with feedback for self and others	Uses contributions to enhance feedback discussions for self and others
Interactivity/Team Working		
Limited interaction with facilitators and participants during sessions and works in isolation	Good interaction with facilitators and participants during sessions and works with other team members	Excellent interaction with facilitators and participants during sessions with excellent engagement and support to team members
Credibility		
Health care staff with little/no prior clinical expertise and GBV response experience and is rarely exposed to GBV health response	Health care staff with significant clinical expertise and GBV response experience, with occasional exposure to managing GBV in clinical practice	Health care staff with extensive prior clinical experience and GBV response experience, with frequent exposure to managing GBV in clinical practice.



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