

UNIT 13:

SEXUAL AND GENDER-BASED VIOLENCE (SGBV)

INTRODUCTION:

Sexual and gender-based violence (SGBV) is sometimes considered a separate issue from sexual and reproductive health. The experience of violence, though, and in particular sexual violence, has direct effects on sexual and reproductive health, mental health, and the health of families, children, and adolescents. In many cultures, violence is taboo, and violence that occurs within the home or is based on gender or sexuality is considered shameful or a private affair. As providers and counselors, it is important to recognize the effects of SGBV on clients and their sexual and reproductive health, and to be prepared to screen for and counsel clients affected by SGBV. Available evidence suggests that many young people's first sexual experience is coerced or forced, and the perpetrator is often known; however, young people may not articulate their experiences as SGBV. The limited data available also suggest that young persons with disabilities are more likely to experience sexual violence than their peers without disabilities. Estimates suggest that 40 to 68 percent of young women with disabilities and 16 to 30 percent of young men with disabilities will experience sexual violence before the age of 18. According to UNICEF, young persons with intellectual and developmental disabilities are among the most vulnerable and are almost five times more likely to be subjected to sexual violence than their peers without disabilities. Reasons for these higher rates of violence include but are not limited to: stigma, discrimination, dependence, negative traditional beliefs, and impunity. Young persons with disabilities can also face the most barriers to accessing services and receiving support.

In any event, if SGBV or an experience of coerced/forced sex is not acknowledged or addressed in a professional, nonjudgmental manner, it can lead to further sexual and reproductive health problems. Providers and counselors should possess good counseling skills and accurate knowledge of both the prevalence and effects of SGBV to help all adolescent clients.

UNIT TRAINING OBJECTIVE:

To help providers recognize and respond to SGBV as a sexual and reproductive health and rights issue.




SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

7. Explain the importance of SGBV as a sexual and reproductive health and rights issue.
8. Identify physical and behavioral indicators of SGBV.
9. Demonstrate how to screen for and counsel clients with a history of SGBV.
10. Identify clinical care needs and appropriate services for survivors of SGBV.

TOTAL TIME: 4 HOURS 55 MINUTES

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
13.1	Group brainstorm Quiz	Flipcharts and markers Participant Handout 13A	1 hour 15 minutes
13.2	Group brainstorm Trainer presentation	Flipcharts and markers Slides 13.1-13.6	1 hour
13.3	Small group work Trainer presentation Role play	Participant Handout 13b Slides 13.7-13.16	1 hour 25 minutes
13.4	Trainer presentation Group brainstorm	Slides 13.17-13.22 Flipcharts and markers Participant Handout 13c	55 minutes
Unit Summary	Individual reflection	Empty box or bag index cards	10 minutes



WORK FOR TRAINERS TO DO IN ADVANCE:

- Review Slides 13.1-13.22.
- Review the materials on SGBV and disability included in the reference list.
- Research common SGBV issues in your area and resources and services available for survivors. Find out if these are accessible and currently used by persons with disabilities and, if not, why.
- Prepare Participant Handouts 13a-c.
- Locate an empty box or bag.



MAJOR REFERENCES AND TRAINING MATERIALS:

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WHO and World Bank. 2011. *World report on disability*. Geneva: WHO.

World Health Organization (WHO). 2016a. *Guidelines on the management of health complications from female genital mutilation*. Geneva: WHO.

World Health Organization. 2016b. *Violence against women: Factsheet*.

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World Health Organization. 2014. *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook*. Geneva: WHO.

World Health Organization. 2013. *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva: WHO.

World Health Organization. 2013. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva: WHO.

SPECIFIC OBJECTIVE 13.1: EXPLAIN THE IMPORTANCE OF SGBV AS A SEXUAL AND REPRODUCTIVE HEALTH ISSUE



TIME

1 hour 15 minutes



METHODS

- Group brainstorm
- Quiz



MATERIALS NEEDED

- Flipcharts and markers
- Participant Handout 13A: SGBV Fact or Fiction



STEPS

1. Introduce the unit by telling participants that adolescents experience many types of violence, physical, emotional, and sexual, and that all of these forms of violence may have an effect on their sexual and reproductive health.

Time: 35 minutes

Write “Types of Violence” on the top of a flipchart. Ask participants to brainstorm some of the kinds of violence they think the adolescents in their community can or do face. Ask them if, in their opinion, adolescents with disabilities experience some forms of violence more than others. If yes, why.

- **Trainer’s Note:** *Some of the types of violence that participants should include are: sexual violence, incest, domestic abuse, bullying, gang violence, early and forced marriage, female circumcision/female genital mutilation, emotional abuse, sexual abuse, sexual assault, harassment, corporal punishment, coercion, rape, relationship violence, intimate partner violence, forced abortion, and forced sterilization.*

Some people may cite “prostitution” or sex work as a type of violence. If a participant calls out prostitution or sex work, clarify that any forced labor of any kind, including sex work, is violence, but that not all sex work is forced or involuntary.

2. Ask participants if they need clarification on any of the terms on the sheet. Make sure there is a clear understanding of what people mean by these terms before moving forward. Some definitions are included for you below in **Supplemental Content: SGBV Terms**.

Supplemental Content: SGBV Terms

Sources: WHO 2016b, UNICEF 2015, Amnesty International 2015

1. **Bullying:** Bullying is an aggressive and repeated pattern of hostile behavior and is based on a real or perceived power imbalance. Bullying can involve physical or sexual

harassment, threats, isolation, shaming and stigmatization, or physical assault. Bullying can happen in schools, in workplaces, in the community, online, or in any space where people regularly gather.

2. **Domestic Abuse/Domestic Violence:** Any violence or abuse that takes place inside the home or family. Violence may or may not be directed against the adolescent but may have physical or psychological effects on the adolescent. The WHO reports that children who grow up in families where there is violence may suffer a range of behavioral and emotional disturbance, which increases their risks for perpetrating or experiencing violence later in life.
3. **Homophobic and Transphobic Violence:** According to the Office of the High Commissioner on Human Rights: "Homophobic and transphobic violence has been reported in all regions of the world. It ranges from aggressive, sustained psychological bullying to physical assault, torture, kidnapping and targeted killings. Sexual violence has also been widely reported, including so-called 'corrective' or 'punitive' rape, in which men rape women assumed to be lesbians on the pretext of trying to 'cure' their victims of homosexuality."
4. **Intimate Partner Violence:** Refers to behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors.
5. **Female Circumcision/Female Genital Mutilation (FGM):** The removal of part or all of the external female genitalia. This practice has been linked in some countries with girls' or young women's rites of passage. It is seen as a way of controlling women's or girls' sexuality and is still practiced in many parts of the world. FGM can have serious consequences for girls' and women's physical and mental health. It sometimes results in excessive bleeding, infection, transmission of diseases, trauma and pain and even death, and often leads to difficulties in intercourse and childbirth.
6. **Rape:** Defined as the use of physical and/or emotional coercion, or threats to use coercion, to penetrate a child, adolescent, or adult vaginally, orally, or anally against her/his wishes. Rape is not a form of sexual passion; it is a form of violence and control. Rape can be perpetrated by a stranger, but is more commonly perpetrated by an acquaintance, spouse, or romantic partner. Rape is also common in conflict areas or against sexual or racial minority communities (see **Homophobic and Transphobic Violence**, above). Rape is always a human rights violation and is also considered a war crime or hate crime.
7. **Sexual Abuse:** Sexual abuse includes all forms of sexual coercion (emotional, physical, and economic) against an individual. It may or may not include rape. Any type of unwanted sexual contact is considered sexual abuse. Sexual abuse can occur anywhere, and to anyone.
8. **Sexual Violence:** Sexual violence includes both physical and psychological attacks directed towards a person's sexual characteristics. It is not limited to a physical invasion of the person's body and may include acts that do not involve penetration or physical contact.
9. **Forced Abortion and Forced Sterilization:** Forced abortion and forced sterilization may occur when the perpetrator causes abortion by force, threat or coercion, or by taking advantage of woman's incapability to give her consent, or where she gives her consent under duress. Women and girls with disabilities are exposed to forced abortion and sterilization more than their peers without disabilities, as they are often denied their sexual and reproductive autonomy, with family members/guardians making decisions

about their reproductive life without asking their opinion or consent. In some cases, due to limited or inaccessible information, they may also have a diminished understanding of what it means to have an abortion or be sterilized, which could lead to agreeing to the procedure without giving truly informed consent.

3. Ask for a volunteer to circle the types of violence that can be sexual or because of an adolescent's sexuality.
4. Ask for another volunteer to circle the types of violence that can be based on an adolescent's gender identity or expression, using a different colored marker. At this point, all of the terms should be circled at least once.
5. On another flipchart page, write "Sexual and Gender-Based Violence." Tell participants that any kind of violence can be sexual or gender-based, if it involves sexual abuse, coercion, harassment, or assault, or if it is violence committed against a person based on their sex, gender, sexuality, sexual orientation, gender identity, or gender expression.
6. Ask participants how they would tell if violence is gender-based. Ask for examples of violence that is gender-based, versus violence that isn't.
7. Underneath "Sexual and Gender-Based Violence" write the term "Violence Against Women and Girls." Tell participants that most gender-based violence is violence against women and girls because of their gender, but that gender-based violence includes violence against people of all genders when it occurs because of how people live and express their gender identity. For example, bullying and violence against boys for being "too feminine" would also be considered a type of gender-based violence.
8. Ask if participants are clear on the various types of sexual and gender-based violence their clients may be experiencing or have experienced. Clarify any definitions or misconceptions.

Time: 40 minutes

9. Introduce the next activity. Tell participants that because of the connection to sex, because much SGBV occurs within the family or within intimate relationships, and because of social taboos around talking about SGBV with others, there are all sorts of misunderstandings and social assumptions about SGBV.
 10. Pass out **Participant Handout 13A: SGBV Fact or Fiction**. Tell participants that they will do a short exercise to uncover some of the common misconceptions about SGBV. Give participants **10 minutes** to complete the handout.
 11. Once participants have finished filling out their handout, go through the answers with the group. Clarify misconceptions and answer questions using **Content: SGBV Fact or Fiction Discussion Guide** below.
- **Trainer's Note:** *You do not need to read out every point on the discussion guide below during your group discussion. These points are here for you to use in case some common but difficult questions arise.*

Content: SGBV Fact or Fiction Discussion Guide

- i. Fact Fiction **Rape happens only to women**

Rape can be committed against and be committed by people of all sexes/genders. Because of the public perception of rape as a crime by men against women, people who experience other forms of rape may not know that it is rape. Men who come forward to report being raped by other men or by women are frequently subjected to social scorn, disapproval, or dismissal leading to additional stigma against men who have been sexually assaulted.

- ii. Fact Fiction **Sexual abuse only means rape.**

Sexual abuse includes all forms of sexual coercion, harassment and assault. It can include emotional abuse, physical abuse or assault, or economic coercion and abuse as weapons. It may or may not include rape, but should not be taken any less seriously. Any type of unwanted sexual contact is considered sexual abuse and is a violation of basic human rights.

- iii. Fact Fiction **Anyone can commit sexual or gender-based violence.**

People can be loving and caring and commit violence against another person. Sometimes, people who commit sexual and gender-based violence think they are doing what the victim wants or is in their best interest. Some examples include:

1. *Parents who want their daughters circumcised to help them fit into their community or to be more marriageable.*
2. *Parents who think that forcing their gay or lesbian children to have heterosexual sex will “cure” them of homosexuality.*
3. *Partners who think beating their wives or husbands is “teaching” them.*
4. *Parents or guardians who think that forcing sterilization upon adolescent girls with disabilities is in their best interest to prevent unwanted pregnancies.*
5. *Parents or guardians who think that forcing abortion upon adolescent girls with disabilities is in their best interest because their impairment would prevent them from being good mothers.*

Providers may sometimes be called upon to educate parents or caretakers about abuse while supporting adolescent clients with services and mental health care.

- iv. Fact Fiction **Rape is an act of uncontrollable sexual desire.**

Rape is about control, power, and violent dominance, not sexual desire. All people can control their sexual desire and should be taught that anger and violence are not an acceptable response to disappointment, rejection, or frustration. Rape is also a tool for social dominance and control, for example:

1. *Rape of “enemy” women in war or conflict zones.*
2. *Rape of “enemy” combatants in war or conflict zones.*
3. *Rape in prison as a form of establishing hierarchy.*

- v. Fact Fiction **SGBV is more common in lower socio-economic groups.**

SGBV can happen anywhere and to anyone. SGBV is not more common in certain groups or communities: it is every society and every community's problem. Certain groups are more at risk for SGBV: these are groups that are already stigmatized or discriminated against because of their sexuality and gender, and include:

1. *Adolescent girls*
2. *Women*
3. *LGBTI Communities*
4. *Commercial Sex Workers*

Because SGBV relies on power imbalances between perpetrators and victims, groups that are marginalized in society may also be at risk for SGBV, combined with other forms of hate-motivated violence. These groups include:

1. *Racial and ethnic minorities*
2. *Communities living in poverty*
3. *Persons with disabilities*
4. *Non-majority religious groups*

vi. Fact Fiction **People in abusive relationships should just leave.**

It is not always easy or safe for someone in an abusive relationship to leave their partner or abuser. Providers can help clients think of a safety plan if they are thinking of leaving an abusive relationship. Abuse can start small and grow slowly, making it hard for someone to realize or admit to themselves that their partner is abusing them. Society and communities don't always make it easy for people to leave abusive partners, and sometimes blame the victim for the abuse or for ending the relationship. Persons with disabilities in abusive relationships may face even more difficulties in leaving their abusive partners when they are economically dependent on them or if the partner is also their caregiver. Moreover, some shelters and other services available to people who experience violence/abuse are not accessible to persons with disabilities.

vii. Fact Fiction **Most rapes are committed by strangers.**

Most rapes are committed by perpetrators who know the victim. Perpetrators can include a parent, spouse, partner, ex-partner, friend, family member, another person in the home, teacher, neighbor, employer, colleague, caregiver. More rarely it is a stranger.

viii. Fact Fiction **You can change another person's violent behavior by changing your own.**

No one can control how someone else will act. You can do specific things to avoid being in risky situations or to protect yourself, including:

- *Asking a friend to walk you home when you are out late.*
- *Not leaving drinks or food unattended at a bar or restaurant.*
- *Meeting people for the first time in groups or in public places.*

Blaming the victim for what they were wearing or how they behave contributes to social stigma against people who have been assaulted.

- ix. Fact Fiction **It is rape if someone puts his or her fingers inside a woman's vagina without her permission.**

Though rape laws vary from country to country, rape is commonly defined as the use of physical and/or emotional coercion, or threats to use coercion, to penetrate a child, adolescent, or adult vaginally, orally, or anally against her/his wishes. Rape does not have to involve penetration with a penis to be rape. The use of fingers or external objects is also considered rape. When coercion or threats are involved, the person being raped may not be able to fight or say no. Adolescents should be taught about consent as a vital part of sexual contact.

- x. Fact Fiction **It is easy to tell if someone has been subject to SGBV.**

People respond to trauma differently: there isn't one "right" way of being a victim. Not all SGBV leaves physical marks or scars that are visible to health providers.

- xi. Fact Fiction **People who experience sexual or intimate partner violence as children are more likely to perpetrate or experience sexual or intimate partner violence as adults.**

Sexual violence during childhood is associated with perpetration of violence and being a victim of violence later in life. Children who grow up in families where there is violence also have a higher risk of perpetrating or being the victim of violence later in life. Sexual violence during childhood is also associated with other physical and mental health risks, including depression, suicide, sleep difficulties, eating disorders, alcoholism, and post-traumatic stress disorder. (Source: WHO 2016b)

- xii. Fact Fiction **SGBV is uncommon among adolescents in my community.**

1 in 3 women worldwide have experienced sexual violence or intimate partner violence in their lifetime. 1 in 4 women aged 15 to 19 worldwide report having been subject to sexual violence since the age of 15. Most women first experience sexual violence during their adolescence. Many women (as many as 70% in some communities) report that their first sexual experience was forced. 1 in 3 girls aged 13 to 15 worldwide experience regular bullying (Source: WHO 2016b, UNICEF 2015, WHO 2013). 40 to 68 percent of young women with disabilities and 16 to 30 percent of young men with disabilities will experience sexual violence before the age of 18 (Source: Management Sciences for Health & UNFPA 2016).

- xii. Fact Fiction **Women ask to be raped when they wear revealing clothing or act flirtatious.**

No one asks to be raped. A woman has the right to wear whatever she pleases without it being taken as an invitation for assault. Dressing attractively and flirting are not an invitation for rape.

- xiv. Fact Fiction **If a victim doesn't want to involve the police, it is because they are lying about having been assaulted.**

Some people who have been assaulted choose to report the assault to the police, and some do not. It is

the victim's choice whether they want to go to the police to report. Many victims have legitimate fear of retribution from the police or from the perpetrator for reporting them. Police stations and services are often inaccessible to persons with disabilities due to physical barriers, communication and attitudinal barriers, as well as lack of accommodation. Attitudinal barriers often exist because of police officers' lack of understanding about disability, as well as misconceptions and wrong assumptions related to sexuality and disabilities.

Some countries have mandatory reporting laws when a provider suspects that a child is being sexually or physically abused. Providers should always communicate to their clients what they are legally required to report.

xv. Fact Fiction **Some people pretend they don't want sex or say "no" when they really mean yes.**

It should always be taken seriously when someone says "No." Many perpetrators of sexual violence use this argument to justify their behavior. Adolescent education about sexual health and sexuality should include a discussion of consent.

xvi. Fact Fiction **Adolescents with disabilities do not experience sexual violence**

Adolescents with disabilities are nearly three times more likely to experience sexual violence than their peers without disabilities. While children with disabilities are also at risk of sexual violence, the available data highlights that this risk increases as soon as they reach puberty. While boys with disabilities are also at risk of sexual violence, girls are more likely to experience it.

12. Remind participants that the clients who come to them for services live in the same societies and are raised hearing the same things that they do. Explain that one reason women and other people who experience SGBV so rarely seek treatment, much less justice, is because they are taught to blame themselves for the violence that they have experienced.
13. Ask participants to quickly brainstorm how they could use this information in their practice. What are some ways they can correct myths and misinformation with their clients?
14. Close the session by thanking participants for their time.



PARTICIPANT HANDOUT 13A: SGBV FACT OR FICTION

- i. Fact Fiction **Rape happens only to women.**

- ii. Fact Fiction **Sexual abuse only means rape.**

- iii. Fact Fiction **Anyone can commit sexual or gender-based violence.**

- iv. Fact Fiction **Rape is an act of uncontrollable sexual desire.**

- v. Fact Fiction **SGBV is more common in lower socio-economic groups.**

- vi. Fact Fiction **People in abusive relationships should just leave.**

- vii. Fact Fiction **Most rapes are committed by strangers.**

- viii. Fact Fiction **You can change another person's violent behavior by changing your own.**

- ix. Fact Fiction **It is rape if someone puts his or her fingers inside a woman's vagina without her permission.**

- x. Fact Fiction **It is easy to tell if someone has been subject to SGBV.**

- xi. Fact Fiction **People who experience sexual or intimate partner violence as children are more likely to perpetrate or experience sexual or intimate partner violence as adults.**

- xii. Fact Fiction **SGBV is uncommon among adolescents in my community.**
- xii. Fact Fiction **Women ask to be raped when they wear revealing clothing or act flirtatious.**
- xiv. Fact Fiction **If a victim doesn't want to involve the police, it is because they are lying about having been assaulted.**
- xiv. Fact Fiction **Some people pretend they don't want sex or say "no" when they really mean yes.**
- xvi. Fact Fiction **Adolescents with disabilities do not experience sexual violence.**

SPECIFIC OBJECTIVE 13.2: IDENTIFY PHYSICAL AND BEHAVIORAL INDICATORS OF SGBV



TIME

1 hour



METHODS

- Group brainstorm
- Trainer presentation



MATERIALS NEEDED

- Flipcharts and markers
- Slides 13.1-13.6



STEPS

Time: 30 Minutes

1. Divide the group into 2 teams. Give each team 2 pieces of flipchart paper and markers.
2. Tell the teams that they will race to see which team can come up with the most correct answers in the time available.
3. Ask the teams to think of as many physical signs of sexual and gender-based violence as they can and write them down on a flipchart page. Give teams **5 minutes** to brainstorm.
4. When time is up, have one participant from each team present their flipchart to the larger group. Supplement their responses with information from the list in **Supplemental Content: Physical Indicators** below.

Supplemental Content: Physical Indicators

1. Difficulty walking or sitting
2. Torn, stained, or bloody underclothing
3. Pain, swelling, itching, bleeding, lacerations, or bruising in the genital area
4. Abdominal pain
5. Abrasions or lacerations of the hymen, labia, perineum, posterior forchette, and breasts
6. Unexplained vaginal or penile discharge
7. Labial fusion
8. Repeated or poorly explained injuries
9. Multiple unwanted pregnancies
10. Repeated STIs
11. Unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches)
12. Sudden unexplained weight gain or loss
13. Self-inflicted injuries or self-harm
14. Recurrent urinary tract infections

5. Have teams return to their charts and give them **5 minutes** to list emotional or behavioral signs of SGBV.
6. When time is up, have the teams report back on the signs they've listed. Supplement their responses with information from **Supplemental Content: Emotional and Behavioral Indicators** below.

Supplemental Content: Emotional and Behavioral Indicators

1. Ongoing emotional health issues (stress, anxiety, or depression)
 2. Suicidal thoughts or suicide attempts
 3. Repeated complaints of non-existent symptoms
 4. Overtly sexualized behavior (excessive masturbation, inability to distinguish affection from sexual behavior)
 5. Post-traumatic stress disorder
 6. Fear, guilt, or shame
 7. Hostility or aggressive behavior
 8. Development of speech impediments
 9. Insomnia or sleeping disorders
 10. Eating disorders
 11. Trouble in school or acting out, sudden changes in behavior
 12. Sexually aggressive or violent behavior
 13. Overreliance on a caretaker or partner for decision-making
7. Invite groups to clap for each other and sit back down. Explain to participants that many of these signs can be controversial or culturally specific, and they should not be seen as diagnostic. Remind participants that people react to trauma in different ways, and there are no “tests” that definitely diagnose adolescents who have experienced sexual and gender based violence.

Time: 30 minutes

8. Introduce the presentation **Content: Screening for SGBV** (Slides 13.1-13.6) below. Tell participants that the best screening tool they have in their toolbox is an open, accepting counseling manner and good history-taking.

Content: Screening for SGBV (Slides 13.1-13.6)

Slides 13.1.13.2: Cultural Environment

Providers should be aware of the different types of sexual and gender-based violence that are most commonly seen in the communities where they work.

1. Globally, about 1 in 3 of all women have experienced either physical and/or intimate partner violence in their lifetime.
2. 1 in 4 women aged 15 to 19 worldwide report sexual violence since the age of 15.
3. As many as 70% of adolescent women report their first sexual experience as forced.
4. 1 in 3 girls aged 13 to 15 experience regular bullying.
5. Globally, 40-68% of young women with disabilities and 16-30% of young men with

- disabilities experience sexual violence before the age of 18.
6. More than 200 million girls and women alive today have undergone female genital mutilation.
 7. 1 in 3 girls in the developing world are married before the age of 18.
 8. People who identify or are presumed to be lesbian, gay, bisexual, transgender, or intersex experience violence and discrimination, including bullying, physical and sexual assault, and murder at increased levels in all areas of the world. (Sources: WHO 2016b, UNICEF 2015, WHO 2014, WHO, *Girls not Brides*, Office of the High Commission on Human Rights, and Management Sciences for Health & UNFPA. 2016)

Slide 13.3-13.4: Screening Environment

What do you do if you suspect that an adolescent client has experienced sexual or gender-based violence?

1. Do not raise the issue in front of partners, parents, or caretakers. Only ask about violence when the client is alone.
2. Establish a safe, private, and confidential environment for the client.
3. Use empathetic, non-judgmental body language and words.
4. Use words that are appropriate and relevant, and that the client is most comfortable using.
5. When clients are adolescents with disabilities, use language that is accessible and understandable, taking into account the specific barriers that persons with different types of disabilities may face and providing accommodation as needed. On communication with adolescents with disabilities, please refer also to unit 7 and to the “Adolescents with Disabilities” chapter.
6. Start with normalizing statements, like:
 - *Many adolescents sometimes have problems with their parents and/or romantic partners and/or or someone with whom they live.*
 - *Sometimes I see health problems like this with other adolescents who have been having trouble at home and/or in school, and/or in their relationship.*
7. Maintain respectful attitude, calm voice, and eye contact as culturally appropriate.
8. Avoid distraction and interruption.
9. Take time to collect all needed information

Slide 13.5: Screening Questions

Source: WHO 2014

Here are some simple and direct questions you can pose if you suspect a client is experiencing SGBV:

1. Are you afraid of your parents/husband/wife/partner/caregiver?
2. Has anyone ever threatened to hurt you or physically harm you in some way? When did it happen?
3. Does someone at home or in your life bully or insult you?
4. Does your partner try to control you, for example, by keeping you in the house against your wish or not letting you out of the house when you desire to do so?

5. Has anyone forced you or pushed you to have sexual contact that you didn't want at the time?
 6. Has anyone threatened to kill you?
9. Ask participants if they have had an experience with a client that they suspected was experiencing violence but who didn't want to disclose to them. Ask a volunteer to share a story about the experience and what they did. Ask participants if they had a similar experience that involved clients with disabilities. If yes, ask a volunteer to share a story. Return to the presentation with **Slide 13.6: Disclosure.**

Slide 13.6: Disclosure

If you suspect sexual or gender-based violence, but the client does not appear willing to disclose, there are still things you can do to support them.

1. Give the client time and make sure they know they can come back for any reason.
 2. Tell them about services that are available if they need or decide to use them.
10. Close by reminding participants that this is an area that many clients aren't comfortable discussing with their health provider, regardless of their age or disability. Tell participants that in the next session they will be brainstorming and practicing some techniques for helping adolescent clients experiencing SGBV.

SPECIFIC OBJECTIVE 13.3: DEMONSTRATE HOW TO SCREEN FOR AND COUNSEL CLIENTS WITH A HISTORY OF SGBV



TIME

1 hour 25 minutes



METHODS

- Small group activity
- Trainer presentation
- Role play



MATERIALS NEEDED

- Participant Handout 13B: List of Barriers to Screening
- Slides 13.7-13.16



STEPS

1. Divide participants into pairs or small groups of three. Pass out **Participant Handout 13B: List of Barriers to Screening**.

Time: 20 Minutes

2. Explain that addressing SGBV and supporting adolescents who have experienced violence can be overwhelming for providers. Assign each barrier to one of the pairs or small groups (you can assign multiple barriers to a group if needed).
3. Ask the pairs or small groups to spend **5 minutes** brainstorming how to address each barrier they are assigned (if groups have more than one barrier, give them **5 minutes** each).
4. When time is up, have groups take turns reporting back on their barriers and responses and discussing with the whole group. Supplement their discussion using **Content: SGBV Barriers Discussion Guide** below.

Content: SGBV Barriers Discussion Guide

a. Time Constraints.

- *Clinics are already seeing clients who have experienced SGBV. SGBV is linked to a higher rate of repeat visits and increased use of services, and can be the cause of chronic or repeat SRH problems.*
- *Early Identification of and attention to SGBV can reduce repeat visits and protect clients' health.*
- *Developing a screening tool and referral program can make dealing with SGBV more time-efficient and less stressful for providers and clients.*

b. Lack of training about the issue.

- *Compassion, empathy, and commitment are important skills for providers to have to provide SGBV care.*
- *Knowledgeable providers could conduct a training for all clinic staff on how to identify, screen and refer women who have experienced SGBV.*

c. Provider feels there is nothing they can do to help.

- *While you may not be able to solve the problem, you can help by:*
 - *Identifying the problem;*
 - *Providing an opportunity for the client to talk;*
 - *Helping the client build a safety plan;*
 - *Helping the client identify a safe space to stay temporarily; and*
 - *Setting up a referral process to existing services.*

d. The clinic is not the place to address SGBV.

- *SGBV is closely tied to sexual and reproductive health problems, mental health issues, and other health concerns.*
- *If adolescents are already coming for SRH care, SRH services may be the only point of contact between adolescents and the health system.*
- *If there are no referral services in the community, the clinic may be the only place where SGBV is addressed.*
- *Screening for SGBV is the next logical action in comprehensive SRH care for adolescents.*

e. There are more important health issues to be addressed.

- *SGBV and its associated health consequences are just as – or even more – common than many other conditions for which providers routinely screen.*
- *SGBV can have significant effects on the clients' future SRH and other health outcomes and can span generations.*
- *Violence against children and SGBV are a global epidemic. All societies can agree on the need to reduce the level of violence faced by adolescents and children.*

f. Adolescents don't want to talk to their health providers about their experiences.

- *Research and clinical experience suggest that adolescents may be more likely to talk to health providers about their experiences, as health providers are seen as a "neutral" safe party.*
- *Many adolescents hope that someone will ask about their experiences or concerns. They may respond well to direct questions.*
- *Providers can ensure adolescents feel safe, by paying attention to privacy and confidentiality, using non-judgmental and empathetic language and engaging in active listening. These actions may encourage adolescents to open up more.*

g. Belief that SGBV is a private or shameful issue.

- *Staff already discuss sensitive or personal topics with clients of all ages.*
- *There is a great deal of cultural and community shame around SGBV and it is rarely discussed.*

- h. **Belief that SGBV doesn't happen in my community or with the clients that I see.**
 - *SGBV happens in all societies and within all different socio-economic classes.*
 - i. **Belief that SGBV is a "normal" part of growing up.**
 - *SGBV may be common but should never be "normal."*
 - *SGBV is a serious problem with concrete health consequences.*
 - j. **There are no services available for survivors, so why bother screening?**
 - *Health programs to identify the resources in their communities and build referral links with those services.*
 - *Screening for SGBV helps establish the link between SGBV and SRH outcomes.*
 - *Screening at health services can help create community awareness about and attention to SGBV.*
 - *Some health programs have started their own programs to deal with SGBV in communities where services are lacking.*
 - k. **Screening for SGBV is not the health provider's responsibility.**
 - *SGBV is an SRH issue, and screening for SGBV is the provider's responsibility.*
 - *If left untreated, SGBV can lead to more complicated SRH problems.*
 - *The provider is often the only person with the opportunity to screen for SGBV.*
5. Ask participants if they can think of any other barriers to SGBV screening or integration of SGBV services with SRH services. Emphasize that all of these barriers can be overcome.

Time: 30 minutes

6. Introduce **Content: SGBV Screening** (Slides 13.7-13.16) below. Tell participants that after the presentation, they will practice some basic screening techniques with each other in small groups.

Content: SGBV Screening (Slides 13.7-13.16)

Slide 13.7: LIVES Technique

When screening for SGBV with adolescent clients or clients of any age, providers can use the "LIVES" technique to identify emotional and practical needs at the same time.

Listen: Listen to the client closely, with empathy, and without judging.

Inquire: Assess and respond to the client's needs and concerns – emotional, physical, social, and practical.

Validate: Demonstrate that you understand and believe your client. Assure your client that they are not to blame.

Enhance safety: Discuss and help your client create a plan to protect themselves from further harm.

Support: Connect your client to information, services, and social support.

Source: Adapted from WHO 2014

Slides 13.8-13.9: Emotional Needs

The goal of first-line support and the LIVES technique is to provide emotional and practical care. It can include:

- Identifying the client's needs and concerns. Building trust and rapport by asking about neutral topics before delving into direct questions about the abuse.
- Listening and validating the client's experiences.
- Helping the client feel connected to others.
- Helping the client remain calm and hopeful.
- Empowering the client to feel able to help themselves and to ask for help.
- Exploring the client's options.
- Respecting the client's wishes.
- Helping the client find social, physical, and emotional support.

You do *not* need to:

- Solve the client's problems.
- Convince the client to leave a violent relationship.
- Convince the client to go for any other services.
- Convince the client to report to the police or any other authority.
- Ask detailed questions that make the client relive painful events.
- Ask the client to analyze what happened or why.
- Provide a justification or explanation for what happened.
- Pressure the client to tell you their feelings or reactions.

Sometimes, our actions can cause more harm than good despite our best intentions. Always pay close attention to the client's physical and emotional language and provide time and space for them to share on their own terms.

Slide 13.10: History Taking

- For reasons of confidentiality and safety interview clients on their own (e.g. away from parent/guardian/ or caregiver), while offering another adult as support.
- General medical information
- Gynecological history
- Questions about the assault
 - Only ask about what is needed for medical care (e.g. penetration, oral, vaginal, anal)

- Minimize need for client to repeatedly describe assault or history of abuse, as it can be re-traumatizing
- Explain Purpose:
 - Guide exam so injuries can be found and treated
 - Assess risk of pregnancy, STIs, HIV
 - Guide specimen collection and documentation
- Assessment of mental state
 - If signs of severe emotional distress, ask specific questions

Slides 13.11 – 13.16: Physical Exam

1. Obtain Informed consent for physical exam and each step.
 - a. What is informed consent?
 - The voluntary agreement of an individual who has legal capacity to give consent.
 - To provide “informed consent,” the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent.
 - Determining who is “legally” able to give consent for certain types of services will depend on the context in which you work.
 - Usually children under age 15 are not legally able to provide consent on their own,
 - The process of obtaining informed consent may require longer time when there are communication barriers linked to a client’s disability. This does not absolve a service provider of their obligation to obtain informed consent. On the contrary, providers must ensure whatever accommodation necessary in order to allow smooth communication with the client. Refer to the “Adolescents with Disabilities” chapter for additional inputs on the subject.
 - b. There are three key components to the informed consent process:
 - Provide all possible information and options to a survivor in a way they can understand.
 - Determine if they can understand this information and/or their decisions. This is also referred to as “capacity to consent”)
 - Ensure that the decisions of all survivors, including survivors with disabilities, are voluntary and not coerced by others such as family members, guardians, caregivers or even service providers.
2. Describe the four aspects of the exam to the client:
 - Medical
 - Pelvic

- Forensic evidence collection
 - Release of medical information/ evidence to police (if she wants legal redress).
3. Tell the patient that s/he is in control of this exam.
 - They should tell you to stop any time they feel uncomfortable.
 - For reasons of confidentiality and safety the patient's parent(s) or caregivers should be asked to leave so that the young person has total privacy.
 - Some survivors of sexual violence may find a physical exam traumatizing. Always allow the client to reschedule. Never act impatient or annoyed if they ask to stop or pause for any reason.
 4. When conducting the exam, have an observer present, preferably a trained support person or same sex health worker.
 - Introduce and explain role of observer
 - Besides the observer, keep the number of people to a minimum
 5. Ask if there is any additional or specific support that the client desires such as a friend or family member.
 6. Ask if the client is comfortable with a male provider examining her. If not, find a female provider.
 7. Communicate to patient during the exam what will happen next. "I will be examining your _____".
 - During a physical exam the provider should report what they observe in a non-emotional, non-judgmental way. "I see you have a small cut here, does it hurt?"
 - Do not explain any diagnosis or ask further questions about the possibility of sexual abuse until after the client is fully clothed and the exam is over.
 8. If necessary, translate all information into the clients' language to make sure they understand. Ensure accommodation is provided as needed to allow full and smooth communication with clients with different types of disabilities.
 9. Close the presentation by asking if there are any questions about screening or the counseling environment for adolescents who have experienced SGBV.

Time: 45 minutes

10. Divide participants into three groups. Each group should identify one person to play the provider and one to play the client.
11. Assign each "client" one of the roles from **Content: SGBV Case Studies** below.

Content: SGBV Case Studies

Client #1: A is a 14-year-old girl with a hearing disability. She does not know sign language but she can read and write. You start communicating with her in writing using a pencil and a piece of paper. She tells you that she has been sent to the clinic by her mother. She seems very depressed and has stopped eating. She shares with you that she is afraid to use the community latrine. When encouraged, she tells you that a few nights ago a neighbor followed her to the toilet and forced himself on her. She is afraid to tell her parents because she knows that they will blame her for “enticing” the neighbor.

Client #2: T is a 13-year-old boy. He comes to you because he is planning to have sex for the first time but seems reluctant or scared. He tells you that his father has hired a sex worker to “teach” him about sex and help him “become a man.” He has bruises on his arms and neck, which he says are from the boys at school. He says that he has always been made fun of for being too feminine, but that recently the boys have started beating him physically. His father thinks the sex worker will “fix” him and solve this problem.

Client #3: S is a 15-year-old girl. She comes into the clinic frequently, complaining of genital pain, discharge, or itching. She never seems to have any real symptoms and has been a challenge to treat. On this most recent visit, her boyfriend accompanies her to the clinic. He seems impatient and irritated with being there, and when he is in the room she appears extremely anxious and defers all questions to him.

Client #4: B is a 16-years old girl with Down syndrome. She comes to you because she is having sex with her boyfriend and she is afraid to get pregnant. He is her neighbor and he is 21. She asks you not to say anything to her parents because, as he told her, they would not approve if they knew she has a boyfriend who is different from her, who does not have Down syndrome. You suspect he is taking advantage of her.

12. In the groups, ask participants to spend **10 minutes** playing out the role they’ve been assigned, while the rest of the group observes. Remind the participants that the volunteer playing the provider should consider the pieces of the LIVES technique. The group members observing should watch for empathy, language, and successful identification of the client’s emotional and practical needs.
13. Allow **10 minutes** for the role play. Then ask groups to stop, and have the observers report back to the volunteers what they think the “provider” did well, what needed improvement, and any suggestions for how to treat this client. Allow an additional **15 minutes** for this feedback.
14. Reconvene the larger group. Ask for general feedback using the following discussion questions:
 - a. *Is it difficult or uncomfortable to ask questions about SGBV?*
 - b. *Is it more difficult or uncomfortable when the client has a disability?*

- c. *How comfortable was it for the client to answer those questions?*
- d. *How can we as providers help make these conversations easier for all our clients, including clients with disabilities?*

15. Thank participants for their time and close the discussion.



PARTICIPANT HANDOUT 13B: BARRIERS TO SGBV SCREENING

What are some responses to these barriers?

1. Time Constraints.

2. Lack of training about the issue.

3. Provider feels there is nothing they can do to help.

4. The clinic is not the place to address SGBV.

5. There are more important health issues to be addressed.

6. Adolescents don't want to talk to their health providers about their experiences.

7. Belief that SGBV is a private or shameful issue.

8. Belief that SGV doesn't happen in my community or with the clients that I see.

9. Belief that SGBV is a “normal” part of growing up.

10. There are no services available for survivors, so why bother screening?

11. Screening for SGBV is not the health provider’s responsibility.

SPECIFIC OBJECTIVE 13.4: IDENTIFY CLINICAL CARE NEEDS AND APPROPRIATE SERVICES FOR SURVIVORS OF SGBV



TIME

55 minutes



METHODS

- Trainer presentation
- Group brainstorm



MATERIALS NEEDED

- Slides 13.17-13.22
- Flipcharts and markers



STEPS

Time: 25 minutes

1. Introduce the topic by explaining to participants that while they have discussed and practiced counseling and screening techniques, they will also need to be aware of the clinical services needed by and available to survivors of SGBV.
2. Present **Content: Services for Survivors** (Slides 13.17-13.22) below.

Content: Services for Survivors (Slides 13.17-13.22)

Source: Adapted from WHO 2014

Slide 13.17: Physical Exam

In cases of SGBV, the physical exam can be both a vital health service and a record of evidence for the police or other authorities. If you suspect that a client has been subjected to SGBV, consider the need for evidence collection as you provide services.

After taking a history, explain the physical exam to the client and obtain informed consent. Explain that you will be writing down what you see during the exam, the same as you would for any health service. Reassure the client that they are in control, and can ask you to stop, pause, or not record anything at any point during the exam.

3. Pause and distribute **Participant Handout 13C: Physical Exam Checklist**. Review the content with participants and leave time for clarifying questions or discussion.
4. Return to the presentation with **Slide 13.18: Recording Findings** below.

Source: Adapted from WHO 2014

Slide 13.18: Recording Findings

Health care providers are sometimes asked to answer questions from the police, lawyers, or other authorities about injuries to women and adolescents they have treated. While confidentiality of the patient must be prioritized, sometimes careful documentation of findings and treatment on the history and exam form can make the difference in protecting and helping a client find justice.

Authorities will look for:

- Type of injury (cut, bruise, abrasion, fracture, other)
- Description of the injury (length, depth, other characteristics)
- Where on the body the injury can be found
- Possible cause of injury (e.g. gunshot, bite marks, knife, other)
- The immediate and potential long-term consequences of the injury
- Treatment provided

Slides 13.19-13.20: Treatment

In addition to the medical treatment of injuries, some particular SRH services may be necessary for adolescents who have experienced SGBV. Some treatments to consider include:

Emergency Contraception: Should be taken as soon as possible. EC can be administered up to five (5) days after an assault. Any woman can take EC, and there is no need to screen for health conditions or test for pregnancy. EC pills will not cause abortion to an established pregnancy.

Emergency Copper IUD: Can provide emergency contraception if inserted within 5 days after an assault. Should only be used for women interested in the IUD and long-term contraception.

STI prevention: Adolescents who have been sexually assaulted can be given antibiotics to prevent or treat potential bacterial infection with chlamydia, gonorrhea, trichomonas, and syphilis. There is no need for testing before treatment.

Hepatitis B Vaccine: Clients who haven't been vaccinated for hepatitis B can receive the first dose at the visit and come back for the rest of the course. If the client is uncertain, test first for antibodies before providing the vaccine.

HIV Post-Exposure Prophylaxis (PEP): PEP can be given to clients within 72 hours of an assault. PEP should be given if the perpetrator is of unknown HIV status, the client's HIV status is unknown, and the client does not want to wait for a test.

5. Ask participants if there are other services or treatments with which clients should be provided following an assault. Ask when they think clients should come back for follow-up and discuss what kinds of follow-up would be needed. Record their responses.
6. Tell participants that some forms of SGBV need specific attention. Return to the presentation with **Slide 13.21: Services for Adolescent Survivors of Childhood SGBV**

Slide 13.21-13.22: Services for Adolescent Survivors of Childhood SGBV

Many clients will have experienced violence at an earlier point in their lives, and it is important to be aware of their SRH needs.

- **Female genital mutilation (FGM)/female genital cutting (FGC):** Adolescent clients who have experienced FGM/FGC may have particular concerns about their genital health, ability to experience sexual intercourse, and need for contraception. Depending on the type of FGM/FGC, girls and young women may also experience infection, inflammation, or severe pain. For adolescents with type III FGM (the most severe form, also known as infibulation), deinfibulation by a trained health professional is recommended. Counseling for preventing or treating female sexual dysfunction is recommended for all women living with FGM.
 - **Young Married Women:** While some adolescents marry before the age of 18 by choice, many women who marry young are forced or coerced by their families, communities, and future spouses. These young women, particularly those married to older men, may be at increased risk for intimate partner violence, STIs and HIV, and pregnancy. They should be screened for violence and counseled on contraception and STI /HIV prevention.
7. Ask if there are any other special concerns that providers have about adolescents in their communities. Take some time to brainstorm specific services, counseling, and social protection services for these adolescents. Discuss if these services are accessible and/or used by adolescents with disabilities and related experiences.

Time: 30 Minutes

8. Break participants into four groups. Assign the groups to the two case studies. Read the scenarios from **Content: Case Studies** below.

Content: Case Studies

a) K comes into your clinic because she thinks she might have an STI. She is 16. After talking with her, you discover that her older cousin, aged 19, who lives with her family, has been forcing her to have sex.

b) K comes into your clinic because she thinks she might have an STI. She is 16 and has a visual disability. After talking with her, you discover that her older cousin, aged 19, who lives with her family, has been forcing her to have sex.

9. Ask each group to brainstorm what steps they would take to make sure K was safe and received assistance. Ask the groups to focus on what services the client would need. Give groups **15 minutes** to discuss.
10. Ask groups to share back with the larger group. Compare their responses, clarify any differences,

and highlight which differences are linked to K's disability.

- 11.** Close by reminding participants that sexual and gender-based violence is a very complex problem. The provider can only do so much. It is important to do what one can but not feel discouraged because one provider cannot solve the whole problem.



PARTICIPANT HANDOUT 13C: PHYSICAL EXAM CHECKLIST

Source: WHO 2014

Job Aid

Physical exam checklist

Look at all the following

- General appearance
- Hands and wrists, forearms, inner surfaces of upper arms, armpits
- Face, including inside of mouth
- Ears, including inside and behind ears
- Head
- Neck
- Chest, including breasts
- Abdomen
- Buttocks, thighs, including inner thighs, legs and feet

Look for and record

- Active bleeding
- Bruising
- Redness or swelling
- Cuts or abrasions
- Evidence that hair has been pulled out, and recent evidence of missing teeth
- Injuries such as bite marks or gunshot wounds
- Evidence of internal traumatic injuries in the abdomen
- Ruptured ear drum

Genito-anal examination

- Genitals (external)
- Genitals (internal examination, using a speculum)
- Anal region (external)

- Active bleeding
- Bruising
- Redness or swelling
- Cuts or abrasions
- Foreign body presence

UNIT 13 SUMMARY



TIME

10 minutes



METHODS

- Individual reflection



MATERIALS NEEDED

- Empty box or bag
- Index cards



STEPS

1. Place an empty box or bag at the back of the room. Distribute one index card to each participant.
2. Ask participants to place their heads down on the table or lie down and close their eyes. Instruct the participants to keep their eyes closed while taking 8 slow, deep breaths.
3. While participants are breathing, remind them that some challenges we deal with as providers can take an emotional toll. Ask them to reflect on how they are feeling after today's discussion. Remind them of the importance of self-care for professionals who provide SGBV services.
4. Tell participants that when they are ready, they can open their eyes. Ask participants to please write one thing they learned today on their index card and leave it in the empty box at the back of the room on their way out.