



Integrating Gender- Based Violence Response into Family Planning and Reproductive Health Service Delivery

TRAINER'S MANUAL



পরিবার পরিকল্পনা অধিদপ্তর

Integrating Gender-Based Violence Response into Family Planning and Reproductive Health Service Delivery

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Shukhi Jibon

PATHFINDER

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Note: A copy of the PowerPoint Slide Decks 1 and 2 are attached at the end of this manual for convenience.

Preface

Message from the Director General, Directorate General of Family Planning



At the Nairobi Summit (ICPD+25) in 2019, the Government of Bangladesh identified three issues to have been "zero tolerance"—maternal mortality, unmet need for family planning, and gender-based violence (GBV). GBV is a global phenomenon.

In Bangladesh, as shown in the Report of Violence Against Women (VAW) Survey 2015, 72.5 percent of women face any form of violence during their lifetime, and 36.1 percent of women said their husbands expect them to get their permission to access health services. Compounding these issues, many women are not receiving the support they need, which contributes to the significant challenges: unmet need for family planning (12%), discontinuation rate of family planning methods (37%), and grave incidence of child marriage (50%).¹

The Directorate General of Family Planning (DGFP) has had tremendous success in increasing contraceptive prevalence rate (CPR) and decreasing total fertility rate (TFR) in the years after its independence. But women and girls in Bangladesh are facing high gender disparity and disequilibrium. One in four (24%) women ages 15–19 have ever been pregnant, and almost one in five (18%) have had a live birth.² The high fertility rate among adolescents (72/1,000 LB) aged between 15–19 and the high maternal mortality ratio (168/100,000 LB)³ demand adequate, intensive action. In addition to enhancing the capacity of Bangladesh's family planning workforce, it is imperative to take action to reduce the gender gap as well as GBV. And this requires addressing the underlying factors; for example, strengthening facility readiness and building workforce capacity in responding to gender- and GBV-related issues.

Many issues could be redressed if we work diligently on GBV and sexual and reproductive health and rights (SRHR). To achieve this, there are areas to be addressed, e.g., increasing service providers' understanding of gender and GBV, minimizing the gap in service delivery, sharing information, and providing GBV-related knowledge to the clients. Moreover, in Bangladesh, we have a paucity of adequate data relating to GBV as part of family planning and SRH services.

This manual, "Integrating Gender-Based Violence (GBV) Response into the Family Planning and Reproductive Health Services" will help end critical gaps. This resource, which will strengthen the capacity of Bangladesh's family planning service providers to identify, record, and assist the management of GBV cases, has been developed through the concerted efforts of the DGFP; the Directorate General of Health Services (DGHS); the National Institute of Population Research and Training (NIPORT); and the USAID-funded-, Pathfinder-led Shukhi Jibon project, in collaboration with the Packard Foundation.

I would like to express my sincere gratitude and appreciation to all who have extended their support for the entire effort in the development and formulation of this resource. Special thanks to all those involved in the Pathfinder International for their well-timed cooperation.

¹ National Institute of Population Research and Training (NIPORT) and ICF. "Bangladesh Demographic and Health Survey 2022: Key Indicators Report." (Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF, 2023).

² NIPORT and ICF, BDHS 2022.

³ Bangladesh Bureau of Statistics, Statistics and Informatics Division, Ministry of Planning, Government of the People's Republic of Bangladesh, *Report on Bangladesh Sample Vital Statistics (SVRS) 2020*, (Dhaka, Bangladesh) 2021.

Using this manual, Bangladesh's family planning service providers will better be able to provide appropriate, high-complied, gender-sensitive services, which are very crucial for a quality program. I hope and believe that all the service providers and managers involved in the family planning program will make the best use of this valuable resource to create a happy, healthy, and violence-free atmosphere addressing all the relevant issues.



Shahan Ara Banu, ndc

Director General (Grade 1)

Directorate General of Family Planning

Message from Director of Finance and Line Director of Family Planning - Field Service Delivery, DGFP

The family planning program in Bangladesh is a milestone activity. In the last fifty years, the TFR in Bangladesh has decreased from 5.21 in 1982 to 2.04 in 2019,⁴ the CPR has increased from 8 percent in 1975 to 63 percent in 2017, and the unmet need has decreased from 17 percent in 2007 to 12 percent in 2017.⁵

However, as per the spirit of various survey reports, there is yet a huge scope to decrease TFR at the targeted base and improve the quality of service to meet the demands of service recipients.

GBV remains a global issue that is frequently and consistently exacerbated in times of stress and crisis. Global estimates by the World Health Organization (WHO) and other UN agencies indicate that one in three women, and one in ten men, will experience sexual violence in their lifetime. As many as two in three women will experience intimate partner violence (IPV), and as many as 30 percent of girls have a non-consensual sexual debut. Bangladesh is no exception.

During the implementation of various programs, it has been seen that even though the service providers have ideas about gender and GBV, they do not have a clear understanding of its connection to family planning services or why integrating GBV response into family planning and reproductive health service delivery is important. In some cases, service providers do not easily understand that their clients are being subjected to GBV while seeking family planning or other reproductive health services. Providers may think GBV is normal, and they have no responsibility to intervene.

I offer my gratitude to Pathfinder International for taking this timely step, considering these contexts, and taking the initiative to prepare this manual “Integrating Gender-Based Violence Response into Family Planning and Reproductive Health Service Delivery” for Bangladesh’s family planning service providers. The manual is a joint venture between DGFP, DGHS, NIPORT, the Multisectoral Program on Violence Against Women (MSPVAW), the Ministry of Women and Children Affairs (MOWCA), representatives of the WHO, UN Women, and the Shukhi Jibon project. My gratitude also to the DGFP, DGHS, NIPORT, and everyone from Pathfinder International who has been involved in supporting the development of this manual, which was finalized through a working group.

Through proper use of this manual, Bangladesh’s family planning service providers will be able to increase their knowledge and skills—to determine, treat, and refer to GBV issues related to sexual and reproductive health and family planning. This manual will make it easier to ascertain that violence exists in family planning and sexual and reproductive healthcare-related services and will help achieve family planning indicators, such as improving CPR, reducing dropout of family planning methods, reducing unmet need, etc. This is a joint venture and will help ensure that service providers offer the highest quality care.

Md. Sohel Parves

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⁴ Bangladesh Bureau of Statistics, *Report on Bangladesh Sample Vital Statistics (SVRS) 2020*, (Dhaka, Bangladesh) 2021.

⁵ Bangladesh Bureau of Statistics, Statistics and Informatics Division, Ministry of Planning, Government of the People’s Republic of Bangladesh, *Report on Violence Against Women Survey 2015* (Dhaka, Bangladesh) 2016.

Acknowledgements

Message from Project Director of USAID Shukhi Jibon and Country Director of Pathfinder International



Recognizing the critical role family planning service providers can play in maximizing the sexual and reproductive health (SRH) sector's capacity to provide first-line response and secondary prevention of GBV through the integration of services and improved referral systems, Pathfinder International is pleased to present this new skill-building resource: "Integrating Gender-Based Violence Response into the Family Planning and Reproductive Health Services—a training manual."

Everyone has a right to SRH and to live a life free from violence. Yet for too many women and girls in Bangladesh, GBV restricts their mobility, access to resources and health care, and decision-making power. GBV is a grave violation of human rights with far reaching impacts, including for family planning and SRH outcomes. A majority of service providers encounter issues of GBV in the line of duty, but many do not recognize its symptoms or may lack training on how to integrate first-line response into family planning or SRH services.

This resource addresses an urgent need within our public health system, providing the first-ever GBV-specific training for family planning providers available in Bangla. Pathfinder developed this manual with funding from USAID through the Accelerating Universal Access to Family Planning project, also known as Shukhi Jibon, and from the David and Lucile Packard Foundation through the Cox's Bazar Sexual and Reproductive Health and Rights project. This manual presents GBV topics clearly and thoroughly, so even providers who have never before incorporated GBV into their work will be able to put this information to use—to expand their knowledge and skills and improve the quality of services they deliver to family planning clients living with GBV.

On behalf of the entire Shukhi Jibon project, the Packard Foundation, and Pathfinder International, I offer our deep thanks to Bangladesh's DGFP, DGHS, NIPORT, the Multisectoral Program on Violence Against Women (MSPVAW), MOWCA; WHO; UN Women; and the working group on GBV with family planning services for their commitment to developing this critical resource.

Most of all, Pathfinder offers enormous gratitude to the health providers, family planning clients, and many survivors of GBV who bravely come forward to ask for help and share their stories, whose journeys informed the work on which this manual was built.

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Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
BDHS	Bangladesh Demographic and Health Survey
CHCP	Community health care service providers
CHW	Community health worker
CPR	Contraceptive prevalence rate
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
FWV	Family welfare visitors
FPI	Family planning inspector
FP	Family planning
FWA	Family welfare assistant
FWC	Family welfare center
GBV	Gender-based violence
GIFPS	Gender-integrated family planning services
HTSP	Healthy timing and spacing of pregnancy
HIV	Human immunodeficiency virus
IGWG	Interagency Gender Working Group
ICPD	International Conference on Population and Development
IUD	Intrauterine device
LAPM	Long-acting or permanent method
MCH	Maternal and child health
MOWCA	Ministry of Women and Children Affairs
OCC	One-stop crisis center and/or cell
PTSD	Post-traumatic stress disorder
PPT	PowerPoint presentation
RTI	Reproductive tract infection
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TFR	Total fertility rate
TBA	Traditional birth attendant
UHC	Upazila health complex
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
VAW	Violence against Women
WHO	World Health Organization

Background

For more than a quarter of a century, the global community has recognized gender-based violence (GBV) as a human rights violation as well as a complex social challenge that presents in multiple forms and contexts. The 1993 United Nations (UN) Declaration on Elimination of Violence Against Women defines GBV as “any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering [*on the basis of gender*], including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.”

GBV remains a global issue that is frequently and consistently exacerbated in times of stress and crisis. Global estimates by the World Health Organization (WHO) and other UN agencies indicate that one in three women⁶ will experience sexual violence in their lifetime. As many as two in three women will experience intimate partner violence (IPV), and as many as 30 percent of girls have a non-consensual sexual debut.⁷ Bangladesh is no exception. Thirty-one percent of women ages 20–49 reported that they were married by age 15.⁸ An estimated fifty percent of ever-married/partnered women ages 15–39 have experienced IPV in their lifetime.⁹ These forms of GBV frequently intersect with reproductive coercion and contraceptive sabotage.¹⁰ While Bangladesh-specific data is unavailable, global evidence suggests that as many as one in four women will experience a form of contraceptive sabotage in her lifetime.¹¹

Since 2016, WHO has outlined clear evidence, strategies, and entry points for the health-sector response to violence against women and girls. Notably, the Global Plan of Action for Health System Response to Violence Against Women and Girls¹² highlights the unique role that health providers—particularly sexual and reproductive health (SRH) care providers—play as an extra-familial, professional point of contact. Furthermore, the report highlights that, globally, those most affected by violence are more likely to need and use health services. Yet, SRH providers and service managers are often ill-supported and undertrained to recognize violence, build confidence and competence in discussing violence, and provide first-line response to clients in need of help.

The Accelerating Universal Access to Family Planning Project, popularly known as Shukhi Jibon, is working to help close this gap. Funded by USAID and led by Pathfinder International, Shukhi Jibon supports the government of Bangladesh to deploy skilled, responsive, and respectful providers who deliver high-quality family planning (FP) and SRH services. This includes strengthening public-sector capacity in GBV integrating GBV-response into FP and RH service delivery.

⁶ WHO. *Violence against Women Prevalence Estimates, 2018*. Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women (Geneva: 2021).

⁷ Claudia García-Moreno, et. al. “WHO Multi-country Study on Women’s Health and Domestic Violence against Women Study Team. Prevalence of intimate partner violence: findings from the WHO multi-country study on women’s health and domestic violence.” *Lancet*. 2006; 368 (9543): 1260–1269.

⁸ National Institute of Population Research and Training (NIPORT), and ICF. *Bangladesh Demographic and Health Survey 2017-18: Key Indicators* (Dhaka, Bangladesh, and Rockville, Maryland, USA: 2019).

⁹ WHO, *Violence against women prevalence estimates, 2018 – WHO South-East Asia Region Fact Sheet* (Geneva: 2021).

¹⁰ Contraceptive sabotage is the deliberate interference with agreed use of contraception.

¹¹ Rowlands S, Walker S. (2019). “Reproductive control by others: means, perpetrators and effects.” *BMJ Sexual & Reproductive Health*; 45:61-67: <https://srh.bmj.com/content/45/1/61>.

¹² WHO Department of Reproductive Health and Research. *Global Plan of Action: Health systems address violence against women and girls* (Geneva: 2016).

Notes to Trainer

Training Goals and Objectives

Overall Goal

This two-day training aims to advance the knowledge and skill set of FP and SRH service providers to address GBV and provide GBV-responsive care.

Learning Outcomes

1. Gain a greater understanding and knowledge of gender norms, dynamics, equity, and their role in GBV.
2. Gain a greater understanding of how GBV manifests in FP and SRH service provision and uptake.
3. Increase knowledge of how GBV is relevant to FP services, including GBV risk identification and analysis.
4. Gain skills to mitigate and respond to GBV threats within the context of FP and sexual and reproductive health and rights (SRHR) activities.
5. Master skills required to deliver the first three steps of the LIVES mnemonic¹³ for disclosure response.
6. Gain knowledge on how to refer GBV survivors to appropriate service providers/facilities in a safe and ethical way.
7. Develop skill sets to manage GBV case recording and reporting during FP and SRH service provision.

This training is not intended to develop providers' skills required to provide comprehensive medical care for GBV, nor the skills required to provide clinical management of rape. Rather, this training is intended to give FP and SRH providers the skills needed to integrate GBV-responsive care into their routine work as FP and SRH services providers.

¹³ WHO. *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook* (Geneva: 2014).

Suggestions for Using This Manual

Timing

The curriculum allows trainers/facilitators to formulate their own training schedule based on local time and training needs. Each module can be used independently, but the curriculum works best when used in its entirety. The modules can also be lengthened or shortened depending on the level of training and expertise of the participants. As currently presented, the training content requires **13 hours and five minutes** (not including meals and breaks) and would be suitable for a **2-day training**.

Participant Selection

The manual is available in English and Bangla languages and can be delivered to family planning health care workers of any cadre. The module was designed with health care providers in mind, but it can also be used as supplementary reference material for gender training and self-directed learning by a wide range of professionals in the health system, both at institutional and facility levels.

Organization of the Manual and Training

This training contains five modules:

- **Module 1:** Introduction to Training
- **Module 2:** Understanding Gender and GBV
- **Module 3:** GBV-Responsive FP and SRH Service Provision
- **Module 4:** Foundational Knowledge of GB Case Recording, Documentation, and Record Keeping
- **Module 5:** Closing

Each module addresses specific learning objectives. At the beginning of each module, you will find guidance on the materials needed, advance preparation required, and additional resources, as well as an overview of the sessions. Activities and content presentations are spread out throughout the modules. Content and supplementary information are incorporated into trainer instructions, while participant handouts and trainer's tools are included at the end of each module.

Guide to Symbols

Symbols are used throughout the manual to help guide and instruct trainers. These symbols include:



TOTAL SESSION/MODULE TIME

Estimated time needed for each module or session. All times listed are suggested and subject to change depending on participant learning needs.



TRAINER NOTE

Additional notes or guidance on how a particular issue or session should be dealt with.



LEARNING OBJECTIVES

What participants can expect to achieve during the training, module, or session.



METHODOLOGIES

Training methods used in the module, for example, discussions or case studies.



MATERIALS NEEDED

Materials needed to teach the module, for example, flipchart and markers.



ADVANCE PREPARATION

Planning and preparation for a session or exercise that should be undertaken in advance.



REFERENCES

Additional background information, guidelines, books, journals, websites, and other documents that may be useful to trainers/facilitators who want more information on topics or issues related to a specific module's content.



FOR GROUP DISCUSSION

A list of questions for participants to reflect on or consider.

PowerPoint Presentation

The PowerPoint (PPT) slide sets were developed to facilitate presentations and discussions throughout the training and are available as separate slide decks. Deck 1 contains slides for Modules 0–2 and Deck 2 contains slides for Module 3–5.

Evaluation

The **Tool A: Pre-/Post-test Assessment** is designed to assess knowledge gained as a result of the training. The tests are identical, except that the pre-test is administered before the start of the training and the post-test at the end of the training.

Participants do not need to write their names on either the pre- or post-test (i.e., it can be completed anonymously). However, as you will need to compare each participant's post-test score with his/her pre-test score, ask each participant to put a 3- or 4-digit number or code at the top of the pre-test. This can be any number or code, such as a favorite number (e.g., 777), year of birth (1962), or code (ABC*). It is very important that participants remember this number or code, as they will need to record the exact same number/code at the top of their post-test. When administering the pre-test, suggest that they write their number/code on the copy of the training schedule—this way they will not forget it.

You will also ask participants to complete a **training evaluation** form at the end of the training. This evaluation form is an important source of feedback and provides much information on how the training could be improved in the future to better meet participant training needs. Upon completion of the training, take at least a half hour to read through the training evaluation forms. Focus on the questions where the ratings were relatively low and think through how these areas can be strengthened in the future. Think of ways to address suggestions offered in response to *“How can we improve this training?”* particularly if mentioned by multiple participants.

Materials Needed

- Trainer's Manual
- Participant's Manual
- PPT slides to accompany each module
- Laptop computer, projector, and screen to show PPT (for all modules)
- Participant handouts and Trainer Tool (located at the end of each module)
- Flipchart papers, easel, and markers
- Index cards
- Sticky notes/post-it notes
- Pens and paper

Guidance on Facilitating Discussion of GBV Issues

To facilitate open and nonjudgmental discussions, trainers should take time to:

- Consider their own assumptions and biases. Take time to consider your opinions about GBV and why you hold them.
- Practice using neutral language (this includes gender-neutral language) and avoid making judgments about “right” or “wrong” behavior. Participants may share stories of behavior that is not evidence-based. It is important to applaud them for sharing and honesty so that open reflection and growth can take place during the training.

The role of the trainer in a participatory session is one of guidance, not authority. The training should be a learning journey that participants and trainers take together, not a one-off delivery of information from expert to audience. While there are content presentations included in the manual, the trainer should always strive to achieve a dialogue with participants.

Setting Ground Rules for GBV Discussions

Before starting the training, work with participants to agree to set of “ground rules.” Because of the sensitive nature of discussions on GBV, the ground rules should emphasize:

- Privacy and confidentiality for participants
- Using nonjudgmental language in the training space
- Allowing space for reaction and emotion
- Admitting when you do not know something
- Treating each other with respect
- Creating space for each person to speak
- Acknowledgement of personal experiences of violence and the potential for participants to need referral to services of their own

It is good practice to post the list of ground rules in the room where participants can see them, and periodically revisit them during the training.

Preparatory Work

Each module in this curriculum has information about work to be done in advance for the sessions in that module. You—the trainer/facilitator or co-trainers/facilitators—should familiarize yourselves with all components of this curriculum well in advance of the training.

The Trainer's Manual was developed to support trainers/facilitators and co-trainers/facilitators to plan and implement the training. At the beginning of each module, you will find Learning Objectives, Methodologies, Materials Needed, Resources, Advance Preparation, and Module/Session Time (see Guide to Symbols above). Each session and activity also include the estimated amount of time required for that activity.

Before conducting the training, you should read through this introductory section carefully. Review the principles of adult learning, suggestions for trainers/facilitators, description of the role of the trainer/facilitator, trainer/facilitator checklist, and tips on managing time, managing difficult participants, and communicating effectively. Then study each of the modules, read the technical content to ensure you understand it, review the exercises closely, take note of exercises that require advance preparation, and try to anticipate participant questions.

Each module includes exercise, such as large group discussion, case studies, small group work, and roleplays. Instructions, including recommended timeframes, for each exercise can be found in the exercise instructions.

- ✓ Be flexible; be ready to change exercises or the order of the agenda to adapt to the needs of participants and the amount of time available.
- ✓ Become familiar with the PPT slides prior to the training by reviewing them several times and comparing them with the module content. You may even want to practice using the slides by presenting a session, or even a module, to colleagues or just on your own. The better you know the content, understand the learning methods, and master the computer equipment and projector, the more confident you will feel!
- ✓ Review the content, in particular the case studies and roleplays, to ensure local and contextual relevance.
- ✓ Case studies can be removed or modified to reflect local content.
- ✓ Names can and should be changed to reflect common local names.
- ✓ Trainers/facilitators can add new case studies based on local statistics, cultural practices, social traditions, and common health issues.
- ✓ Review the PPT presentations and flow of the session.
- ✓ Print all participant handouts and trainer tools needed for the sessions.
- ✓ Gather any additional materials needed.

For some sessions, trainers/facilitators may want to consider:

- ✓ Preparing flipcharts with some information already written on them.
- ✓ Rearranging chairs or the training space to allow room for particular activities.
- ✓ Doing some additional research and preparation on local laws, policies, or context.

✓	COMPLETE THE FOLLOWING BEFORE STARTING EACH MODULE
	Read curriculum objectives, technical content, and teaching exercises.
	Prepare for each of the exercises according to the Trainer's Instructions.
	Obtain or develop and organize the materials needed.
	Read the content and the suggestions for facilitating group discussion. Add your own questions or tips that will help you engage participants and ensure that key messages are discussed.
	Review the PowerPoint slides and become familiar with their content. Practice using the computer and projector and practice presenting technical content using the slides. Practice on your own or find friends or colleagues who are willing to be "participants."
	Practice! It is not always easy to explain group exercises or to draw responses from an audience. Be prepared by thinking ahead and developing strategies. For complicated exercises or discussions, consider co-facilitation.
	Have a plan for monitoring time and keeping to the schedule.
	Have a plan for coping with difficult or disruptive participants.
	Choose a technique for creating small groups. If this is done multiple times during the day, choose a different method for each instance, unless it is specified that groups should remain the same.
	Learn what you can about participants before the training (for example, their worksite, roles, responsibilities, skills, and experience). This effort should continue throughout the training.

Ask to yourself and your facilitation team: *Are we ready to start two days GBV training?* Yes/No

If you answer "No," please read the manual instructions carefully again.

Key Principles of Adult Learning Theory¹⁴

- **Respect** – Adult students must feel respected and feel like equals.
- **Affirmation** – Adult students need to receive praise, even for small attempts.
- **Experience** – Adult students learn best by drawing on their own knowledge and experience.
- **Relevance** – Learning must meet the real-life needs of adults for their work, families, etc.
- **Dialogue** – Teaching and learning must go both ways, so that the students enter into a dialogue with the teacher.
- **Engagement** – Adult students must engage with the material through dialogue, discussion, and learning from peers.
- **Immediacy** – Adult students must be able to apply the new learning immediately.
- **20-40-80 Rule** – Adult students typically remember 20% of what they hear, 40% of what they hear and see, and 80% of what they hear, see, and do.
- **Thinking, feeling, and acting** – Learning is more effective when it involves thinking, feeling (emotions), and acting (doing).
- **Safety and comfort** – Adult students need to feel safe and comfortable in order to participate and learn. They need to know that their ideas and contributions will not be ridiculed or belittled.

This curriculum is firmly grounded in a participatory approach to learning. The sessions benefit learning through interactive activities, discussions, and small group work. Participatory learning methodologies help learners build their knowledge and skills through shared reflection, critical analysis, and collective problem solving.

¹⁴ Partners in Health (PIH), Training of Trainers: A manual for training facilitators in participatory teaching techniques (Boston: PIH, 2011).

DOs and DON'Ts of Training

The following should always be kept in mind by the trainer/facilitator in any learning session:

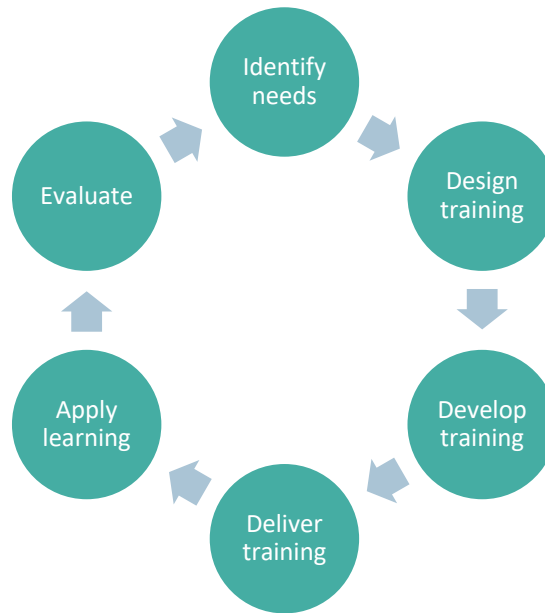
Do:

- ✓ Maintain good eye contact.
- ✓ Prepare in advance.
- ✓ Involve participants.
- ✓ Use visual aids where possible.
- ✓ Speak clearly, loudly, and slowly.
- ✓ Encourage questions.
- ✓ Admit when you do not know an answer and commit to revisiting it.
- ✓ Recap at the end of each session.
- ✓ Bridge one topic to the next.
- ✓ Encourage participation.
- ✓ Write clearly and legibly.
- ✓ Summarize.
- ✓ Reflect participants' reactions back to them.
- ✓ Use good time management.
- ✓ Give constructive and positive feedback.
- ✓ Be aware of the participants' body language and level of participation.
- ✓ Provide clear instructions.
- ✓ Check to see if your instructions are understood.
- ✓ Evaluate and adjust as you go.
- ✓ Be patient, understanding, and empathetic.

Don't:

- ✗ Talk to the flipchart or slide presentation.
- ✗ Block the visual aids.
- ✗ Stand in one place (it's helpful to move around the room).
- ✗ Ignore participants' questions, comments, or feedback.
- ✗ Force anyone to participate.
- ✗ Shout at or criticize participants.
- ✗ Dismiss participant's beliefs or opinions.
- ✗ Let factually incorrect, biased, or judgmental statements go uncorrected.
- ✗ Let one strong participant dominate conversation.

The Training Cycle



For effective training, remember the following:

- A training helps trainee master a specific set of skills through a direct (or “hands-on”) interaction.
- It is critical to first understand the need for the training and design the sessions to create the best scenario/ knowledge and skill base to address this need.
- The whole facilitation process should be practical and application-oriented, so the trainees can apply their new knowledge and skills into a real work situation.
- Training is a continuum of knowledge, skill, competency feed to trainees, so the facilitator’s role is to develop desire and aspiration.

Tips for Training as a Team

When planning a module presentation with another trainer/facilitator, discuss the following questions to help clarify your roles:

- Which parts of the module would you like to be responsible for?
- Which parts would you like your colleague to handle?
- What is your teaching style? How does your teaching style differ from that of your colleague?
- What challenges might arise? How can you and your colleague ensure that you will work well together?
- What signal could you and your colleague use to interrupt when the other person is presenting?
- How will you handle staying on task?
- How will you field participant questions?
- How will you make transitions between each of your presentations?
- How will you get participants back from breaks in a timely manner?

Overview of Training

Day 1	Duration
MODULE 0: Introduction to Training	
Session 0-A: Introductions, Group Norms, and Pre-test	30 min.
Total Module Time	30 min.
MODULE 1: Understanding Gender and GBV	
Session 1-A: Understanding Gender in FP Services	1 h. 30 min.
Session 1-B: Gender Relevance in FP Success and Failure	1 h.
Total Module Time	2 h. 30 min.
MODULE 2: Foundations of GBV	
Session 2-A: Understanding and Conceptualizing GBV	45 min.
Session 2-B: GBV Risk Analysis in FP and SRHR	45 min.
Session 2-C: Male Engagement in GBV Prevention Awareness	30 min.
Session 2-D: Understanding GBV in FP and SRH for Adolescents and Youth	1 h. 10 min.
Session 2-E: Day 1 Wrap Up	40 min.
Total Module Time	3 h. 50 min
DAY 1 TOTAL TRAINING TIME*	6 h. 50 min.

Day 2	Duration
MODULE 3: GBV-Responsive FP and SRH Service Provision	
Session 3-A: GBV-Responsive Counseling in FP and SRHR	1 h. 30 min.
Session 3-B: Responding to Disclosures of GBV	1 h.
Session 3-C: Making GBV Referrals	1 h. 30 min.
Total Module Time	4 h.
MODULE 4: Foundational Knowledge of GBV Case Recording, Documentation, and Record Keeping	
Session 4-A: Legality, Protecting Confidentiality, and Reporting GBV	45 min.
Total Module Time	45 min.
MODULE 5: Closing	
Session 5-A: Closing Session and Post-Test	1h. 30 min.
Total Module Time	1 h. 30 min.
DAY 2 TOTAL TRAINING TIME*	6 h. 15 min.
TOTAL TRAINING TIME	13 h. 05 min.

**Note: Does not include lunch or other breaks (two hours for two days)*

Module 0: Introduction to Training

The introductory module provides the overview of the training, including objectives and methodologies. It is also an opportunity to create an enabling environment for learning, respect, and active participation in the training. This module includes a pre-test. The purpose of the pre-test is not to evaluate the knowledge of the participants, but rather to enable facilitators to structure the sessions and their explanations accordingly. It will also serve to measure the group's change in knowledge, when compared to the results of the post-test administered at the end of the training.



TOTAL MODULE TIME: 30 MIN.

- Session 0-A: Introductions, Group Norms, and Pre-test



LEARNING OBJECTIVES

Participants will be able to:

- Get to know each other.
- Gain a clear understanding of the overall goal and objectives of this training.
- Agree on ground rules and norms for training.
- Assess baseline knowledge via pre-test.



METHODOLOGIES

- Presentation
- Assessment



MATERIALS NEEDED

- Flipchart and markers
- Trainer PPT Slide Deck 1
- Index cards
- Tool A: Pre-test Assessment
- Participant list
- Nametags



ADVANCE PREPARATION

- Review slides and training content
- Prepare training room

Session 0-A: Introductions, Group Norms, and Pre-test



30 MIN.

Activity 1: Welcome

Welcome and Introduction of Trainers (5 min.)



TRAINER NOTE

Prepare the training room as follows:

- Ensure projection equipment is working and the Day 1 PPT slide deck is loaded.
- Have a minimum of two flip chart stands ready at the front of the room. Write a welcome message on one. On the other, write instructions for each participant to take materials upon entering.
- On a second page of one of the flip charts, write out the ground rules as found on **PAGE 15** of this manual.
- Place participant manuals, printed copies of the pre-test, name tags, a registration sheet, and index cards on a table at the entrance to the training space.
- Prepare and place instructions for the expectations cards by the materials table.
Participants should write 1–2 expectations for the training on a card and hand them to a facilitator as they arrive and get settled.

Step 1

Ask participants to take their seats and offer a warm greeting. Remind participants they should be filling out an expectations card and to please do so now, if they have not already completed one.

One facilitator should go around, collecting outstanding cards, while the welcome and introduction continues.

Step 2

Welcome the participants into the training room and introduce yourself and all facilitators to the participants.

Step 3

Turn to the ground rules page of your flip chart and review the ground rules for this training. Ask if any participant has any other norms or ground rules to request/suggest to the group.

Activity 2: Presentation

Overall goal, objectives, and learning outcomes (5 min.)

STEP 1

Present PPT **SLIDES 2–5**.

When presenting **SLIDE 5**, explain the following:

This training is not intended to develop the skills required to provide comprehensive medical care for GBV, nor the skills required to provide clinical management of rape. Rather this training is intended to give you the skills needed to integration GBV responsive care into your routine work as SRH service providers. When in doubt, always bring in or refer clients to specialized providers or points of care.

Activity 3: Assessment

Pre-Test (20 min.)

Step 1

Distribute **Tool A: Pre-test Assessment**.

Step 2

Inform participants that the pre-test is intended to help facilitators structure the sessions over the next two days in a way that is most helpful to them. Let them know that there will be a post-training assessment, including both a knowledge assessment and a skills assessment component, at the end of the training.



TRAINER NOTE

Participants do not need to write their names on either the pre- or post-test (it can be completed anonymously). However, as you will need to compare each participant's post-test score with their pre-test score, ask each participant to write a unique 3- or 4-digit number or code at the top of the pre-test. This can be any number or code, such as a favorite number (e.g., 777), or code (ABC*). It is very important that participants remember this number or code, as they will need to record the exact same number/code at the top of their post-test. When taking the pre-test, suggest that they write their number/code on the copy of the training schedule—this way they will not forget it.

The skills assessment will only take place at the end of the training and is not conducted during this activity.

Module 0 Tools and Handouts

Tool A: Pre- and Post-Test Assessment

Participant's unique code: _____ Date: _____

1. True or False? Indicate if the below statements about gender and family planning are true or false by circling "true" or "false" for each statement. (5 points total; 0.5 each)

- a) **True / False** – Decision-making power and access to resources affect women's ability to obtain and continue using family planning.
- b) **True / False** – Reproductive coercion (threatening, harassing, or forcing someone to have or not have a child) is a form of gender-based violence.
- c) **True / False** – The signs of gender-based violence are always easy for a provider to see.
- d) **True / False** – One of the key principles guiding gender-sensitive client-provider interaction is "do not harm."
- e) **True / False** – Gender is the sex difference between men and women.
- f) **True / False** – Gender is the social difference between men and women
- g) **True / False** – "Gender equity" and "gender equality" mean the same thing.
- h) **True / False** – Gender inequalities are barriers in family planning.
- i) **True / False** – Adolescents and youth age are in the same age group.
- j) **True / False** – "999" is the number of National Emergency Service Bangladesh.

2. Do the following items refer to gender or sex? Tick the appropriate answer. (2 points)

	Gender	Sex
Menstruation		
Women should do all the cooking		
Breastfeeding		
Wet dreams		
Men are natural leaders		
Women can get pregnant		

- 3. What is the definition of “gender equity”?** Circle the correct answer. (1 point)
- a) Providing the same resources to women and men.
 - b) Ignoring a person’s gender.
 - c) The process of being fair to women, men, and those with diverse gender identities, according to their diverse needs.
 - d) Legal rights are given to women.
- 4. What can impact a woman’s or a girl’s access to family planning, as well as her choice of method and ability to use it?** Circle the correct answer. (1 point)
- a) Violence and/or fear of violence.
 - b) Pressure on women and couples to “prove” fertility soon after marriage.
 - c) The taboo on women and girls accessing reproductive health information.
 - d) All of the above.
- 5. Violence against women and girls is:** Circle the correct answer. (1 point)
- a) An effective way to correct behaviors.
 - b) A private family matters.
 - c) Any act that is based on gender norms or unequal power dynamics that results in, or is likely to result in, physical, sexual, or mental harm to women.
 - d) None of the above.
- 6. Which of the following is an appropriate opportunity to involve men in family planning?** Circle the correct answer. (1 point)
- a) A client says she would like her male partner to be present for family planning counseling.
 - b) A male client is interested in family planning methods he can use.
 - c) A male community leader says he wants to help young couples understanding the benefits of family planning.
 - d) All of the above.
- 7. Which two abbreviations are correct?** Circle the correct answers. (1 point)
- a) GATHER: Greet – Acquire information – Teach – Help – Experience – Refer
 - b) GATHER: Greet – Ask – Tell – Help – Explain – Recommend a return
 - c) LIVES: Listen – Inquire – Validate – Enhance safety – Support
 - d) LIVES: Listen – Initiate – Validate – Educate – Serve

8. **True/False - Child Marriage refers to the marriage of a girl before the age of 18.** (1 point)
9. **True/False - 109 is a 24/7 National Helpline Centre for Violence against Women and Children.** (1 point)
10. **Which of the following points do you consider incorrect in the following referral checklist?**
Circle your answer. (1 point)
- a) Advocate for and support survivors in accessing services
 - b) Lead case coordination
 - c) Provide direct services to the scope and designation of your role and facility
 - d) Make specific referrals relevant to where a client lives
11. **What type of gender-based violence occurred in this case?** Circle the correct answer. (3 points)

Sushila (*pseudonym*), age 24, is an RMG worker at a garment factory at Ashulia. Sushila has learned that she is pregnant. She formally notifies her supervisor using the proper procedure and requests approval of maternity leave. However, her supervisor is upset at the thought of losing a good worker and having to pay benefits. The supervisor tells Sushila that if she just gets MR, this will not be a problem, and she can continue to earn good money to help her family. Sushila is distraught and consults with her husband about the matter. Her husband tells her she must quit her job, or he will stop giving her bus money.

- a) Reproductive coercion
- b) Intimate partner violence
- c) Workplace harassment
- d) All of the above

SCORE: /18 POINTS

Tool B: Pre- and Post-Test Answer Key

1. True or False? Indicate if the below statements about gender and family planning are true or false by circling “true” or “false” for each statement. (5 points total; 0.5 each)

- a) **True** / False – Decision-making power and access to resources affect women’s ability to obtain and continue using family planning.
- b) **True** / False – Reproductive coercion (threatening, harassing, or forcing someone to have or not have a child) is a form of gender-based violence.
- c) True / **False** – The signs of gender-based violence are always easy for a provider to see.
- d) **True** / False – One of the key principles guiding gender-sensitive client-provider interaction is “do not harm.”
- e) True / **False** – Gender is the sex difference between men and women.
- f) **True** / False – Gender is the social difference between men and women
- g) True / **False** – “Gender equity” and “gender equality” mean the same thing.
- h) **True** / False – Gender inequalities are barriers in family planning.
- i) True / **False** – Adolescents and youth age are in the same age group.
- j) **True** / False – “999” is the number of National Emergency Service Bangladesh.

2. Do the following characteristics refer to gender or sex? Tick the appropriate answer. (2 points)

Characteristics	Gender	Sex
Menstruation		X
Women should do all the cooking	X	
Breastfeeding		X
Wet dreams		X
Men are natural leaders	X	
Women can get pregnant		X

3. What is the definition of “gender equity”? Circle the correct answer. (1 point)

- a) Providing the same resources to women and men.
- b) Ignoring a person’s gender.
- c) **The process of being fair to women, men, and those with diverse gender identities, according to their diverse needs.**
- d) Legal rights are given to women.

4. **What can impact a woman's or a girl's access to family planning, as well as her choice of method and ability to use it?** Circle the correct answer. (1 point)
- a) Violence and/or fear of violence.
 - b) Pressure on women and couples to "prove" fertility soon after marriage.
 - c) The taboo on women and girls accessing reproductive health information.
 - d) All of the above.**
5. **Violence against women and girls is:** Circle the correct answer. (1 point)
- a) An effective way to correct behaviors.
 - b) A private family matters.
 - c) Any act that is based on gender norms or unequal power dynamics that results in, or is likely to result in, physical, sexual, or mental harm to women.**
 - d) None of the above.
6. **Which of the following is an appropriate opportunity to involve men in family planning?** Circle the correct answer. (1 point)
- a) A client says she would like her male partner to be present for family planning counseling.
 - b) A male client is interested in family planning methods he can use.
 - c) A male community leader says he wants to help young couples understanding the benefits of family planning.
 - d) All of the above.**
7. **Which two abbreviations are correct?** Circle the correct answers. (1 point)
- a) GATHER: Greet – Acquire information – Teach – Help – Experience – Refer
 - b) GATHER: Greet – Ask – Tell – Help – Explain – Recommend a return**
 - c) LIVES: Listen – Inquire – Validate – Enhance safety – Support**
 - d) LIVES: Listen – Initiate – Validate – Educate – Serve
8. **True / False – Child Marriage refers to the marriage of a girl before the age of 18.** (1 point)
9. **True / False – 109 is a 24/7 National Helpline Centre for Violence against Women and Children.** (1 point)

10. Which of the following points do you consider incorrect in the following referral checklist?

Circle your answer. (1 point)

- a) Advocate for and support survivors in accessing services
- b) Lead case coordination**
- c) Provide direct services to the scope and designation of your role and facility
- d) Make specific referrals relevant to where a client lives

11. What type of gender-based violence occurred in this case? Circle the correct answer. (3 points)

Sushila (*pseudonym*), age 24, is an RMG worker at a garment factory at Ashulia. Sushila has learned that she is pregnant. She formally notifies her supervisor using the proper procedure and requests approval of maternity leave. However, her supervisor is upset at the thought of losing a good worker and having to pay benefits. The supervisor tells Sushila that if she just gets MR, this will not be a problem, and she can continue to earn good money to help her family. Sushila is distraught and consults with her husband about the matter. Her husband tells her she must quit her job, or he will stop giving her bus money.

- a) Reproductive coercion
- b) Intimate partner violence
- c) Workplace harassment
- d) All of the above**

SCORE: /18 POINTS

Module 1: Understanding Gender and GBV



TOTAL MODULE TIME: 2 H. 30 MIN.

- Session 1-A: Understanding Gender in FP Services
- Session 1-B: Gender Relevance in FP Success and Failure



LEARNING OBJECTIVES

Participants will be able to:

- Gain clear concepts of gender, gender equity and equality, and their impact on power and violence.
- Identify gender discrimination issues and practices in FP and SRH settings and society.
- Gain insights into gender's role in FP success and failure.
- Articulate the relevance of gender-discrimination and GBV to optimize FP and SRH services.



METHODOLOGIES

- Presentation
- Reflection
- Discussion
- Case study



MATERIALS NEEDED

- Flipchart and markers
- Trainer PPT Slide Deck 1
- Case Studies 1–5



ADVANCE PREPARATION

- Review slides and training content

Session 1-A: Understanding Gender in FP Services



1 H. 30 MIN.

Activity 1: Presentation and Reflection

Introduction, Objectives, and Gender Reflection (15 min.)

STEP 1

Present the learning outcomes on **SLIDE 7**. After presenting this information, be sure to note:

A separate training on Gender-Integrated Family Planning Service is available. If you have not taken that training, please consider speaking with your supervisor and/or facility manager about participating in an upcoming cohort.

STEP 2

Project **SLIDE 8** and ask participants, “What does gender mean to you?”

Direct participants to turn to a person near them and take turns sharing reflections based on the following three prompts:

1. **Share a time when you became aware of your gender.**
2. **Think of a time when you felt happy about your gender.**
3. **Has there been a time when you felt scared, discriminated against, or sad because of your gender?**

STEP 3

Present **SLIDE 9** and note the following:

It's important to remember that gender is socially constructed and separate from biological sex which is determined by genetics and most commonly identified through congenital anatomy.

STEP 4

Present **SLIDE 10** focused on inequality.

Women are half the world's population. Yet, women live with a 3x greater lifetime experience of gender-based violence. In low- and middle-income countries, gender discrimination results in an estimated 3.9 million excess deaths among women and girls by the age of 60.^{15,16}

¹⁵ World Bank. World Bank Group Gender Strategy (FY16-23): Gender Equality, Poverty Reduction and Inclusive Growth (Washington, DC: 2015).

¹⁶ World Bank. World Development Report 2012: Gender Equality and Development (Washington, DC: 2011).

Activity 2: Reflection

Gender Quiz (10 min.)

STEP 1

Project **SLIDE 11** and say: “So let’s see how much you already know about the differences between gender and sex.”

STEP 2

Direct participants to turn to the **Gender Quiz on page 16 in their Participant’s Manual**.

Ask participants to read each statement below carefully. Then check the appropriate box to answer the question: ***Does this issue relate to sex, or does it relate to gender?***

Instruct participants to complete the four-question quiz quietly and independently. After a few minutes, review the correct answers all together—as a group—asking for volunteers to share what answers they selected and why.

GENDER QUIZ

	Tick the correct box	
	Gender	Sex
1. Women must consume extra calories and safe water during lactation.		
2. It is a man’s responsibility to protect his family’s honor.		
3. Female-bodied people will need resources and space to enable optimal menstrual hygiene.		
4. Women and girls have a responsibility to ensure they don’t get pregnant or have sex before they are married.		



TRAINER NOTES

The following notes relate to each answer of the gender quiz:

1. Because these nutritional needs are physiological and based in biology, they are related to a person’s **sex**.
2. Concepts of responsibility and honor are constructed by society and change over time. This a **gender**-based norm.
3. Female-bodied people menstruate due to their biological **sex**.
4. Concepts of morality, marriage, and appropriate timing for pregnancy differ from one culture to another and change over time. These are **gender**-based and social values.

Activity 3: Presentation

Gender and Biological Sex (15 min.)

STEP 1

Present **SLIDE 12** on the differences between gender and sex, noting the following:

Gender and sex are not the same. While sex is generally permanent and universal, gender construction varies from one society to another.

Gender	Sex
Socially constructed roles, responsibilities, and attitudes (e.g., division of labor)	Physically, biologically defined
Gender rules and regulations are learned/imposed; we build it in our own minds	Determined by birth; we are born with it
Differences in dress and behavior	Determine our physical functions
Differences between and within cultures, includes variables identifying differences in roles, responsibilities, attitudes, opportunities, expectations, needs, and constraints	Same throughout the world
Changeable over time	Generally unchangeable



REFERENCE: DEFINITIONS

From WHO:

Gender refers to socially constructed characteristics of women and men—such as norms, roles, and relations of and between groups of women and men.¹⁷

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females.¹⁸

From USAID, Interagency Gender Working Group (IGWG):¹⁹

Gender is a culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations associated with being female and male, as well as the power relations between and among women and men, boys, and girls. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, age, and sexual orientation. Transgender individuals, whether they identify as men or women, are subject to the same set of expectations and sanctions.

Sex is classification of people as female, male, or intersex. At birth, infants are assigned a sex based on a combination of bodily characteristics including chromosomes, hormones, internal reproductive organs, and genitalia.

Definitions from Pathfinder International:²⁰

Gender is about the roles, norms, and behaviors that society consider appropriate for women, men, girls, boys, and those with diverse gender identities, such as transgender. These are socially constructed and vary widely within and across cultures, religions, class, and ethnicity. For example, in many societies a common gender norm is that women and girls should do most of the domestic work.

Sex is typically assigned at birth and refers to the biological characteristics that define humans as female, male, or intersex.

¹⁷ WHO. Gender mainstreaming for health managers: a practical approach (Geneva: 2011).

¹⁸ "Sexual health: definitions," WHO, accessed January 20, 2023, https://www.who.int/health-topics/sexual-health#tab=tab_2.

¹⁹ "Handout: Gender-related Terms and Definitions," IGWG, accessed January 23, 2023, <https://www.igwg.org/wp-content/uploads/2017/05/HandoutGenderTerms.pdf>.

²⁰ For more information, visit <https://www.pathfinder.org/focus-areas/gender/>

STEP 2

Present **SLIDES 13–14**.

KEY GBV-RELATED TERMS AND CONCEPTS

Gender Norms

What society considers male and female behavior, leading to the formation of gender roles, which are the roles men and women, and boys and girls, are expected to take in society.

Gender Awareness

An awareness of the differences in roles and relations between women and men. It recognizes that the life experiences, expectations, and needs of women and men are different, varying across the culture and society.

Gender Equity

The absence of discrimination based on a person's sex or gender. Gender equity means providing the same opportunity to each person, including access to and control of social, economic, and political resources, including protection under the law, such as health services, education, and voting rights.

Gender Discrimination

Any distinction, exclusion, or restriction made on the basis of socially constructed gender roles and norms, which prevents a person from enjoying full human rights.

Gender-Related Barriers

Obstacles to access and use of health services, which are related to deep-rooted social and cultural norms about the roles of women, men, and those with diverse gender identities.

Gender-Based Violence (GBV)

Any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. This includes threats or acts of coercion, arbitrary deprivation of liberty, neglect, or discrimination, whether occurring in public or in private life. GBV encompasses physical or sexual assault, emotional or psychological harm, denial of resources or access to services, and denial of legal self-autonomy.

When presenting **SLIDE 14**, emphasize the following to participants:

Please note that gender discrimination and gender-based violence are two separate things. While many forms of gender discrimination enable and/or are perpetuated by gender-based violence (e.g.: laws that require women to comply with their husband's requests for intimate relationships regardless of their desire in a given moment); there are forms of GBV that would not qualify as gender discrimination (e.g., physical intimate partner violence).

Gender discrimination entails systematic and/or policy-based behaviors that place one gender at a disadvantage over another. Gender-based violence may occur as an isolated incident.

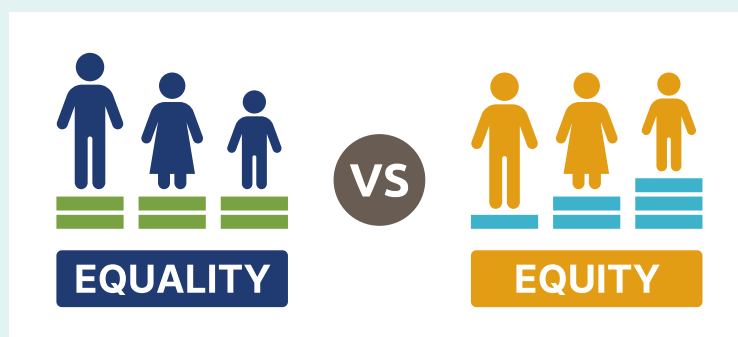


REFERENCE: GENDER EQUALITY VS GENDER EQUITY

- **Gender equality** is the absence of discrimination based on a person's sex or gender. It means providing the same opportunity to each person, including access to and control of social, economic, and political resources, including protection under the law (such as health services, education, and voting rights).
- **Gender equity** is the process of being fair to women, men, and those with diverse gender identities. It recognizes that men and women have different needs, power, and access to resources, which should be identified and addressed in a manner that rectifies the imbalances. Addressing gender equity leads to equality. For example, an affirmative action policy adopted by a health facility to increase the number of women in senior leadership posts may be gender-equitable because it leads to ensuring equal rights among men and women.
- The goal of gender equality is not for women and men, girls, and boys, to become the same. The goal of gender equality is to ensure that women and men have the same chances to access and benefit from social, economic, and political resources (e.g., have the same opportunities to vote, to be educated).
- The goal of gender equity moves beyond equality to strive toward equality of outcomes. Thus, it moves beyond considering women and men as being equal under the law to ensuring that conditions will not block their equal participation in health promotion activities. It recognizes, for example, that women and men may have different needs, preferences, and interests, and that achieving equality of opportunity (e.g., gender equality) may require treating women and men differently and/or separately.
- Gender equality differs from gender equity in that gender equity is about how health services meet different population needs, whereas gender equality is about making sure that everyone is given the same services.

GENDER EQUALITY	GENDER EQUITY
<ul style="list-style-type: none"> • Equality means sameness • Giving everyone the same • It works if everyone starts from the same place 	<ul style="list-style-type: none"> • Equity means fairness • Access to the same opportunity • We must first ensure equity before we can enjoy equality

An Example of Equality vs. Equity



Activity 4: Presentation, Case Study, and Group Discussion

Understanding Gender and Power (50 min.)

STEP 1

Present **SLIDE 15**, which focuses on power and covers the following information:

UNDERSTANDING GENDER AND POWER

Power is the capacity or ability to direct or influence the behavior of self, others, or the course of events.

Power Over

An individual or institution's degree of power translates to their capacity to exploit others, regardless of intention or action to do so.

Power To

An individual or institution's capacity to create without using relationships of domination. The capacity to act and to exercise agency and realize the potential of goals, rights, or aspirations.

Power Within

A person's sense of their own capacity and self-worth. It is related to the productive sense of 'power to' and a prerequisite to holding or increasing one's 'power to.'

Power With

Collective power within, to, or over that comes from intentional solidarity amongst individuals or groups. This collective power can be mobilized both within and across class, caste, religious, gender and age differences.

Share the following with participants:

The case study we are going to look at next helps unpack how a person's power or lack of power influences their FP choices, service seeking, and SRH outcomes.

Historically, power was understood as something one either had or did not have. More recent conceptualization from the fields of sociology, psychology, and gender studies have helped us understand that people and groups of people may have certain forms of power, but not others. This provides valuable insight into how to empower someone even if they are in a vulnerable position or part of a marginalized group.



TRAINER NOTE

This is a new and challenging framework for many. Be sure to pause for questions and expect them. Here are some examples that may help clarify these power dynamics:

- Parents have **power over** their children, which they can use in a positive way to teach responsibility through chores, household contributions, etc. Parents can also use power over their children in an exploitative or negative way (e.g.: forced, early marriage). Children rarely have power over others, but they may have **power to** ask their parents for help or to inform a teacher if another student is harassing them.
- **Power within** is a pre-requisite to having power to act. Think of power within as the fuel for agency. It is important to realize that someone may have **power within**, such as a young woman who is confident in her right to complete school and advocates for herself in that regard, but not have the power **to** actually do something (e.g.: legally, her parents may be permitted to withhold permission for her to complete secondary school).
- It is valuable to remember that a person who has little to no power on their own can still have or develop **power with** others. As health workers, you may be able to help someone living with GBV who has little to no power within, power to act for their safety, or power over others identify groups or individuals **with whom** they can find some power to change their circumstances. Power **with** is often a critical form of power for enacting change to address GBV at a community, societal, or systems level.

STEP 2

Project **SLIDE 16**.



Share the following information to participants:

When considered together, understanding power dynamics helps one understand the following:

1. *GBV is any action, threat, or exercise of control that uses gender roles and norms to decrease a person's power.*
2. *Intersectional factors increase or decrease a person's vulnerability.*
3. *The greater the power an individual or institution holds, the easier it is for them to perpetrate GBV.*

STEP 3

Project **SLIDE 17**.

Direct participants to turn to **Case Study 1: Rahima on page 21 of their Participant's Manual** (page 51 of this Trainer's Manual). Instruct them to take a few minutes to read Rahima's story to themselves, after which we will have a group discussion focused on these questions:



For Group Discussion

- 1) What elements of Rahima's story demonstrate the common gender norms and expectations in your communities?
- 2) Do you see examples of the men and women in Rahima's story having different levels or different types of power?
- 3) Do you think that gender norms and gender-specific power influences the FP choices in Rahima's story? Why or why not?
- 4) Do you see examples of GBV in Rahima's story? Why or why not?



TRAINER NOTE

Be sure to highlight the following points if they are not raised during participants' discussion:

Related to question 1

- Gender norms related to educational attainment value (e.g.: male education is more important than female education)
- Expectations for early marriage for girls
- Pressure to conceive and bear children

Related to question 2

- Rahima's father is the decision maker regarding his children's education and marriage. It does not appear that Rahima's mother has much of a say or was even consulted.
- Rahima appears to have some power, as she has advocated to delay her first pregnancy successfully. She has strong **power within** herself to affirm that agency as a new bride.
- Rahima's father has robust **power over** his children and family. He makes decisions, and these decisions are followed.

Related to question 4

- Rahima and Aklina were both forced into child marriages.
- From the information provided but is not possible to tell whether other forms of GBV are present. Given Rahima's mother's strong desire for her daughters to complete higher education, the ultimate outcome suggests there may be threats or actual violence within her marriage. However, this may also be a manifestation of gender inequity and power imbalances without any actual violence. It is important that, as we become more aware of GBV, we also remember that challenges and inequity can exist without violence.

Session 1-B: Gender Relevance in FP Success and Failure



1 H.

Activity 1: Reflection

Introduction and FP's Influence on Broader Health (30 min.)

STEP 1

Present **SLIDE 18**. Sharing the following information with participants:

We began to look at the ways that gender and power interact with FP success or failure. Now, we will explore that more deeply. But first a reminder on how broadly FP influences SRH, family health, and social health.

STEP 2

Present **SLIDE 19**. Participants may turn to **page 22 of their Participant's Manual** to follow along. Ask participants to raise their hands to share their answer, including their reason for any given answer. More questions have been provided than can typically be discussed in the planned time. Choose **5–6** questions that feel most relevant—based on participants' stated expectations (You can reserve any of the questions you do not initially use to further expand upon these ideas, should participants need additional time and reflection to understand how gender affects FP and RH).

Take **2–3** responses for each question. Allow for brief, respectful debate among participants.



TRAINER NOTE

Points to consider highlighting—based on participants' responses—are noted in **green text** in the table on the next page.

QUESTIONS TO ASK TO ACCESS HOW GENDER AFFECTS FP AND RH OUTCOMES

Question	Answer
<p>Are there gender constraints around who has the authority to access FP and RH services?</p> <ul style="list-style-type: none"> • Women may not have independent financial resources • Women may have limited independent mobility to reach a FP clinic or may be expected to have an escort • Women may be expected to have a husband's permission to access FP and RH services 	
<p>Who in the couple typically makes FP decisions?</p> <ul style="list-style-type: none"> • This depends on perspective and varies widely between households. In some cases, it is neither the husband nor the wife, but may be another household member, such as the woman's mother-in-law. • It is important to be mindful that even if a woman is at an FP consultation alone, the decisions she expresses may be stemming from fear of violence at home. This is coerced decision making. 	
<p>Do women need permission from husbands/in-laws to seek an FP method for themselves?</p> <ul style="list-style-type: none"> • Legally, no. However, this brings up the complex nature of this subject. Many women do need permission in order to keep themselves safe from various forms of domestic or intimate partner violence. 	
<p>Are there gender norms that affect men's or women's perception of using FP?</p> <ul style="list-style-type: none"> • Consider norms related to proving fertility, the perception of contraception as a means to hide infidelity, the idea that large families signal male virility, etc. 	
<p>Are there gender norms that affect men's or women's use of FP and RH services?</p> <ul style="list-style-type: none"> • Gender norms play an even more varied role in <u>behaviors</u> and <u>use of services</u> than they do in perception and attitudes. In addition to the norms that influence perception of FP highlighted in the previous question, gender norms affect: • Men and women's likelihood of being available during FP clinic hours. • An individual's comfort and ability to move from their home to an FP point of service. • An individual's level of agency and autonomy to make decisions about for FP and RH. 	
<p>Are there unequal decision-making abilities between men and women about whether and when to seek FP and RH services?</p> <ul style="list-style-type: none"> • Potential questions to pose to participants: <ul style="list-style-type: none"> • Is it common for women to feel they need their husband's permission to seek FP services? What about men feeling the need to seek their wife's permission? 	

<ul style="list-style-type: none"> • Do most women need to justify and explain their time spent outside of the home? Do men? • Do you know women who worry about experiencing violence if men in their household discover they are using FP? Do you know men who worry about experiencing violence if they use FP? 	
<p>Is there accessible, relevant, and accurate information about FP and RH tailored to young men?</p> <ul style="list-style-type: none"> • Men, and young men in particular, often lack tailored, accessible information. FP/RH providers have an important role to play in giving young men and all men relevant, accurate information. • Increasingly, global job aids and IEC materials tailored to young men are being developed. You might consider speaking to your facility head to inquire about securing a Bangla translation. 	
<p>Do FP and RH service providers treat men and women equally?</p> <ul style="list-style-type: none"> • Potential questions to pose to participants: <ul style="list-style-type: none"> • Do you or have you ever questioned a female client on whether she really wants a permanent method? Have you hesitated to provide one? What about your male clients? • Have you have asked a female client if her husband knows she is at the clinic? Have you ever asked a male client the same about his wife? • Do you respond differently when a male adolescent requests condoms versus when a female adolescent does the same? 	
<p>Do FP and RH facility- and/or community-based providers facilitate male involvement?</p> <ul style="list-style-type: none"> • There are structural, systemic, and individual pathways to facilitate male involvement. • Respective examples include ensuring FP providers have information education communication (IEC) materials that are designed for men as well as women, ensuring providers have job aids and visit flow guidance that includes invitations for couple-based counseling, and using the skills we'll be practicing in this training to be mindful of how power dynamics may help or hinder male involvement. 	

Activity 2: Presentation

FP's Influence on Broader Health (10 min.)

STEP 1

Present **SLIDES 20–23**, which highlight the importance of FP to global goals and Bangladesh's longstanding commitment to FP.



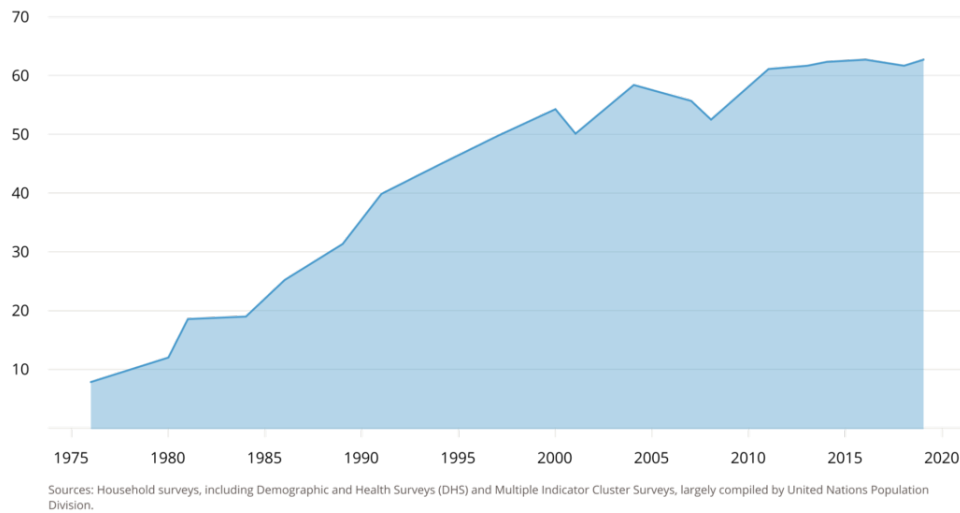
“Investing in family planning is a development ‘best buy’ that can accelerate achievement across the 5 Sustainable Development Goal themes of People, Planet, Prosperity, Peace, and Partnership.”²¹

²¹ Ellen Starbird, Maureen Norton, and Rachel Marcus. “Investing in Family Planning: Key to Achieving the Sustainable Development Goals,” *Global Health: Science and Practice*, 2016 Jun 20; 4(2): 191–210.

Bangladesh has achieved historic progress in expanding access to voluntary contraception for nearly half a century. The percentage of married women of reproductive age who are using family planning increased sevenfold in less than 50 years.

Increase in Contraceptive Use

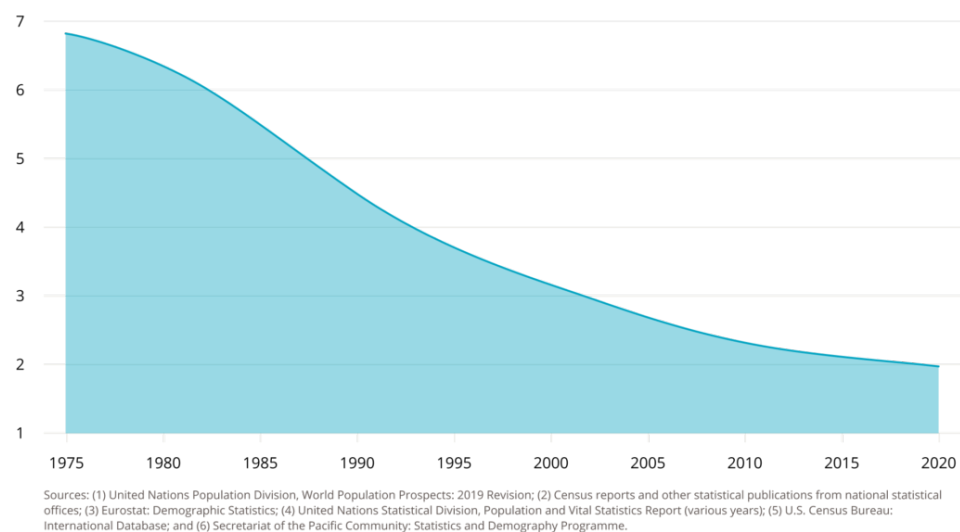
The percentage of married women ages 15–49 who are using any method of contraception



When given options, many women in Bangladesh are choosing to have fewer children.

Decrease in Total Fertility Rate

The number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with age-specific fertility rates of the specified year





REFERENCE: BANGLADESH'S FP PROGRESS

Bangladesh was the tenth most populous country in the world when it achieved independence in 1971. The government of Bangladesh set out to address what it saw as urgent, interconnected threats to families and the young nation: rampant poverty, limited food and resources, devastating rates of infant and child death, and mounting population pressures. Bangladesh took swift action to enhance family planning education and services.

A cornerstone of Bangladesh's strategy to bring contraceptive options to people's doorsteps was the deployment of a massive cadre of female frontline health workers (called "family welfare assistants") who provided contraceptive counseling and services to women where they live.²² Between 1976 and 1980, when it was uncommon for women in Bangladesh to work outside of the home, the government recruited 22,500 women from local communities as family welfare assistants. These frontline health workers became a symbol of empowerment in communities and revolutionized family planning service delivery for hard-to-reach women and families.

For the next 50 years, public and private-sector stakeholders, policymakers, health care providers, religious leaders, researchers, academics, international donors, media agencies, and organizations teamed up to achieve family planning milestones. Bangladesh has leveraged the power of these partnerships to transform its health systems, generate new evidence, and remove barriers that keep women and girls from exercising their right to contraception and sexual and reproductive health care.

Bangladesh's achievements demonstrate what's possible when generations of women gain the health care, knowledge, and support they need to achieve their desires for smaller, healthier, more educated, and more prosperous families. Bangladesh's longstanding investment in family planning has paid off.

But today, Bangladesh's family planning agenda remains unfinished. Progress is stalling. The percentage of women currently using modern contraceptives decreased from 54 percent in 2014 to 52 percent in 2017–18.²³

²² Sidney Ruth Schuler, Syed M. Hashemi, and Ann Hendrix Jenkins. "Bangladesh's Family Planning Success Story: A Gender Perspective." *International Family Planning Perspectives*, Volume 21, Number 4, December 1995.

²³ BDHS 2017–2018.

Bangladesh's Historic FP Progress²⁴

- One of the **oldest family planning programs** in the world (launched 1953).
- In less than 50 years, **percentage of married women** of reproductive age who are **using family planning increased sevenfold**.
- Today, **contraceptive prevalence rate** is **62 percent**, and 52 percent of women are using modern contraceptive methods.*
- GOB and DGFP has **strong commitment** and **farsighted vision** for FP program.

Bangladesh has been a leader in FP programming transforming women's access to essential services. Currently, the contraceptive prevalence rate among currently married women ages 15–49 is 62 percent, and 52 percent of women are using modern contraceptive methods.²⁵ More needs be done to ensure all have access to a full range of contraceptive options.

Opportunities for Progress

- **Address high rates of discontinuation:** 37% of contraceptive users stop their selected method within 12 months.
- **Improve service quality and method mix:** only 9% of currently married women are using a long-acting or permanent method.
- **Address unmet need among adolescents:** 16% of adolescents ages 15–19 have an unmet need for FP, compared to 5% among women at the end of their childbearing years (45–49)
- **Improve services offered to women who were or are child brides:** Nearly one-third (31%) of women ages 20–49 report that they had married by age 15.
- **Areas of Need:** While the national CPR is 62 percent, there are sizable variations across age geographies. For example, modern method use is highest in Rangpur (59%) and lowest in Chattogram and Sylhet (both have a CPR of 45%).

Twelve percent of currently married women in Bangladesh have an unmet need for family planning services.²⁶ Too many women continue to struggle to exercise their right to access and use family planning.

Inequality in household decision-making and finances affects women's ability to independently access and use FP. According to the Report on Violence Against Women (VAW) Survey 2015,²⁷ women do not

²⁴ BDHS 2017–2018.

²⁵ BDHS 2017–2018.

²⁶ BDHS 2017–2018.

²⁷ Bangladesh Bureau of Statistics, Statistics and Informatics Division, Ministry of Planning, Government of the People's Republic of Bangladesh, Report on Violence Against Women Survey 2015 (Dhaka, Bangladesh: 2016).

enjoy equal participation as men in household decision making. There is a correlation between women who experience GBV and a decreased ability to negotiate using family planning methods, making them more vulnerable to unintended pregnancies.²⁸

Furthermore, as mobility was restricted during COVID-19 pandemic (social distancing and repeated lockdown) for COVID-19 prevention, Bangladesh saw a spike in GBV,²⁹ requiring recognition of the impact that gender has on access to FP and other health services. Although the issues of FP access and coverage were an area of concern before the pandemic, worsening conditions during the pandemic period highlighted the importance of integrating GBV services into current and future pandemic preparedness responses.

²⁸ Pallitto, C. C., Campbell, J. C., & O'Campo, P. (2005). Is Intimate Partner Violence Associated with Unintended Pregnancy? A Review of the Literature. *Trauma, Violence & Abuse*, 6(3), 217–235. <http://www.jstor.org/stable/26636659>.

²⁹ UN Women, *Measuring the Shadow Pandemic: Violence Against Women During Covid-19: Country Report: Bangladesh* (New York: 2022).

Activity 3: Case Study, Discussion, and Presentation

Gendered Barriers and Drivers to Achieving National Goals (20 min.)

STEP 1

Project **SLIDE 24**.

Ask participants to turn to the **Case Studies on PAGES 27–30 of their Participant's Manual** (pages 53–56 of this Trainer's Manual).

Using a random assignment technique, such as counting off, divide participants into **four small groups**. Assign each group one of the following case studies: Hena, Nazma, Rani, or Mr. Hossain. Instruct participants to read their assigned case study as a group and discuss the three questions beneath the case study. Explain that they will have approximately **10 min.** in their small group before reporting back in plenary.



For Group Discussion

- How does gender influence the power of the people in the story?
- Where do you see gender and power helping achieve FP and SRH?
- Where do you see gender and power being a barrier to good health?

STEP 2

Present **SLIDE 25**.

Remind participants of the following:

While gender norms and power dynamics have significant impact on FP and RH, they are far from the only determinants of service quality and outcomes.

OTHER RELEVANT BARRIERS

- Stock outs
- Lack of funding
- Lack of skilled service providers
- Distance to health service point
- Misinformation in communities
- Opportunity costs
- Service provider bias
- Legislative and legal barriers
- Cultural norms and traditions

Module 1 Tools and Handouts

Case Study 1: Rahima

Rahima (*pseudonym*) is a bright child. She is one of her parents' four children (two boys and two girls). Rahima's mother always dreamed Rahima would be a doctor one day, so she made her all children go to school for primary education. Unfortunately, when Rahima and her elder sister, Aklima (*pseudonym*), passed to fifth and seventh class, her father suddenly told Rahima's mother that, day by day, the education of all their children has become too great a burden. Although they can avail free education, the tutor and other expenses were becoming unbearable for him, so he decided to stop the girls' education. He would only continue with the boy children—to finish their education at least to SSC level, so they can manage to find any primary-level job. He also planned to get the elder daughter married off, so the family could get a better husband (with less dowry-related demand); if they delay, the dowry will be high.

Rahima's mother and the two daughter became very upset hearing this. Although Rahima's mother insisted that she could convince her husband to continue Rahima's education up to class eight, by the time Aklima got married and gave birth to one child, Rahima realized that her fate is going to be the same within a few months.

One fine morning, Rahima woke up from a bad dream—that someone snatched her stethoscope from her neck, stealing this precious belonging that she carried every day and cherished most in her life. To her great dismay, the next morning, her soon-to-be husband gave a flower garland for her neck. Her dream of becoming a doctor became tarnished. She had to start the same cycle of life as her elder sister.

Now, it is almost two years later. Rahima is married, though she is not pregnant yet. Because of her education, she managed to convince her husband and in-laws to continue with an FP method. Still, her dream of having her stethoscope stolen haunts her every night!



For Group Discussion

- 5) What elements of Rahima's story demonstrate the common gender norms and expectations in your communities?
- 6) Do you see examples of the men and women in Rahima's story having different levels or different types of power?
- 7) Do you think that gender norms and gender-specific power influences the FP choices in Rahima's story? Why or why not?
- 8) Do you see examples of GBV in Rahima's story? Why or why not?

Case Study 2: Hena

Hena (*pseudonym*) got married at the age of 14 to Rahim (*pseudonym*), age 35, who lives in the neighboring upazila. Rahim's family is comparatively better off than Hena's family, so they didn't ask for any dowry during the marriage. However, the in-laws started imposing pressure on Hena to become pregnant soon after marriage, which was not resisted by Rahim. In just six months after getting married, Hena became pregnant. Hena was very shy, so she didn't feel comfortable talking to her husband about taking any FP methods. Her first child, a daughter, was delivered at home, assisted by her grandmother-in-law.

Then, within two years, Hena got pregnant again and delivered another girl child. Pressured by her in-law to give birth to a boy child, Hena had to take the risk—to get pregnant a third time by age 19. This time, she started suffering from various pregnancy-related complications.

Luckily, Hena was introduced to an FP field worker who is also a distant relative of Hena's husband. As a field worker, this woman is quite empowered and also very much valued in society for her good work. So, she supported Hena all the way throughout the pregnancy and convinced her in-laws to allow her to take her into the nearby community clinic for a regular checkup. Due to high risk of complications, the CHCP referred Hena to the nearby upazila health complex, where she delivered a healthy boy child. Hena's in-laws and her husband became very happy and started believing in health care checkup for Hena, so allowed her to send for regular postpartum checkups. During these checkups, Hena learned more about FP methods and also other important SRHR information, which helped her to maintain a healthy life for herself and her children.



For Group Discussion

- How does gender influence the power of the people in the story?
- Where do you see gender and power helping achieve FP and SRH?
- Where do you see gender and power being a barrier to good health?

Case Study 3: Nazma

Nazma Begum (*pseudonym*) is an 18-year-old mother of two female children. Her husband is a laborer. Nazma and her husband got married five years ago, when Nazma was 13.

At the time, Nazma's husband demanded a chain of gold, but Nazma's father failed to fulfill the dowry, due to his poverty (Nazma's father is a school teacher, and he has seven daughters and one son). Nazma's husband and mother-in-law tortured her for this. Moreover, they always made her feel guilty for giving birth to two female children. They forced Nazma to conceive a male child. As a result, she is now in her third pregnancy with heavy weakness. She is experiencing acute anxiety at the thought of continuing this pregnancy or not.



For Group Discussion

- How does gender influence the power of the people in the story?
- Where do you see gender and power helping achieve FP and SRH?
- Where do you see gender and power being a barrier to good health?

Case Study 4: Rani

Rani (*pseudonym*), age 25, worked in a house in Mohammadpur, Dhaka. Rani worked day and night to provide for her husband and two children. The house owner and other members treated her well since she had working there for two years. When she got pregnant with her third child, her Madam from work supported her financially, so Rani could get proper treatment. They recommended that Rani visit a health care facility for her antenatal care (ANC) checkup and treatment and took her there to get registered.

Rani took a break from her work during pregnancy but got salary and other benefits from the house owner every month. Then, one day after the ninth month, Rani disappeared with her family. Her husband took her to Gaibandha where his family lives. They did not allow Rani to come back to Dhaka for delivery. They did not consider Rani's decision and opinion. When the time came, one native Daye (TBA) made the delivery at home. During the process, Rani experienced postpartum hemorrhage and died along with her newborn baby.



For Group Discussion

- How does gender influence the power of the people in the story?
- Where do you see gender and power helping achieve FP/SRH?
- Where do you see gender and power being a barrier to good health?

Case Study 5: Mr. Hossain

Mr. Hossain (*pseudonym*) is a well-known, well-respected, mid-aged member of his community of Olipur, Hajigonj. He always inspires people with his speech in the light of Islam. He is also a father of three daughters and one son. However, one day he brought his wife in for menstrual regulation (MR), and the provider noticed this was her ninth MR in five years. The provider congratulated the couple on their healthy family and asked if the couple was using contraception. Mr. Hossain replied that he is against family planning, but he doesn't want any more children, so his wife must take MR.



For Group Discussion

- How does gender influence the power of the people in the story?
- Where do you see gender and power helping achieve good FP and SRH?
- Where do you see gender and power being a barrier to good health?

Module 2: Foundations in GBV



TOTAL MODULE TIME: 3 H. 50 MIN.

- Session 2-A: Understanding and Conceptualizing GBV
- Session 2-B: GBV Risk Analysis in FP and SRHR
- Session 2-C: Male Engagement in GBV Prevention Awareness
- Session 2-D: Understanding GBV in FP and SRH for Adolescents and Youth



LEARNING OBJECTIVES

After completing this module, participants will be able to:

- Articulate the many different forms and manifestation of GBV.
- Understand how GBV is an intersectional issue that can affect anyone regardless of age, marital status, or economic class.
- Communicate the health risks and impacts suffered by those living with GBV.
- Recognize and communicate GBV impacts across the life cycle.
- Identify verbal and non-verbal cues that an FP and SRH client is high risk for current GBV.
- Clarify concepts around male engagement in GBV prevention awareness.
- Articulate the risks and impacts of child, early, and forced marriage and unions (CEFMU) and GBV among young people.
- Understand how national laws impact FP & RH service provision for CEMFU-involved clients.



METHODOLOGIES

- Presentation
- Case Study
- Discussion
- Reflection



MATERIALS NEEDED

- Flipchart and markers
- Trainer PPT Slide Deck 1
- Case Studies 6–8
- Tool C: Vote with Your Feet Statements
- Participant Manual for each participant



ADVANCE PREPARATION

- Review slides and training content
- Review Vote with Your Feet Statements
- Arrange the area, so that there is adequate space for participants to move from one side of the room to the other and post flipchart paper on opposite ends of the room—the one on the right saying “Agree” and the one on the left saying “Disagree”

Session 2-A: Understanding and Conceptualizing GBV



45 MIN.

Activity 1: Presentation and Discussion

GBV—Forms, Patterns, and Health Impacts (45 min.)

STEP 1

Present **SLIDES 26–27** and identify the session's learning objectives:

- Be able to articulate the many different forms and manifestation of GBV.
- Understand how GBV is an intersectional issue that can affect anyone regardless of age, marital status, or economic class.
- Be able to communicate the health risks and impacts suffered by those living with GBV.

STEP 2

Project **SLIDE 28**. Share the following with participants:

Let's look at the definition of gender-based violence again. Within that very broad definition, there are many different forms and types. Particularly impacting FP/SRH is violence against women and girls.

As FP providers, it is critical to be aware of GBV, its various forms, and its impact on clients' health and wellbeing, including on FP and RH. GBV refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. GBV inflicts harm on women, girls, men, and boys. It encompasses:

- *Threats of violence and coercion*
- *Physical or sexual assault*
- *Emotional or psychological harm*
- *Denial of resources or access to services*
- *Denial of legal self-autonomy*

GBV takes many forms. Some forms of GBV are outwardly apparent, such as physical violence, and some are subtler or hidden, such as verbal abuse or reproductive coercion. All forms of GBV are harmful and have a negative impact on an individual's health and wellbeing.

GBV can impact anyone, regardless of class, religion, caste, or ethnicity; however, GBV impacts women and girls far most frequently.

Violence and/or fear of violence can influence a woman or girl's access to FP, as well as her choice of method and ability to use it.

Acts of GBV are perpetrated to gain power and control. In a couple, this can include power over reproduction and the use of FP.

Violence Against Women and Girls (VAWG) refers to any act that is based on gender norms or unequal power dynamics that results in, or is likely to result in, physical, sexual, or mental harm to women, including threats, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life. VAWG can include:

- Intimate partner violence (IPV)
- Sexual assault and rape
- Female genital cutting
- Reproductive coercion
- Forced marriage
- Trafficking
- Denial of education, financial, and legal services

STEP 3

Ask participants to reflect and look back on the vignettes discussed in their small groups during the last session. Ask: *“Do you think any of the case studies we have looked at include one or more of these forms of violence? Which ones? Why?”*

Take **10 minutes** to hear responses.



TRAINER NOTE

For reference, here are the forms of violence by case study:

- Hena's story – reproductive coercion; CEFMU
- Nazma's story – CEFMU; emotional abuse; reproductive coercion
- Rani's story – denial of services; denial of legal autonomy
- Mr. Hossain's story – reproductive coercion

STEP 4

Present **SLIDE 29**.

FORMS AND MANIFESTATIONS OF GBV

Physical

- Hitting, beating, burning, and cutting
- Trafficking
- Acid attacks and honor killings

Social

- Discrimination and/or denial of opportunities
- Denial of education
- Denial of inheritance and/or property rights

Emotional/Psychological

- Abuse and humiliation
- Confinement/isolation
- Intimidation/threats
- Blame for uncontrollable outcomes

Sexual

- Forced Marriage
- Sexual Exploitation/Forced Prostitution
- Rape
- Harassment
- Female Genital Cutting

Present **SLIDE 30**.

REPRODUCTIVE COERCION

Reproductive coercion is a complex form of VAWG that can be perpetrated using physical, sexual, psychological and/or social violence, most commonly through a combination of these forms. Examples include:

- Repeated shaming and blaming of a woman until she gives birth to a son.
- Forcing a women or girl to undergo MR to avoid pregnancy.
- Throwing away contraceptive pills or condoms.
- Using a pin to put holes in condoms.
- Denying a women freedom of movement and/or access to resources to access FP

Emphasize the following to participants:

***Reproductive coercion** can be very explicit and direct, such as contraceptive sabotage or directly refusing to allow a woman to go to a FP appointment, refusing to take her for MR, forcing a woman to have unprotected sex when she is fertile, etc.*

It can also be more indirect, using forms of social and psychological/physical violence, such as patterns of humiliation and abuse against women who do not demonstrate fertility early and frequently.

Present **SLIDE 31**.

BANGLADESH'S NATIONAL PREVALENCE OF GBV

VAW in Bangladesh Facts

2017 study | total 1,143 victims³⁰

- 63.78 percent belong to age group of 16–30 years, and 19.16 percent belonged to the age group of 1–15 years.
- Regarding the marital status of victims, 71.91 percent were married, and 25.63 percent were unmarried.
- Most of the victims (60.37%) were “housewives” followed by “others” (11.46%), “students” (11.11%) and “maid servants” (10.85%).
- Most of the perpetrators were “husbands” (64.65%) followed by the “known person” (14.00%), neighbors (13.30%), “lovers” (3.15%), “house master and mistress” (2.62%), and “in-laws and others” (2.27%).

Report on VAW Survey 2015³¹

- 72.6 percent of ever-married women experienced violence by their husband at least once in their lifetime.
- 27.8 percent of women reported lifetime physical violence by someone other than their husband.
- The lifetime rates of emotional and sexual violence are 28.7 percent and 27.2 percent, respectively.

³⁰ Nashid Tabassum Khan, et. al., “Violence against Women in Bangladesh.” *Delta Med Col J.* Jan 2017; 5 (1):25 – 29.

³¹ Bangladesh Bureau of Statistics, Statistics and Informatics Division, Ministry of Planning. *Report on Violence Against Women Survey* (2015).

Present **SLIDE 32**.

UNITED NATIONS DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN

Declaration adopted December 1993:

Article 1

For the purposes of this Declaration, the term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life.

Article 4

States should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence against women.



REFERENCE: CEDAW RECOMMENDATIONS

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW)

General Recommendation No. 19, January 1992:

Article 1

The definition of discrimination [against women] includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty.

From Article 16 (and Article 5)

Lack of economic independence forces many women to stay in violent relationships.

For the full General Recommendation, visit ohchr.org

Present **SLIDE 33**.

BANGLADESH NATIONAL LAWS AND COMMITMENT

- In 2014, Bangladesh made a commitment to ending child marriage in the country by 2041.
- Multiple facets of the penal code provide for severe punishment in cases of specific forms of GBV, including acid attacks, femicide to gain new or increased dowry, and denial of child custody.
- Signatory to international conventions include ICPD and the UN Special Declaration against Violence against Women.
- Marital rape is exempt from legal prosecution, except cases where the wife is below age 13.

Share the following with participants:

It is important to note that the legal framework regarding marital rape in Bangladesh is complex and contradictory. All laws confirm that intimate relations between spouses when the wife is under the age of 13 is rape.

It is also clear that marital rape is not criminalized in Bangladesh when the wife is of legal age to be married (18). However, for married adolescents ages 13–18, it is unclear what level of legal protection they may have. As health providers, what you need to know is this:

- *All women, regardless of age or marital status, are entitled to access emergency contraception services.*
- *All girls under the age of 18 are legally entitled to refuse marriage.*

Session 2-B: GBV Risk Analysis in FP and SRHR



45 MIN.

Activity 1: Presentation, Discussion

Introduction and Learning Objectives (15 min.)

STEP 1

Present **SLIDE 34**, highlighting the following learning objectives:

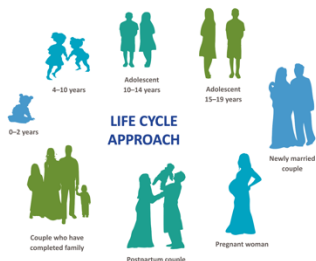
- Recognize and communicate GBV impacts across the life cycle.
- Identify verbal and non-verbal cues that an FP and SRH client is high risk for current GBV.

STEP 2

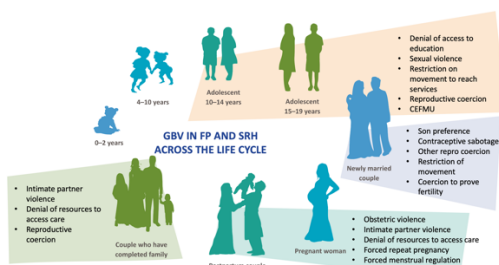
Project **SLIDE 35** and ask participants:

“Can you name a gender or GBV-based FP/SRH service access barrier at each stage of a client’s lifecycle?”

Take **5–10 minutes** for discussion, then advance to the next slide.

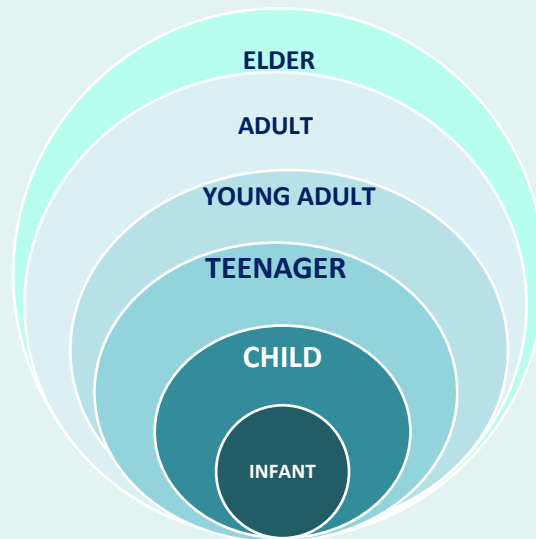


Present **SLIDE 36**.





REFERENCE: GBV ISSUES ACROSS THE LIFE CYCLE



INFANT: Female feticide, sex-selected abortion, infanticide, mal/undernourishment by withholding nutritious food, medical care withheld.

CHILD: Little or no schooling, child labor, child prostitution, physical abuse, neglect, sexual abuse, molestation, abusive 'teasing' by sibling.

TEENAGER: Coerced sexual initiation, rape, forced marriage to parent's choice, much older man, teen's rapist; ignorance about sex, anatomy, and sexual health; control over sexuality and sexual orientation; trafficking; forced into prostitution; cyber stalking by boyfriend or unknown predators; date violence; harassment; public lewdness; and sexual harassment by extended family, teachers, coaches, peers.

YOUNG ADULT: Date violence; drug-facilitated rape; rape, including wartime rape; denial of choice of marriage partner and/or sexual orientation; dowry-related deaths; intimate partner violence; sexual harassment at work, college.

ADULT: Domestic violence, same-sex domestic violence, violence by father-, mother-, sisters-, brothers-in-law and natal family members; sexual abuse, including marital rape, forced to watch and imitate pornographic acts, extreme sexual neglect or coldness; economic abuse, including ruined credit or gambling; isolation, permanent or temporary abandonment; battery during pregnancy; coerced into criminal activity; extreme exploitation of household labor; sexual harassment by employers, other employees, fathers-, brothers-in-laws, clergy, therapists, doctors; victim-blaming and rejection by community; forced into unprotected sex; infected with STIs, HIV; denying mothers access to custody of children, abduction/kidnapping; intimate homicide, femicide, and honor killings; withholding adequate food, clothing, daily necessities; stalking, cyber stalking.

ELDER: Physical abuse by adult children, caretakers; spousal abuse; exploitation of household labor; childcare; withholding health care, medications, daily necessities; demeaning widowhood; and coerced suicide pacts or mercy killings.

Present **SLIDES 37–38**.

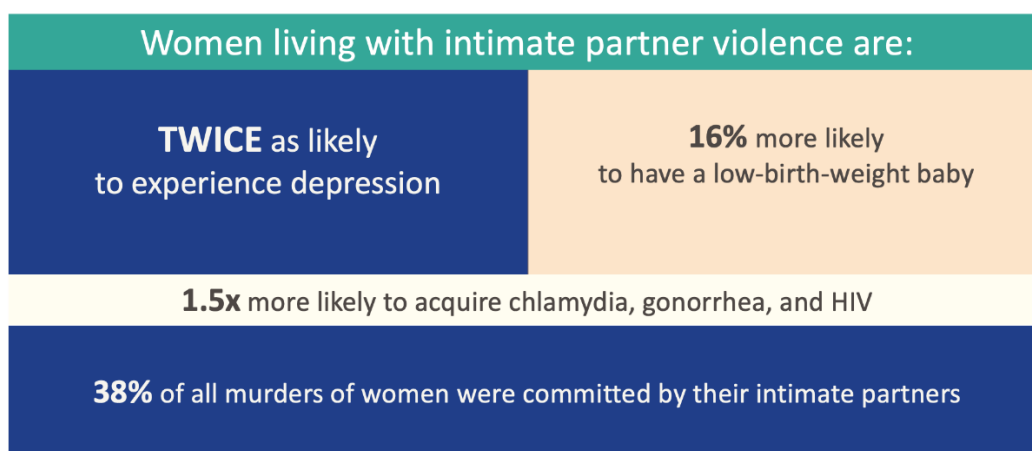
GBV IMPACTS ACROSS THE LIFE CYCLE

Mental health impacts: e.g., depression, anxiety, flashbacks, substance abuse, and suicidal ideation.

SRH impacts: e.g., unintended pregnancy, HIV, STIs, cervical cancer, miscarriage, pre-term labor, and stillbirth.

Physical impacts: e.g., broken bones, contusions, internal bleeding, malnourishment, and death.

Social impacts: e.g., school dropout, unemployment, isolation, limited contribution to civil society, and poverty.



Source: WHO, *Caring for women subjected to violence: a WHO curriculum for training health-care providers, revised edition* (Geneva: 2021).

STEP 3

Present **SLIDE 39**.

WHAT CAN GBV LOOK LIKE IN FP AND SRH?

- A woman in the postpartum ward who waits until her mother-in-law has gone outside to ask about PPF
- An FP client who frequently has bruises on her face or wrists when she comes for refill appointments
- An adolescent girl who doesn't speak for herself when brought by a parent for MR
- A FP client who asks if there are options that her husband cannot throw away
- An IUD client who returns with her partner soon after insertion asking for removal

Remember: Living with GBV is different for everyone! Never force a disclosure. Never assume someone is immune to GBV.

Activity 2: Reflection

Our Lived Experience (30 min.)

STEP 1

Introduce the reflection activity to participants. Remind everyone of confidentiality and other *Do No Harm* principles, as well as group norms related to self and collective care. Let participants know that there will be a lunch break following this activity and all facilitators are available during the break if anyone would like to speak further and/or privately about challenges they are facing.

STEP 2

Invite participants to share their experience as providers. Encourage participants to share—by show of hands—experiences they have had in their course of work as an FP provider with clients living with GBV, suspecting but not being able to confirm GBV, or providing care and/or referrals to a client who has experienced GBV. Remind participants not to share identifying information about clients and to focus on sharing personal experiences, not the experiences of colleagues. Ask participants to keep the stories brief (**2-4 minutes**) so that anyone who wishes to share has time. No one is obligated to share.

STEP 3

Wrap up and emphasize the following:

Universal sharing of GBV referral options is a best practice. Many women living with GBV show no warning signs and will not choose to disclose.

On Day 2, you will have further opportunity to practice encouraging disclosure in these types of client encounters through role play and vignettes.

LUNCH BREAK before continuing to next session.

Session 2-C: Male Engagement in GBV Prevention Awareness



30 MIN.

Activity 1: Presentation

Introduction, Learning Objectives, and Foundation (20 min.)

STEP 1

Present **SLIDE 40**, highlighting the session's learning objectives:

- Clarify concepts around male engagement in GBV prevention awareness, including pros and cons, challenges and successes, and evidence.

Present **SLIDE 41–46**, further illustrating why male engagement in GBV prevention is important.

LOOKING AT MEN FROM A DIFFERENT PERSPECTIVE

- Men have the status and power to help change social and behavioral norms to end the abuse of women
- Men play many roles in society that place them in positions to discourage the abuse of women—as fathers, judges, police officers, community leaders, husbands, sex partners, health care providers, policy makers, and community advocates/positive influencers.

POTENTIAL ROLE OF MALE ENGAGEMENT TO IMPROVE WOMEN'S FP AND SRHR STATUS



“Engaging men and boys as users, supportive partners, and agents of change improves health outcomes. More specifically, engaging men in FP/RH programs has been successful in decreasing unintended pregnancies, improving maternal health, reducing sexually transmitted infections (STIs) and HIV/AIDS, and better meeting the needs of youth.”³²

Engaging men in FP can be beneficial for contraceptive access, use, and continuation. When done correctly, male engagement has been shown to promote positive couple’s communication and cooperative decision making. When men are engaged in constructive ways—as FP users, supportive partners, and agents of change—it can improve both health and gender outcomes. Evidence has shown that engaging men in FP and RH programs has been successful in decreasing unintended pregnancies, improving maternal health, and reducing STIs, including HIV.

³² Breakthrough ACTION. *Advancing male engagement in family planning and reproductive health: An advocacy tool*. Johns Hopkins Center for Communication Programs (Baltimore: 2018).

BENEFITS OF MALE ENGAGEMENT IN SRHR

- Male engagement can reduce the spread of HIV and AIDS and sexually transmitted infections.
- Male engagement can lessen the ill effects of men's risky sexual behavior on the health of women and children.
- Men and husband, in most cases, approve of FP.
- Men make decisions that affect women's and men's health.
- Men can gain awareness that gender affects sexual behavior, reproductive decision-making, and reproductive health.
- Male engagement can help meet demands from women for more involvement.
- It provides opportunities for men to promote better RH, and they can play a role.
- As individuals, men benefit from intentional family building and chosen timing and spacing of children.
- As family members, men honor their responsibilities to care for their wives and children by only having children and when safe and healthy for the family.
- As community leaders and policymakers, men support strong, thriving communities by encouraging intentional FP and health timing and spacing of pregnancies.

RISKS OF MALE ENGAGEMENT

- Already imbalanced power over fertility and health decisions.
- More attention to men in limited resource setting (human resource, logistics, and client time) can result in unintentional pulling of resources away from women- and girl-centered outreach and services.

ENGAGING MEN IN FP IS A PERSONAL ISSUE^{33,34}

- Check your assumptions.
- Understand power dynamics.
- Own the reality: for better or for worse, men are involved.
- Men are underserved, yet many want to be engaged fathers and supportive partners.
- Men are family planning clients and users in their own right.
- Don't count men out from health services.
- Providers need to think about social norms, too.
- Address men even when they are not present.
- Reach men where they are, through their networks.
- Men can and do participate positively in family planning.
- When done right, involving men in family planning yields significant benefits for women and families.

In Safe Motherhood and SRHR, men play many key roles, their decisions and actions make a difference during:

- Pregnancy
- Delivery
- Postpartum period

³³ Faramand TH, Treleaven E. 2012. Integrating Gender in Improvement Activities. Implementation Guide. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

³⁴ MEASURE Evaluation, Male Engagement in Family Planning Indicator Brief, 2018.

Activity 2: Discussion and Presentation

Questions on Male Engagement (10 min.)

STEP 1

Project **SLIDE 47**. Tell participants that it is time to for a pop quiz! Ask participants to call out answers as you read each statement in turn.

STEP 2

If there is not general consensus on the answer, ask 1–2 participants to share why they gave the answer they did. Clarify and correct any misinformation. The correct answer is shown in **green** text below.

MEN: FULL PARTNERS AND ADVOCATES FOR GOOD REPRODUCTIVE HEALTH

- Reaching men is a winning strategy. **Yes / No**
- To encourage sexual responsibility. **Yes / No**
- To foster men's support of their partners' contraceptive choices. **Yes / No**
- To address the reproductive health care of couples. **Yes / No**
- Men play dominant roles in decisions. **Yes / No**
- Men are more interested in family planning than assumed. **Yes / No**
- Need communication and services directed specifically to them. **Yes / No**
- Understanding-and influencing-the balance of power is important. **Yes / No**
- Couples who talk to each other reach better, healthier decisions. **Yes / No**

Session 2-D: Understanding GBV in FP and SRH for Adolescents and Youth



1 H. 10 MIN.

Activity 1: Presentation

Introduction and Learning Objectives (20 min.)

STEP 1

Present **SLIDE 48**, highlighting the learning objectives for this session:

- Be able to articulate the risks and impacts of child, early, and forced marriage and unions (CEFMU) and GBV among young people.
- Understand how national laws impact FP and RH service provision for CEMFU-involved clients.



REFERENCE: BACKGROUND

The term adolescence is derived from the Latin word “adolescere,” meaning to grow, to mature. Adolescence is considered a period of transition from childhood to adulthood, characterized by rapid physical growth. Adolescents are no longer children, but not yet adults.

The term “young people” includes girls and boys aged between 10 and 24 years, spanning the periods defined as adolescence (10 to 19 years) and youth (15 to 24 years). Young people make up a significant proportion of countries’ populations and comprise 16 percent of the global population.³⁵

³⁵ “Youth,” United Nations, accessed Feb 3, 2023, www.un.org/en/global-issues/youth

STEP 2

Present **SLIDE 49**.

ADOLESCENTS AND YOUTH: BASIC CONCEPTS

Age Groups

- Adolescents: 10–19 years
- Youth: 15–24 years
- Young People: 10–24 years

Child, Early, and Forced Marriage and Unions (CEFMU)

Child and early marriage are any marriage in which one of the parties involved is below the age of 18. Forced marriage and unions refer to any union in which one party did not consent—regardless of their age. This term includes both formal, legal marriages, and as well informal union and cohabitation.

Present **SLIDE 50**.

Essential Elements of Comprehensive SRH Services for Young People³⁶

- Provision of a full range of contraceptive information and supplies, including emergency contraceptives.
- Counseling and information services on FP, pregnancy, and the prevention and treatment of STIs, HIV and AIDS, and reproductive tract infections (RTIs).
- Basic equipment for provision of reproductive health services (e.g., FP, ANC, and laboratory testing for STIs/RTIs).
- Services that cater for interrelated issues, such as mental health, nutrition, sexual abuse, and GBV.
- Capacity to accommodate the needs of young people with special needs.
- A referral system.

The issues that affect young people's SRH status can be complex and often interrelated.

³⁶ WHO. *Core competencies in adolescent health and development for primary care providers: including a tool to assess the adolescent health and development component in pre-service education of health-care providers* (Geneva: 2015).



REFERENCE: INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD)

The Program of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Platform for Action of the Fourth World Conference on Women (FWCW) held in Beijing in 1995 drew the attention of policymakers to the needs and rights of the world's adolescents.

Declarations urged that governments, nongovernmental organizations (NGOs), and the private sector to prioritize programs, such as education, income-generating opportunities, vocational training, and health services for adolescents, including services related to SRH. At ICPD, government representatives agreed that to the following:

From ICPD Program of Action paragraph 7.3:

“Full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.”

Present **SLIDE 51**.

CONCEPTUALITY OF CHILD MARRIAGE

According to BDHS 2017–18, 71% of women ages 20–49 were married by age 18, and nearly one-third (31%) of women 20–49 reported that they had married by age 15.

The current law in Bangladesh that addresses child marriage is the Child Marriage Restraint Act, 2017 (CMRA), which repealed the earlier British law of 1929. The Act sets the minimum age of marriage for a male as 21 years and for a female as 18 years. This refers to both formal marriages and informal unions in which children under the age referred with a partner as if married.

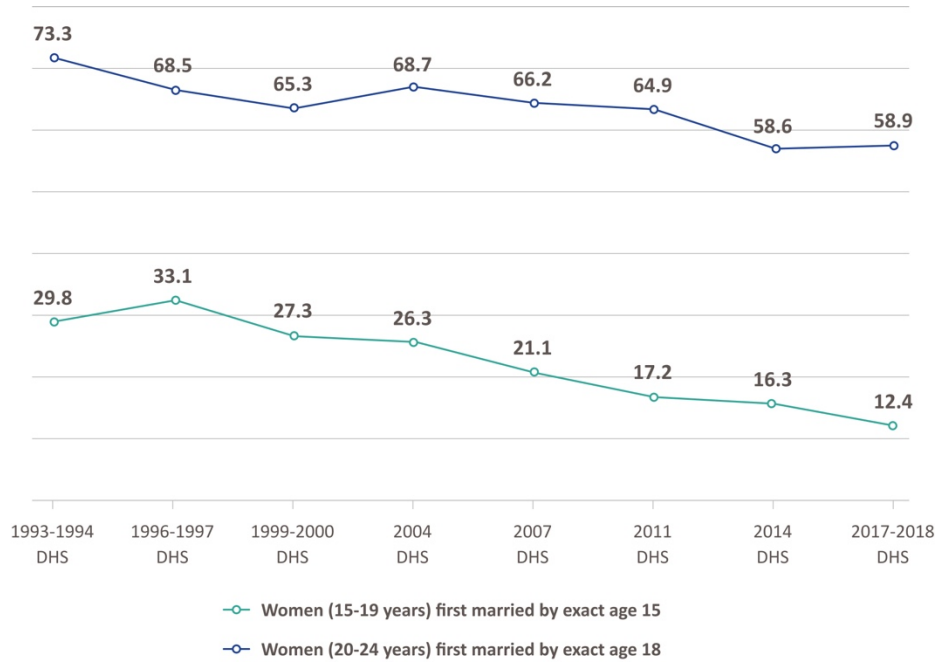
To address Bangladesh's child marriage situation, the Prime Minister of Bangladesh made the following commitments in 2014:

- Create a National Plan of Action by the end of 2014 (prepared in 2018).
- Revise the Child Marriage Restraint Act 1929 (revised in 2017).
- End the marriage of under 15-year-olds and reduce, by one third, child marriage under 18 years by 2021.
- Eradicate child marriage from the country by 2041.

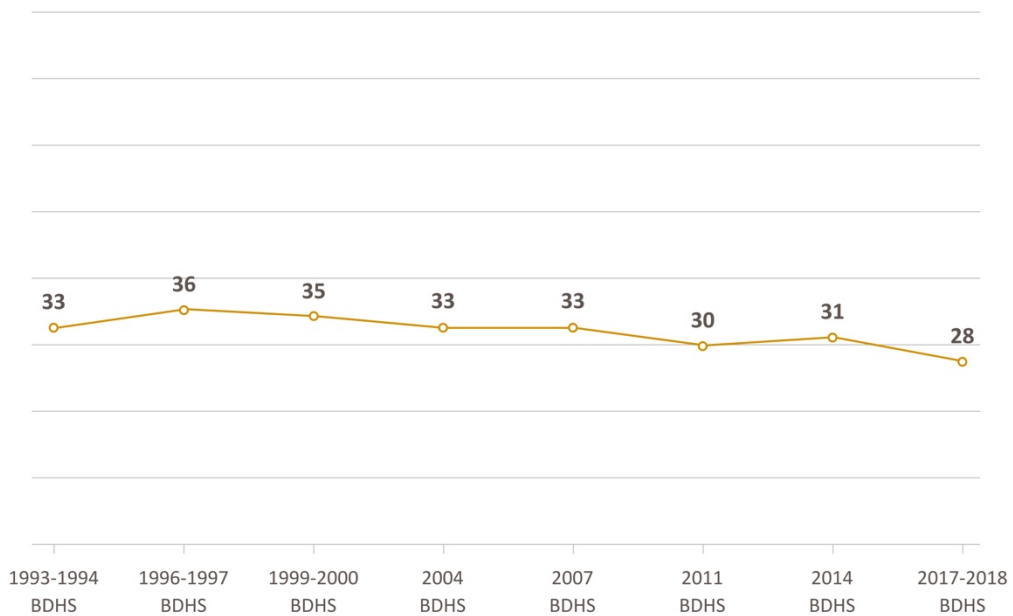
Present **SLIDES 52–53**.

NATIONAL TRENDS RELATED TO ADOLESCENT AND YOUTH SRH

Trends (%) of Child Marriage in Bangladesh, 1993–2017 (Source: BDHS)



Teenage Childbearing in Bangladesh (Source: BDHS)



DRIVERS OF ADOLESCENT CHILDBEARING

- Social stigma and poverty.
- After giving birth, the status of girls' and boys' (wife and husband) may improve.
- Lack of girls' individual identity/empowerment/agency.
- Barriers to contraceptive access and use among adolescent girls (unmet needs).
- Misconceptions around contraception.
- Familial and social pressure, and insecurity.
- Presumptions of infidelity and/or extra marital relationship.



REFERENCE: EXISTING LAWS TO ADVANCE AYRH AND RIGHTS

- **The Dowry Prohibition Act of 1980** made the taking and giving of dowry an offense punishable by fine and imprisonment.
- **The Cruelty of Women Act (Deterrent Punishment Act of 1983)** provides punishment by death or life imprisonment for the kidnapping or abduction of women for unlawful purposes, trafficking women, or causing death or attempting to cause death or grievous injuries to wives for dowry.
- **The Child Marriage Restraint Act** ruled that, for marriage, the age of females should be minimum 18 years and for male's minimum 21 years (2017 6 No. Act).
- **The Muslim Family Ordinance, 1961 (Amended in 1985)** regulates certain aspects of divorce, polygamy, and inheritance.
- **The Penal Code (Second Amendment Ordinance)** provides capital punishment for causing grievous injuries or acid throwing.
- **The Family Court Ordinance 1985** deals with causes of marriage and divorce, and the maintenance, guardianship, and custody of children.
- **The Correctional Home for Juvenile Offenders (Ordinance 1974)** provides rehabilitation programs for adolescent offenders under the supervision of magistrate.
- **The Penal Code 1860 (Sections 312–314)** permits abortions only for saving the life of expectant mothers.
- **The Anti-terrorism Ordinance of 1992** provides punishment for all types of terrorism including teasing through making mockery of women or abducting children and women.

Activity 2: Discussion

SRHR Service Needs of Adolescents and Youth (20 min.)

STEP 1

Project **SLIDE 54**. Ask participants to turn to **page 45 of their Participant's Manual**. Tell participants they can make notes in their manual through the discussion and keep the page as a reminder/reference after the training.

STEP 2

For each classification of health need, ask for volunteers to share how common a need they think it is among adolescents and youth and why. Request 1–3 comments for each type of service need. Check marks in **green** in the table below indicate the actual prevalence of these needs at a national level in Bangladesh.

Let's make a list of the SRHR service needs of adolescents and youth

Type of Service Needs	Most Common	Sometimes	Rare Need	GBV as Driver — Y/N
Malnutrition		✓		
General health problems (e.g.: viral infection, bacterial illness, asthma, UTI)	✓			Y
Menstrual problems	✓			Y
Mental health issues (e.g.: depression, anorexia, sexual identity questions)	✓			Y
Contraception		✓		Y
Emergency contraception and menstrual regulation		✓		Y
Sexually transmitted infection		✓		Y
Addictive behaviors			✓	Y
Physical trauma (e.g.: broken bones, contusions, lacerations)		✓		Y
Sexual abuse and assault response		✓		Y

Activity 3: Case Studies

GBV and FP Experiences of Adolescents and Youth (30 min.)

STEP 1

Project **SLIDE 55**.

Ask participants to turn to the **Case Studies on pages 46–48 of their Participant's Manual** (pages 83–85 of this Trainer's Manual).

Using a random assignment technique, such as counting off, divide participants into **three small groups**. Assign each group one of the following case studies: Meena, Parvin, and Khadija. Instruct participants to read their assigned case study as a group and discuss the prompts/questions:



In your group, prepare to present the following:

- Key facts of the vignette
- How was the case first noticed in the FP/SRH clinic?
- What are your gender- and GBV-relevant observations?
- What are the solution points you considered—to handle the case?

Explain that they will have approximately **10 min.** in their small group before presenting their feedback in the plenary. Allow **15 min.** group work and **15 min.** for plenary presentation/discussion.

Session 2-E: Day 1 Wrap Up



40 MIN.

Activity 1: Reflection

Vote with Your Feet (30 min.)

STEP 1

Place the words “Agree” and “Disagree” at opposite ends of a room (or shared whiteboard if conducting the exercise in a virtual environment).

Project **SLIDE 56**.

STEP 2

Ask the group to stand in the center of the room. Explain that you are going to read a statement aloud (**Tool C: Vote with Your Feet Statements on page 83 of this Trainer's Manual**). Tell the participants to vote with their feet by moving to stand under the “Agree” sign or the “Disagree” sign.

Participants may stand anywhere—from an edge next to one of the words to the exact middle of the room. Proximity to “Agree” or “Disagree” should align to the strength their belief. Some participants may be conflicted and choose to stand in the middle of the room.

STEP 3

Read the first statement twice, making sure everyone heard it. Ask participants to move themselves to where they personally fall on the spectrum.

STEP 4

After everyone chooses whether they agree or not, ask 2–3 participants from each side to explain why they voted the way they did. Facilitate a brief discussion on their reasons.

STEP 5

Read more statements, following the same process, and ensuring enough time for discussion. Based on time available and amount of discussion, you are likely to get through 6–8 statements. A greater number of statements are provided here, so you may choose which statements are most relevant based on how the day has unfolded. Prioritize allowing for reflective discussion even if it means you are not able to read out all the statements.

STEP 6

Debrief the activity by explaining the following:

- *There is no right answer.*
- *Power dynamics, values, and beliefs are complicated.*

Activity 2: Presentation

Takeaways and Closing Questions (10 min.)

STEP 1

Present **SLIDE 57**, highlighting the following **KEY TAKEAWAYS** from the first day of training:

- Gender is socially constructed and gives everyone habits, values, biases, and assumptions.
- GBV affects 2–3 women in Bangladesh and has significant impacts on FP and SRH outcomes.
- People from all walks of life and of all ages experience GBV.
- Reproductive coercion is GBV.
- Addressing GBV is something men and women can and should tackle together.

STEP 2

Give participants a preview of Day 2, emphasizing the following:

Now that you have a better understanding of GBV, how it impacts FP and SRH services and outcomes, and the needs many of your clients, you will have a chance to learn and practice skills for identifying cases, making referrals, and documenting.

STEP 3

Project **SLIDE 58**.

Ask if there are any questions before ending the training for the day.

Module 2 Tools and Handouts

Case Study 6: Meena

Meena (*pseudonym*) was 16 years old when her parents decided to get her married. Her groom was a 22-year-old CNG driver in Ukhiya, Cox's Bazar. Meena's wedding date was determined according to the last day of her period. Meena wanted to complete her HSC, so she didn't want to be a mother so soon. She asked for advice from her close aunts and relatives. They advised her to take contraceptive pills before the wedding night but did not give her information about what these pills were or how they worked. When she shared the matter with her husband, he bought a random pill for her without a prescription. Meena got pregnant soon after marriage and faced painful side effects from the pills she was taking. She had a complicated pregnancy and faced early labor. After her delivery, she was traumatized to have a second child in the future. Meena wanted to pursue her study and wait to have another child until completing her schooling. Her husband got angry after hearing about her taking a FP method and abused her badly. Her in-laws were also negative; they believe her duty is as a mother now.



In your group, prepare to present the following:

- Key facts of the vignette
- How was the case first noticed in the FP/SRH clinic?
- What are your gender- and GBV-relevant observations?
- What are the solution points you considered—to handle the case?

Case Study 7: Parvin

Parvin (*pseudonym*) was a bright student studying in class 7 at Naf High School. Due to the family's vulnerable financial situation, she got married early. She wanted to study after marriage and complete her school. But her mother-in-law insisted she become a mother first and started torturing Parvin every day. Her husband and family members were against Parvin.

Parvin went to her school teacher who used to work at an FP service center part-time. After hearing Parvin's situation, her teacher reached out to her family and husband. The teacher made them understand that Parvin is only 13 years old, and she might not be able to survive if she gets pregnant. The teacher explained that if Parvin uses a method now, she will still be able to become pregnant in the future. But for now, her body is not ready for her to be a mother.

After this counseling, Parvin's family agreed to delay starting the next generation until Parvin is 18 and followed the counselor's referral to go to a clinic and get an FP method for Parvin to take for the next five years. The FP provider also gave information on other risks from child marriage and encouraged delay in sharing a marriage bed and that the family should help Parvin complete her studies.



In your group, prepare to present the following:

- Key facts of the vignette
- How was the case first noticed in the FP/SRH clinic?
- What are your gender- and GBV-relevant observations?
- What are the solution points you considered—to handle the case?

Case Study 8: Khadija

Khadija (*pseudonym*) got married at the age of 16. Now, at 20, she is a mother of two children. When the FP service providers reached Khadija's village, Khadija got to know about FP methods and received the required consultation. When Khadija expressed her wish not to have a child for the next few years, the provider suggested taking a long-acting reversible contraceptive method (IUD/Implant) to prevent pregnancy.

Khadija's husband supported her decision, but her mother-in-law wanted more grandchildren. Khadija and her husband then took her mother-in-law to FP center for consulting. There, the counselors described to her how a back-to-back pregnancy harms a women's body, and that a women's body needs time to heal. Khadija's mother-in-law started to listen to the fact and, once she understood, Khadija took a long-term method and lives peacefully.



In your group, prepare to present the following:

- Key facts of the vignette
- How was the case first noticed in the FP/SRH clinic?
- What are your gender- and GBV-relevant observations?
- What are the solution points you considered—to handle the case?

Tool C: Vote with Your Feet

Trainer's discussion facilitation points are included below each statement in **green**.



TRAINER NOTE

This values clarification exercise can be very personal and uncomfortable for some participants. To introduce the exercise and to diffuse tension, here are some neutral, non-GBV-related statements to use as needed:

- I would rather ride a bike a mile than walk a mile.
- I love to cook.
- I am a good dancer.

INTRO STATEMENTS

1. Sex and gender are the same thing. They can be used interchangeably.

Sex and gender are distinct terms and should not be used interchangeably. Sex is determined by biology and reflects the genetic, anatomical, and physiologic make up of an individual. A person can be male, female, or intersex. Gender is defined and created by social norms and applied roles and values. Any person of a nondominant gender (in almost all geographies, this will mean women or non-binary genders) is at greater risk of gender-based violence.

2. In patriarchal societies, women's gender norms and roles are harmful.

While in many patriarchal societies, women's gender norms and roles can be harmful, such as when they create inequity or limit access to education or health care, there are always both positive and harmful norms for every gender identify. For example, the gender norms for women and girls that encourage social networks, sharing of problems and emotions, and validate sadness and grief are healthy norms.

3. I am comfortable talking about gender-based violence.

Gender-based violence can be a very challenging subject to discuss, even for individuals who work on related topics or provide related services on a regular basis. Any given day or week may be particularly difficult based on personal history, memories, events, and family circumstance. **IT IS ALWAYS OKAY TO TAKE A BREAK, DECLINE TO SPEAK, EXCUSE YOURSELF, AND ASK FOR SUPPORT.**

GBV STATEMENTS

4. As a health care worker, how I care for a woman who has suffered violence from a partner or is being pressured into a specific reproductive decision will not make much difference.

Women subjected to violence often do not disclose their experience of violence to anyone because of fear of being blamed or stigmatized or that no one will believe them. As a health care provider, even if a woman does not disclose violence to you, studies show that such women are more likely to seek health care for a range of related conditions. Hence, you are likely to encounter survivors of violence. Women also indicate that an empathic response from a health-care provider can gain their trust for disclosing their experience. Therefore, an empathetic,

validating, and nonjudgmental response to a survivor is very important to the survivor and to putting her on a path to healing.

5. Violence against women is a private matter and should not be discussed publicly.

Violence against women is a public health issue with grave effects on the health of women and families. There are economic impacts as a result of the need to treat and respond to women's health impacts, as well as the negative impact on survivors' economic productivity. There are also compounding effects on children/witnesses of violence who may become violent themselves, drop out of school, or otherwise be unable to lead productive lives as a result of the violence to which they were exposed. At the same time, individual experiences of violence are deeply private, and confidentiality can be critical to the ongoing survival of a person living with GBV.

6. A man is entitled to have sex with his wife whenever he wants.

Every woman has the right to bodily integrity and the right to refuse sex. In many settings, however, gender norms socialize women and men into believing that once you are married, the man is entitled to have sex with his wife whenever he wants. In fact, in many countries, forced sex with your spouse is not considered to be rape. However, women always have the right to control their own bodies and sexuality, and this means that they can say "no" to sex with their husbands.

7. Women are just as violent as men in relationships.

The few population-based studies that have examined women's perpetration of violence have found that the level of violence experienced by men at the hands of their female partners is much lower than violence experienced by women at the hands of their male partners. The violence perpetrated by women is less likely to result in physical injuries, and often the violence is in response to violence perpetrated by the men. Violence by men against women is also more likely to include sexual violence.

8. Most women are abused by strangers. Women are safer when they are at home.

Studies show that, in most settings, most perpetrators of sexual abuse are known to the survivors. Moreover, intimate partner violence—that is, physical and/or sexual violence—is the most common form of violence experienced by women. Therefore, unfortunately for many women, home is not necessarily a safe space.

9. Women who work outside the home in conservative areas are provoking sexual harassment or assault.

There is never any excuse or justification for rape or any type of violence. Women who are abused should never be blamed or told that it is their fault.

10. If a woman stays with a violent partner, it is her fault.

There are many reasons why a woman might stay with a violent partner. It is not our place to judge these women. In fact, leaving a violent relationship can result in increased risk of violence from a controlling, violent partner. Other reasons, such as economic dependence and social pressures not to break up the family, can prevent a woman from leaving her violent partner.

11. A sex worker cannot be raped.

The fact that a person sells sex for a living does not mean that she/he is always ready and willing to have sex. Rape is the act of forcing someone to have sex without their consent. Sex workers are often forced to have sex because of the stigma that they are always available for sex. Even clients and potential clients can force sex workers to have

sex. If someone has sex with you once, even when you paid for it, she/he does not necessarily have the right to have sex with you again without your consent.

12. Men who have sex with men do not experience gender-based violence.

Gender-based violence is defined as “Any act, omission, or conduct that is perpetuated against a person’s will and that is based on socially ascribed differences (gender) between males and females.” Men who have sex with men defy the socially ascribed roles for males and females and, as a result, may experience abuse and violence. This is considered a form of gender-based violence, although it is more precisely described as violence on the basis of sexual orientation.

Module 3: GBV-Responsive FP and SRH Service Provision



TOTAL MODULE TIME: 3 H. 30 MIN.

- Session 3-A: GBV-Responsive Counseling in FP and SRHR
- Session 3-B: Responding to Disclosures of GBV
- Session 3-C: Making GBV Referrals



LEARNING OBJECTIVES

After completing this module, participants will have learned:

- The difference between universal counseling versus selective screening for GBV.
- The pros and cons of different FP methods for clients living with intimate partner violence (IPV) and/or reproductive coercion.
- How to demonstrate active listening during client-centered counseling.
- To explain the purpose and value of psychological first aid.
- The role of quality disclosure response in FP settings.
- Be able to deliver the first three steps of the LIVES approach to first line response.
- When and how to provide referrals for comprehensive first-line response to GBV.



METHODOLOGIES

- Presentation
- Role Play/Skills Practice
- Case Study
- Discussion



MATERIALS NEEDED

- Flipchart and markers
- Trainer PPT Slide Deck 2
- Participant manual for each participant
- Index Cards and string for Web of Referral Activity



ADVANCE PREPARATION

- Review slides and training content
- Review Skills Practice / Role Plays 1–7
- Prepare Web of Referral Activity Cue Cards

Session 3-A: GBV-Responsive Counseling in FP and SRHR



1 H. 30 MIN.

Activity 1: Presentation

Learning Objectives, Concept of Counseling, and Active Listening (20 min.)

STEP 1

Present **SLIDES 1–2**. Welcome participants and review the day’s objectives, including:

- Develop foundation skills in GBV-responsive FP and SRH service provision, disclosure response, and referrals to comprehensive GBV services.
- Develop knowledge and foundation skills on GBV case recording, reporting, and referral confirmation.

Present **SLIDES 3–4**. Introduce Session 3-A, letting participants know that they can expect to learn the following:

- The difference between universal counseling versus selective screening for GBV.
- The pros and cons of different FP methods for clients living with intimate partner violence (IPV) and/or reproductive coercion.
- How to demonstrate active listening during client-centered counseling.



REFERENCE: GBV IN THE CONTEXT OF SRH

Reproductive Health as defined by WHO:³⁷

“Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”

³⁷ “Reproductive Health,” World Health Organization, accessed February 3, 2023, <https://www.who.int/southeastasia/health-topics/reproductive-health>.

Present **SLIDES 5–8**.

Concept of Counseling

- A two-way interaction between a client and a provider.
- An interpersonal, dynamic communication process that involves a kind of contractual agreement between a client and a counselor who is trained to an acceptable standard and who is bound by a code of ethics and practice.
- A process of dialogue and mutual interaction between counselor and counselee aimed at facilitating problem-solving, motivation, and decision-making of the counselee.
- Requires empathy, genuineness, and the absence of any moral or personal judgment.

PRINCIPLES OF CLIENT-CENTERED COUNSELING

- Privacy; ensure audio and visual privacy.
- Take sufficient time.
- Maintain confidentiality.
- Ask the client about their priorities. Listen to their answer.
- Keep it simple; use common language. Avoid overly scientific/technical words.
- First things first: do not cause confusion by giving too much information.
- Say it again; repeat the most important information at the beginning, in the middle, and the end.
- Use available visual aids, like posters and flip charts, etc.
- Seek feedback from the client.

SUMMARY OF TIPS FOR COUNSELING WITH ACTIVE LISTENING

It is important to:

- Use eye contact, as long as this is culturally acceptable in your particular setting. It shows interest.
- Use open-ended questions. They allow clients to express themselves.
- Check your understanding by summarizing (paraphrasing).
- Nod and use acknowledgment sounds that convey your interest and keep the conversation flowing, but avoid unnecessarily interrupting your client.
- Use a tone of voice that shows interest.
- Listen for feelings as well as facts.
- Limit active note taking and verbally communicate to the client why you are writing things down as they speak.

Do not:

- Interrupt the client unnecessarily.
- Finish the client's sentences.
- Let your mind wander and spend listening time formulating your responses or thinking about your dinner!



REFERENCES:

TIPS FOR GENDER-SENSITIVE FP COUNSELING

- Protect the client's privacy and confidentiality.
- Ensure that counseling is done in a room where others cannot see or hear.
- Do not announce to the waiting area what services the client is at the clinic for.
- Sit at eye level with the client.
- Welcome the client warmly.
- Ask open-ended questions.
- Do not do all the talking.
- Ask about the woman's relationship with her partner. Under no circumstances should a woman be denied contraception or a contraceptive method because her husband has not approved.
- Emphasize the importance of healthy timing and spacing of pregnancy.
- Do not let your own values and biases affect the consultation.
- Provide accurate information, never give wrong information, and if you do not know something, say you do not know (and will find out).
- Use simple words.
- Encourage the client to ask questions.
- Use visual aids (e.g., a picture, flipchart) if available, or show a person how to do a task as you explain.
- Listen carefully to what is said and repeat back to make sure you have understood correctly.

SPECIFIC STEPS TO FOLLOW PROVIDING GBV COUNSELING IN AN FP SETTING

- Listen to a survivor's story.
- Respond to a survivor's story.
- Assess specific needs.
- Determine how a survivor wants to proceed.

CHECKLIST: INTRODUCTION AND ENGAGEMENT

- Greet and comfort the survivor in a warm and open way
- Introduce yourself and your role
- Discuss all aspects of informed consent, including confidentiality, mandatory reporting, etc.
- Answer questions.
- Get permission from survivor to continue.

WHEN TO GET INFORMED CONSENT

- Before you begin an assessment, that is, before listening to a survivor's story, gathering, or documenting any information about the person's case.
- Before making case referrals. Any time you share information with other service providers who can help the survivor meet their needs, you must seek permission to share information for each new referral.
- Before you take any other actions on behalf of the person, e.g., carrying out advocacy or case coordination.

WAYS TO MAKE A CLIENT FEEL MORE AT EASE

Asking a client to talk about what happened to them may feel difficult and scary for them. Here are some strategies for making a client feel more at ease:

- Using an open-ended question to invite the client to begin, e.g., "Would you like to tell me about what happened?" or "Can you tell me what brought you here today?"
- Listening carefully to the story as the client tells it.
- Watch a client's body language closely for any signs of discomfort, such as crying, staring into space, mumbling, giving one-worded answers, turning away, or changing the topic.
- Actively check in with the client along the way. Consider if they okay with continuing to talk about this or need a break.
- If the client verbally or non-verbally expresses that they are not comfortable answering questions or sharing information with you, respect their wishes and stop. Forcing a survivor to tell their story is harmful. You should not do this under any circumstances.
- Take notes if needed but keep your focus on your client.
- As the client tells you what happened, encourage, and empathize through both verbal and non-verbal communication. Phrases such as "continue," "go on," or "I am listening" can be helpful.
- Once the client has disclosed, respond to the disclosure with compassion, validation, and reassurance.
- Ask clarifying questions only after you have let the client speak and have responded to their disclosure.
- Avoid unnecessary questions; only ask questions that will give you information to help the client. As you begin this step, you will continue to build trust by fostering a safe environment in which the person feels listened to, not judged, and not blamed for what happened.

Activity 2: Presentation and Skills Practice

GATHER Approach Job Aid and Role Play, and IPV/Reproductive Coercion Considerations in FP Counseling (70 min.)

STEP 1

Present **SLIDE 9** on the GATHER approach,³⁸ sharing the following information with participants:

*Some of you may already be familiar with the GATHER approach to FP counseling. On **page 55 of your Participant's Manual**, you will find a modified version of this job aid that helps you remember to give GBV-relevant information.*

*Remember: you may never know if a person is living with GBV, so offering information on GBV services and hotlines **TO ALL CLIENTS** is the best practice. This also reduces stigma if someone is found to have such information or materials from a clinic.*

COUNSELING JOB AID: GATHER APPROACH

- **G - Greet** the client respectfully.
- **A - Ask** them about their FP needs. Ask if they have any other concerns about their health or safety.
- **T - Tell** them about different contraceptive options and methods, including information on the FP method's vulnerability to sabotage and degree of partner involvement needed for proper use.
- **H - Help** them to make decisions about choices of FP methods.
- **E - Explain** and demonstrate how to use the FP methods.
- **R - Return**, referring and scheduling an appropriately timed return visit. Ask the client for their preferred method of follow up communication and seek consent to send texts or make phone calls. Offer information on GBV services and referral availability.

³⁸ Pathfinder International, Comprehensive Reproductive Health and Family Planning Training Curriculum, Module 3: Counseling for Family Planning Services (Watertown, MA: 1998).

STEP 2

Present **SLIDE 10** focused on IPV/Reproductive Coercion Considerations in FP Counseling, emphasizing the following points:

Being mindful of the possibility of reproductive coercion and/or IPV triggered by FP use enables better counseling. Consider including some of these questions (on the slide) in your counseling.

Here are some additional specific points to share with participants:

- *IUD strings can be cut short and tucked into the cervical os OR left long and swept behind the cervix to limit detection by the partner during intercourse.*
- *Extra pill packs may be given to reduce need for repeat visits if access to a refill site is difficult.*
- *Emergency contraceptive pills can be taken up to 120 hours after unprotected sex but are most effective if taken sooner.*

IPV/REPRODUCTIVE COERCION CONSIDERATIONS IN FP COUNSELING³⁹

Method	Pros	Cons	Discussion Points
Injectable Contraceptive	<ul style="list-style-type: none"> • Does not leave any signs on the skin • No supplies to store 	<ul style="list-style-type: none"> • With two- and three-month types, monthly bleeding often stops after time • Another injection is needed every one, two, or three months, depending on type 	<ul style="list-style-type: none"> • <i>Are you concerned that your partner may track your periods?</i> • <i>Do you think you could go for re-injection visits without fail?</i>
Implant	<ul style="list-style-type: none"> • Works well for several years • Usually, no follow-up required • No supplies to store 	<ul style="list-style-type: none"> • Sometimes can be felt and seen under the skin of arm • May cause spotting or changes in menstrual bleeding (often improves after three months) 	<ul style="list-style-type: none"> • <i>Are you concerned that your partner may track your periods?</i>
Copper or LNG IUD	<ul style="list-style-type: none"> • Remains out of sight in the uterus • Copper IUD works well for at least 12 years; LNG-IUD, for 3–5 years • Usually, no follow-up required • No supplies to store 	<ul style="list-style-type: none"> • Copper IUD often increases menstrual flow • Hormonal IUD can make period lighter or stop • Caution if women has current STI or high STI risk • Partner may feel ends of strings in cervix 	<ul style="list-style-type: none"> • <i>Are you concerned that your partner may track your periods?</i> • <i>Do you think you may have an STI or are likely to get an STI?</i>
Pill	<ul style="list-style-type: none"> • Does not leave any signs on skin • Little effect on menstrual bleeding 	<ul style="list-style-type: none"> • Must be taken every day • Pills/packaging must be kept in safe place 	<ul style="list-style-type: none"> • <i>Do you have a safe place to keep the pills?</i>

³⁹ Adapted from WHO. *Caring for women subjected to violence: a WHO curriculum for training health-care providers*. Revised edition, 2021 (Geneva: 2021).

STEP 3

Project **SLIDE 11**.

Ask participants to turn to the **Role Play activities on PAGES 57–59 of their Participant Manual**.

Using a random assignment technique, such as counting off, divide participants into **three small groups**. Assign each group one of the following role play assignments:



TRAINER NOTE

Role Plays 1–3 can be found on the following pages:

ROLE PLAY	PAGE	
	IN TRAINER'S MANUAL	IN PARTICIPANT'S MANUAL
1: Partner IUD Concerns	112	54
2: CEFMU and HTSP	113	55
3: Couple Supported Permanent Method	114	56

Ask participants to read their assignment.

Each person in the group will have a chance to be the client, the provider, and an observer. Instruct participants to use the information in their participant manual for each role. Each “provider” will have **5 min.** to practice counseling using the GATHER approach.

Observers should provide feedback on:

- Did the provider follow the steps and use active listening?
- Did the provider follow client cues to guide discussion and selection of methods?
- Did the provider give information that was GBV-responsive?

Clients should give feedback on:

- Did you feel listened to? Why or why not?
- What did the provider do that was helpful?
- What could the provider have done to make you feel more comfortable?

Explain that they will have approximately **10 min.** in their small group before coming together for a plenary discussion, during which participants will be expected to share feedback. Allow **15 min.** group work and **15 min.** for plenary presentation/discussion.

Session 3-B: Responding to Disclosures of GBV



1 H.

Activity 1: Presentation

Learning Objectives and Introducing LIV(ES) Psychological First Aid (25 min.)

STEP 1

Present **SIDE 12**, explaining that participants can expect to learn the following from this session:

- The purpose and value of psychological first aid.
- The role of quality disclosure response in FP settings.
- How to deliver the first three steps of the LIVES approach to first-line response.

Present **SLIDE 13**, making sure to emphasize the following points:

Using client-centered counseling and active listening will help you identify cases of GBV and increase the likelihood that a client will choose to disclose their experiences and fears to you. So, what then?

As FP providers, you may be the first and/or only person this woman has been able to tell about what she is dealing with. Your response matters.

Many, if not all people who have survived or are living with GBV, have been made to feel isolated or as though the violence is their fault. It may be scary for them to share this information with you. How you respond will impact whether they tell anyone else and whether they choose to seek additional services.

The act of validating a survivor's experiencing and affirming their right to safety is called psychological first aid. It's just as important as putting a bandage and pressure on a cut to slow/stop the bleeding before sutures or more advanced care can be given.

Present **SLIDE 14**, presenting the **LIV(ES)** mnemonic to deliver psychological first aid.

JOB AID: LIV(ES) PSYCHOLOGICAL FIRST AID

WHO developed the LIVES mnemonic⁴⁰ to ensure first-line support in primary and preventative health care settings that responds to the needs of survivors of sexual assault or intimate partner violence.

- **L - Listen** closely with empathy and no judgment.
- **I - Inquire**. Assess and respond to the client’s needs and concerns—emotional, physical, social, and practical.
- **V - Validate**. Show the client you believe and understand them.
- **E - Enhance safety**. Discuss a plan to protect the client from further harm if violence occurs again.
- **S - Support**. Help connect the client to information, services, and social support.

Emphasize the following points to participants:

- ***The first three steps of the LIVES mnemonic make up psychological first aid and can be delivered by any level of health worker in any setting where privacy is available. In most cases, delivering these three steps adds no more than 5 minutes to a client encounter.***
- ***Do not be intimidated by the term “psychological first aid.” Health workers of any level are qualified to learn how to do this with very simple orientation such as you are receiving today. Just as physical first aid in the form of a band aid, ice pack, or pressure wrapping is far removed from surgery; psychological first aid is far removed from advanced psychological care requiring a mental health professional. But, as in the case of physical first aid, it can make a tremendous difference.***

⁴⁰ WHO. *Caring for women subjected to violence: a WHO curriculum for training health-care providers, revised edition* (Geneva: 2021).

Present **SLIDE 15**, emphasizing the following to participants:

It can be overwhelming at times when a client discloses violence. It's appropriate and often helpful to have some standard phrases ready to use.

Sample Phrases to Use When Providing Psychological First Aid

LIVES STEP	SAMPLE PHRASES
<p>L - Listen</p>	<ul style="list-style-type: none"> • I hear you. • I'm listening. • We have time if you there is anything else you want to tell me.
<p>I - Inquire</p>	<ul style="list-style-type: none"> • What can I do to help? • Are you worried about your safety if you tell your partner? • How are you feeling? Are you in pain?
<p>V - Validate</p>	<ul style="list-style-type: none"> • That must have been very difficult. • I'm so sorry this happened to you. • You did not/do not deserve this. • Thank you for telling me. • Sadly, this happens to many women. You are not alone.

Activity 2: Presentation and Skills Practice

(LIV)ES Psychological First Aid Role Play (30 min.)

STEP 1

Project **SLIDE 16**, telling participants:

Let's practice the first three steps of the LIVES approach with another role play activity. In real world, you would go on to offer referrals, but you don't need to do that for this exercise. We will cover referral to safety planning and other support services this afternoon.

Using a random assignment technique, such as counting off, divide participants into three small groups. Assign each group one of the following role play assignments:



TRAINER NOTE

Role Plays 4–6 can be found on the following pages:

ROLE PLAY	PAGE	
	IN TRAINER'S MANUAL	IN PARTICIPANT MANUAL
4: IPV	116	58
5: CEFM	117	59
6: Sexual Violence	118	60

Ask participants to read their assignment.

Each person in the group will have a chance to be the client, the provider, and an observer. Instruct participants to use the information in their participant manual for each role. Each “provider” will have five min. to practice counseling using the initial three steps of the (LIV)ES approach.



Reflection Questions:

- How did it feel just to listen and not offer “advice” or solutions?
- What did the provider do that was helpful?
- What could they have done differently?

Explain that participants will have approximately **15 min.** in their small group before coming together for a plenary discussion, during which participants will be expected to share feedback. Allow **20 min.** group work and **10 min.** for plenary presentation/discussion.

Activity 3: Presentation

Risk Identification (5 min.)

STEP 1

Present **SLIDE 17**, telling participants:

As FP providers, in most cases, you should not take on further response services. Many clients will not choose to act on referrals that you offer. However, there are some signs that your client is in immediate danger:

RISK IDENTIFICATION

Should you see these signs or behaviors, you may wish to go fetch a GBV specialist colleague and have them join you in the appointment room:

- The client tells you she is afraid she will be killed if she returns home.
- A client is accompanied by a partner or family member and not allowed to answer questions for themselves.
- A child under 13 is seeking MR or emergency contraception.

Tell participants:

We will cover referral to safety planning and other support services this afternoon.

Session 3-C: Making GBV Referrals



1 H. 30 MIN.

Activity 1: Presentation, Discussion, and Case Study

Learning Objectives, Effective Referral Pathway (30 min.)

STEP 1

Present **SLIDE 18**. Explain that, by the end of this session, participants can expect to learn:

- When and how to provide referrals for comprehensive first-line response to GBV.

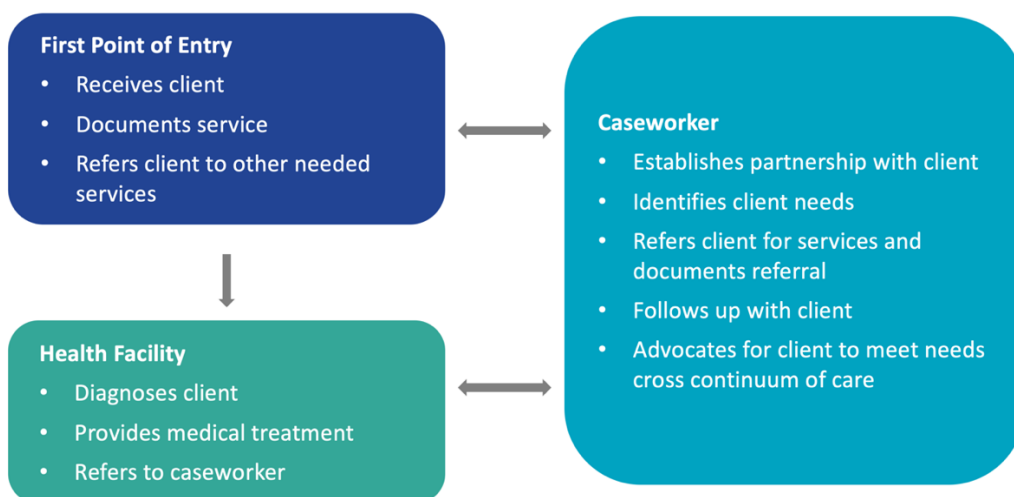
STEP 2

Present **SLIDE 19**, which focuses on **Effective Referral Pathway / Case Management Referral System**.



REFERENCE: REFERRAL DEFINITION

A referral is the act of officially sending someone to another person or authority—a qualified professional—to address with the individual's needs. For any legal assistance to GBV, such as legal aid, providers may often refer clients/GBV cases to centers where the client can get services, support, or solutions.



Share the following point with participants:

As FP providers, YOU are often a client's point of entry into the health system and offer a crucial link for onward referrals and additional emergency treatment and/or GBV services.

Ask participants to reflect on the role plays they just completed (when practicing counseling and provision of psychological first aid).

Ask for a few volunteers to share which clients in those Role Plays would benefit from referral to other services. Spend **5 min.** on this discussion then move to next slide.

STEP 2

Project **SLIDE 20**. Ask participants to turn to the **Case Study 9: Lovely on page 66 of their Participant's Manual** (page 122 of this Trainer's Manual).

Instruct participants to take a couple of minutes to read the case vignette to themselves. Once they have read it, participants should turn to 1–2 neighbors and discuss the questions on the slide. **Give participants 5-10 min., or until you see conversation slowing down—whichever happens first.** Ask for 2–3 volunteer groups to share their reflections.



For Group Discussion

- What are the steps you will follow to counsel her in a real situation?
- In what way you will support the case so she can continue her pregnancy?
- What kinds of referrals might you want to make for this case?



TRAINER NOTE

Additional questions and discussion prompts if necessary based on participant discussion and comments:

- What realistic opportunities are there for male engagement in this situation? As a provider how might you facilitate positive male engagement?
- Remembering our client-centered principles, is it helpful to Lovely to spend time discussing how she got into this situation or whether she should have asked for help sooner?
- Given Lovely's priorities and concerns, which kinds of referrals/additional services will be most helpful from her perspective?

Activity 2: Presentation

One-Stop Crisis Cell, Referral Helplines, and other Referral Locations (20 min.)

STEP 1

Present **SLIDES 21–26**, providing valuable information for making GBV referrals.

ONE-STOP CRISIS CENTER AND CELLS

The one-stop crisis center (OCC), which was formed in 2001 to provide medico-legal assistance for victims of physical and sexual assaults, has evolved into a medical treatment center. The goal of the initiative is to provide all required services for a woman-child victim of violence in one location.

One of the most significant components of Bangladesh's Multi-Sectoral Program on Violence Against Women, OCCs Providing various services to the women and children victims of violence in one place, including:

- Medical treatment
- Social reintegration
- Safe custody/shelter home
- Rehabilitation
- Psychosocial counseling
- Social welfare services
- Legal support
- Police assistance
- Forensic DNA test



REFERENCE: ONE-STOP CRIS CENTER CONTACT NUMBERS

Below is a list of OCC Mobile Numbers in Bangladesh, as of January 2023.

OCC Mobile Number of Medical College Hospital in Bangladesh		
	Name of Medical College Hospital	Mobile Number
01	Dhaka Medical College Hospital	01713423490
02	Rajshahi Medical College Hospital	01713366637
03	Chattogram Medical College Hospital	01713366635
04	Sylhet Medical College Hospital	01713366634
05	Khulna College Hospital	01313881919
06	Barisal College Hospital	01713366638
07	Rangpur College Hospital	01755584574
08	Faridpur College Hospital	01755584573
09	Cox's Bazar Medical College Hospital	01730781039
10	Bogra Medical College Hospital	01730781012
11	Pabna Medical College Hospital	01730781014
12	Kushtia Medical College Hospital	01730781019
13	Jessore Medical College Hospital	01730781024
14	Comilla Medical College Hospital	01713659562
15	Noakhali Medical College Hospital	01713659563
16	Mymensingh Medical College Hospital	01713659564
17	Gopalganj Medical College Hospital	01713659565
OCC Mobile Number of District Sadar Hospital in Bangladesh		
	Name of District	Mobile Number
01	Munshiganj Sadar Hospital	01730781000
02	Narsingdi Sadar Hospital	01730781001
03	Gazipur Sadar Hospital	01730781002
04	Kishoregonj Sadar Hospital	01730781003
05	Netrokona Sadar Hospital	01730781004
06	Tangail Sadar Hospital	01730781005
07	Sherpur Sadar Hospital	01730781006
08	Madaripur Sadar Hospital	01730781007
09	Shariatpur Sadar Hospital	01730781008
10	Narayanganj Sadar Hospital	01730781009
11	Chapainawabganj Sadar Hospital	01730781010
12	Naogaon Sadar Hospital	01730781011

INTEGRATING GBV-RESPONSE INTO FP AND RH SERVICE DELIVERY | TRAINER MANUAL
 MODULE 3: GBV-RESPONSIVE FP AND SRH SERVICE PROVISION

13	Natore Sadar Hospital	01730781013
14	Sirajganj Sadar Hospital	01730781015
15	Panchagarh Sadar Hospital	01730781016
16	Lalmonirhat Sadar Hospital	01730781017
17	Dinajpur Sadar Hospital	01730781018
18	Meherpur Sadar Hospital	01730781020
19	Chuadanga Sadar Hospital	01730781021
20	Jhenaidah Sadar Hospital	01730781022
21	Magura Sadar Hospital	01730781023
22	Satkhira Sadar Hospital	01730781025
23	Bagerhat Sadar Hospital	01730781026
24	Sunamganj Sadar Hospital	01730781027
25	Habiganj Sadar Hospital	01730781028
26	Jhalokathi Sadar Hospital	01730781029
27	Pirojpur Sadar Hospital	01730781030
28	Patuakhali Sadar Hospital	01730781031
29	Barguna Sadar Hospital	01730781032
30	Brahmanbaria Sadar Hospital	01730781033
31	Chandpur Sadar Hospital	01730781034
32	Lakshmipur Sadar Hospital	01730781035
33	Feni Sadar Hospital	01730781036
34	Khagrachari Sadar Hospital	01730781037
35	Bandarban Sadar Hospital	01730781038
36	Jamalpur Sadar Hospital	01713659550
37	Thakurgaon Sadar Hospital	01713659551
38	Manikganj Sadar Hospital	01713659552
39	Bhola Sadar Hospital	01713659553
40	Narail Sadar Hospital	01713659554
41	Kurigram Sadar Hospital	01713659555
42	Nilphamari Sadar Hospital	01713659556
43	Joypurhat Sadar Hospital	01713659557
44	Rajbari Sadar Hospital	01713659558
45	Gaibandha Sadar Hospital	01713659559
46	Moulvibazar Sadar Hospital	01713659560
47	Rangamati Sadar Hospital	01713659561

NATIONAL TRAUMA COUNSELING CENTER

The National Trauma Counseling Centre (NTCC) provides psychosocial counseling support related to violence against women and children totally free of cost, including:

- Individual face-to-face counseling
- Individual tele-counseling
- Couple counseling
- Family counseling
- Group counseling
- Online counseling

For more information, visit <http://ntcc-mowca.gov.bd/>

NATIONAL CALL LINES

Women affected by violence and in need of services can be referred to an OCC through Bangladesh’s National Resource Call Lines.

109	National Helpline Centre for Violence against Women and Children	Offering multisectoral referral and psychosocial support, this is the main helpline number to call and is circulated nationwide. It is a 24-hour-per-day, 365-days-per-year, free emergency phone service for women and children in need of aid and assistance.
333	National Hotline Number	Immediate reports/help for any social problems, from queries related to COVID-19 to child marriage and sexual harassment cases.
10921	National Helpline Center for Violence against Women	Immediate service for victims, offering links to relevant agencies, including doctors, counselors, lawyers, DNA experts, police officers.
16767	DGFP Call Center	Call center that is available 24 hours per day, seven days per week for any information on FP, maternal and child health, and nutrition.
999	National Emergency Service Bangladesh	A centralized 24-hours-per-day, seven-days-per-week emergency support service allowing any citizen within the country border to directly connect with the police, fire, and ambulance emergency responding teams on the ground to get aid in an emergency state.

WHERE TO REPORT

There are several places where you can report:

- One-Stop Crisis Center
- Trauma Counseling Center
- Forensic DNA Laboratory
- National Help Line for Violence Against Women
- Legal Aid Center
- Legal Action Center/Police Station
- Social Support Center/rehabilitation center
- Safe Custody/Shelter Home
- Rehabilitation Center

NATIONAL TRAUMA COUNSELING CENTER

Objective of NTCC

- Provide psychosocial counseling support in NTCC, OCC, and safe home to those experiencing violence against women and children.
- Conduct different types psychosocial counseling training for Human Resource Development.
- Organize awareness-raising program for changing mindsets.
- Establish a strong network among organizations/stakeholders who work on GBV issues.

Psychosocial Counseling Service

NTCC provides psychosocial counseling support for those experience VAWC free of cost. NTCC provides a wide range of counseling support including:

- Individual face-to-face counseling
- Individual tele-counseling
- Couple counseling
- Family counseling
- Group counseling
- Online counseling

Present **SLIDE 27**, emphasizing the following points:

- “Do No Harm” principals call us to limit the number of contacts a survivor will need to go through. Refer a client directly to the location with the largest number of indicated/desired services.
- It is also important balance distance and access for the client with privacy and confidentiality afforded by getting services outside of one’s home community. Let the client lead when deciding that balance.

INTRA-FACILITY VERSUS INTER-FACILITY REFERRAL

Intra-Facility

- Facility has an emergency department, GBV specialist, and/or other needed services.
- Client has declined legal referral and is seeking medical aid only.

Inter-Facility

- Client has a need and desire for full case management and the full scope of an OCC cell.
- FP service facility does not house:
 - GBV subject matter expert
 - Necessary equipment and/or commodities for treatment
 - Capacity to protect confidentiality of the client

Activity 3: Presentation, Role Play, and Discussion

Web of Referrals (35 min.)



TRAINER NOTE

You will need to prepare for this activity in advance by creating eight (8) cue cards. See the cue card instructions on **PAGE 123** of this Trainer Manual.

STEP 1

Project **SLIDE 28**. Introduce the activity objective:

- To better understand and gain empathy for how uncoordinated systems and too much specialization can make referrals burdensome for a survivor of GBV.

STEP 2

Review directions with participants:

- *In this role play, we will follow “Rose” as she seeks help for intimate partner violence.*
- *We need 9 volunteers. One volunteer will play Rose, and 8 will play people she visits to seek advice or ask for help.*
- *Rose will ask each person she visits to take hold of the string that she carries.*
- *People she visits will have been given a cue card that directs their response and where Rose goes next.*

Step 3

- Ask for a volunteer to play the part of Rose.
- Ask for 8 additional volunteers to play a member of the referral web.
- All other participants will serve as active observers and will be asked to share reflections during the activity debrief.

Step 4

- Distribute cue cards and role signs to volunteers.
- Give the volunteer playing “Rose” a roll of string or ribbon. Ask this person to hold firmly to one end of the string and pass the ball to each person they visit.
- Instruct the other 8 volunteers that Rose will visit to hold firmly to the point on the string that reaches them before handing the ball back to Rose to take with her to her next stop.
- At the end of the exercise, the string will have created a visible web between the many people that Rose has visited.

Step 5

Following the activity, conduct a debriefing discussion. Use the following questions to prompt participants:

- Ask Rose what the experience was like.
- Ask observers to share anything they noticed about:
 - Rose' body language as the referral web progressed
 - the way Rose spoke or shared information as the referrals progressed
 - if they noticed points in the referral chain where Rose could have been spared a trip and/or a repetition of her story
- Ask the 8 volunteers (who Rosie visited) to share any reflections they have
- Ask the whole group how this might look different if Rose had an FP visit with a nurse who was trained to notice signs of IPV and refer **her** appropriately.



TRAINER NOTE

If participants do not bring up the following issues during the debrief discussion, raise these points for consideration:

- ✓ Even if individual responses to disclosures of violence are survivor-sensitive and compassionate, as a provider you might be encountering someone who has already had to tell their story too many times and/or has had multiple experiences with someone who didn't respond appropriately.
- ✓ Referral systems are often complicated and difficult for a client to navigate.

Activity 4: Presentation and Skills Practice

GBV Referral Slip (5 min.)

STEP 1

Project **SLIDE 29**. Share the following with participants:

While confidentiality MUST be protected, we also want to confirm referrals and be able to follow up on care as much as possible. You will need to use a numeric coding system to assign a non-identifying code to each client referral. This enables tracking without having identifying information on the referral slip. Records linking numeric codes to client identifying information should be stored separately and in a locked location. We will discuss more on record storage when we discuss documentation in the next session.

*Let's practice. Using the case study of Lovely, complete the sample GBV Referral Slip on **page 73** in your **Participant's Manual**.*

Project **SLIDE 30** and say:

You can see Lovely's story again on this slide for your easy reference.

Module 3 Tools and Handouts

Tool D: GATHER Approach Counseling Job Aid⁴¹

- **G - Greet** the client respectfully.
- **A - Ask** them about their FP needs. Ask if they have any other concerns about their health or safety.
- **T - Tell** them about different contraceptive options and methods, including information on the FP method's vulnerability to sabotage and degree of partner involvement needed for proper use.
- **H - Help** them to make decisions about choices of FP methods.
- **E - Explain** and demonstrate how to use the FP methods.
- **R - Return**, refer and schedule an appropriately timed return visit. Ask the client for their preferred method of follow up communication and seek consent to send texts or make phone calls. Offer information on GBV services and referral availability.

⁴¹ Pathfinder International, Comprehensive Reproductive Health and Family Planning Training Curriculum, Module 3: Counseling for Family Planning Services (Watertown, MA: 1998).

Role Play 1: Partner IUD Concerns

GATHER Counseling Skills Practice

Provider Info

A woman presents for IUD removal. Her health card indicates that she has two living children and is 25 years old. She is soft spoken and is cradling her left wrist as she speaks to you.

Client Info

You are 25 years old, married, and the proud mother of two children. You and your husband have received counseling from a FHW and, after the last pregnancy, which was a very difficult one with complications, have decided to wait some time before having any more children. You were very relieved when your husband agreed to delay a third child, as he can be very strict and has a big reputation to uphold in the village.

However, after getting the IUD, during marital relations, your husband complained that he could feel the IUD and it affected his pleasure. He became angry and rough, shouting that you must find a different way or just have another child now if God wills it. You are worried he might have injured your wrist as it has been hurting very much; you can't use it as normal for household chores.



Observers should provide feedback on:

- Did the provider follow the steps and use active listening?
- Did the provider follow client cues to guide discussion and selection of methods?
- Did the provider give information that was GBV-responsive?

Clients should give feedback on:

- Did you feel listened to? Why or why not?
- What did the provider do that was helpful?
- What could the provider have done to you feel more comfortable?

Role Play 2: CEFMU and Healthy Timing and Spacing of Pregnancy

GATHER Counseling Skills Practice

Provider Info

A young woman has just delivered her first baby at the health center. Her client card indicates that she is 16. You are providing PFP counseling. She is very clear that she does not want any more children at this time, but states that she cannot take any FP because her husband will be angry.

Client Info

You are happy to be at the health center for a few days and very relieved to have given birth to a healthy baby boy. A cousin abducted you from your parent's home when you were 15 and forced you into wedlock. Your husband can be very cruel and has threatened to take away your visits to your family if you did not give him a son. At least while at the health center, you are getting some peace and are so in love with your new baby.



Observers should provide feedback on:

- Did the provider follow the steps and use active listening?
- Did the provider follow client cues to guide discussion and selection of methods?
- Did the provider give information that was GBV-responsive?

Clients should give feedback on:

- Did you feel listened to? Why or why not?
- What did the provider do that was helpful?
- What could the provider have done to make you feel more comfortable?

Role Play 3: Couple-Supported Permanent Method

GATHER Counseling Skills Practice

Provider Info

A middle-aged couple comes to you on referral from their FHW. They are happy with their family of four children and are interested to hear that there are options to not have any more children. However, they live a bit far from the health center and are hoping you can help them with something that doesn't require them to come back.

Client Info

As a 32-year-old mother of four, you have come with your husband for something to keep you from having any more children. Your husband doesn't want you to miss time away from the children and home, but you have heard about permanent methods and really like the sound of this option as you won't have to think about contraception again once it is done. Your sister received bilateral tubal ligation (BTL) at a mobile clinic a couple of years ago and is always talking about how wonderful it is not to have to worry about becoming pregnant.



Observers should provide feedback on:

- Did the provider follow the steps and use active listening?
- Did the provider follow client cues to guide discussion and selection of methods?
- Did the provider give information that was GBV-responsive?

Clients should give feedback on:

- Did you feel listened to? Why or why not?
- What did the provider do that was helpful?
- What could the provider have done to make you feel more comfortable?

Tool E: LIV(ES) Psychological First Aid

WHO developed the LIVES mnemonic⁴² to ensure first-line support in primary and preventative health care settings that responds to the needs of survivors of sexual assault or intimate partner violence.

- **L - Listen** closely with empathy and no judgment.
- **I - Inquire**. Assess and respond to the client's needs and concerns—emotional, physical, social, and practical.
- **V - Validate**. Show the client you believe and understand them.
- **E - Enhance safety**. Discuss a plan to protect the client from further harm if violence occurs again.
- **S - Support**. Help connect the client to information, services, and social support.

⁴² WHO. *Caring for women subjected to violence: a WHO curriculum for training health-care providers, revised edition* (Geneva: 2021).

Role Play 4: IPV

LIV(ES) Skills Practice

Provider Info

A woman presents for IUD removal. Her health card indicates that she has two living children and is 25 years old. She is soft spoken and is cradling her left wrist as she speaks to you.

Client Info

You are 25 years old, married, and the proud mother of two children. You and your husband have received counseling from an FHW, and after your last pregnancy, which was a very difficult one with complications, you have decided to wait some time before having any more children. You were very relieved when your husband agreed to delay a third child, as he can be very strict and has a big reputation to uphold in the village.

However, after getting the IUD, during marital relations, your husband complained that he could feel the IUD and it affected his pleasure. You reminded him that it was dangerous for you to become pregnant again and this was protecting your life, but he became angry and grabbed your wrist, bending your hand back until you cried out. You haven't been able to use your wrist as normal for household chores, but your husband tells you not to be weak. Finally, you ask for permission to go to the health center to have the IUD removed, and he agrees.

You do want the IUD removed so your husband stops being angry, but you also really hope the doctor can help your wrist.



Reflection Questions:

- How did it feel just to listen and not offer “advice” or solutions?
- What did the provider do that was helpful?
- What could they have done differently?

Role Play 5: CEFM

LIV(ES) Skills Practice

Provider Info

A young woman has just delivered her first baby at the health center. Her client card indicates that she is 16. You are providing PFP counseling. She is very clear that she does not want any more children at this time, but states that she cannot take any FP because her husband will be angry.

Client Info

You are happy to be at the health center for a few days and very relieved to have given birth to a healthy baby boy. A cousin abducted you from your parent's home when you were 15 and forced you into wedlock. Your husband can be very cruel and had threatened to take away your visits to your family if you did not give him a son. At least while at the health center, you are getting some peace. You are very worried about going back home. Your husband beats you when he isn't satisfied with your housework, and you already feel so tired from caring from your new son.



Reflection Questions:

- How did it feel just to listen and not offer “advice” or solutions?
- What did the provider do that was helpful?
- What could they have done differently?

Role Play 6: Sexual Violence

LIV(ES) Skills Practice

Provider Info

A woman comes to the clinic asking for MR. She hesitates when you ask for her name and does not have her ID card with her. She says she is due to begin bleeding in one week but has heard the clinic can make sure her menstruation comes and that she does not end up with a baby.

Client Info

Your husband has been away to find work these past six weeks. Last night, a neighbor came by to ask how you were doing, but he insisted on coming into the house and forced you to have sex. You are so scared you will become pregnant because your husband would know it was not his child.



Reflection Questions:

- How did it feel just to listen and not offer “advice” or solutions?
- What did the provider do that was helpful?
- What could they have done differently?

Case Study 9: Lovely

Lovely Begum (*pseudonym*) is only 16 years old. Her parents had arranged to have her married to a nearby acquaintance when she turns 18, but a jealous cousin abducted her and forced her into wedlock. She tried to escape to her parents' home after that the cousin made her isolated from everyone in the family, but her parents explained that because the marriage had been consummated, her previous betrothed will not take her anymore and told her she needed to go back to her husband.

Lovely returns to her husband's house. Her husband continues to keep her at home and does not allow her to visit her parents anymore. He is angry that she tried to stay at her parents. He yells at Lovely and beats her frequently. He accuses Lovely of not getting pregnant on purpose.

Finally, after six months of life as a wife, Lovely discovers she is pregnant and goes to the SRH service center to get help for continuing her pregnancy. She is very worried about protecting her precious child in her womb and concerned that the beatings she is receiving at home will harm her child.



For Group Discussion

- What are the steps you will follow to counsel her in a real situation?
- In what way you will support the case so she can continue her pregnancy?
- What referral pathway you will follow to refer her and where to refer this case?

Role Play 7: Web of Referral

Cue Card Content



TRAINER NOTE

Prepare the cue cards in advance of the activity. You may either print and fold a piece of paper or use two sides of a note card. The important thing is that everyone can see one side of the cue card where the name/role is easily visible, but only the individual playing this role (holding the cue card) can see the speaking/acting prompts on the reverse side of the card.

CUE CARD 1

Front (*visible to everyone*): **Client - Rose**

Back (*visible to "Rose" only*): You are Rose, a 24-year-old woman who has been experiencing physical and sexual abuse from your boyfriend for the last six months. You don't know what to do and you are scared for your life. You want help leaving your boyfriend, so he won't hurt you when you say it is over. You go to your sister for support and advice.

CUE CARD 2

Front: **Sister**

Back: Listen to Rose, talk to her, and encourage her to work things out. Then send her to a community/religious leader for better guidance.

CUE CARD 3

Front: **Religious Leader**

Back: Listen to Rose, talk to her, and explain that this is really a women's issue. Then give her the name and phone contact for a member of the local women's group for support.

CUE CARD 4

Front: **Women's VAWG NGO Volunteer**

Back: Listen to Rose, talk to her, and then send her to a health clinic for first line support.

CUE CARD 5

Front: **Doctor at Clinic #1**

Back: Listen to Rose, talk to her, and then send her to the police to file an official complaint. You wish young women would realize that this is why intimate relationships outside of marriage are a bad idea.

CUE CARD 6

Front: Officer at Police Station #1

Back: Listen to Rose, talk to her, and then send her to a One-Stop Crisis Center. Explain that no charges can be filed as she did not bring a forensic report and so there is no medical proof.

CUE CARD 7

Front: Nurse at Clinic #1

Back: The doctor Rose saw previously is not working today. Listen to Rose, talk to her, take her history, perform a medical examination, and then send her with medical details and a formal exam report back to the police.

CUE CARD 8

Front: Officer at Police Station #2

Back: Listen to Rose, talk to her, and then send her to a legal aid lawyer.

CUE CARD 9

Front: Legal Aid Lawyer

Back: Ask Rose to tell her story, ask for all the documents, and then make her tell her story again to practice telling it in court if the prosecution gets that far.

Tool F: GBV Referral Slip

REFERRAL SLIP

Client number (as recorded):

Name of client (first name only/optional):

Age:

Gender:

Immediate management given (if any): first aid / LIV / Helpline info

Cause of referral:

Place of referral:

Date referral completed:

Source: Pathfinder International

Module 4: Foundational Knowledge of GBV Case Recording, Documentation, and Record Keeping



TOTAL MODULE TIME: 45 MIN.

- Session 4-A: Legality, Protecting Confidentiality, and Reporting GBV



LEARNING OBJECTIVE

After completing this module, participants will have learned:

- About the legality and reporting aspect of a GBV case identification, notification to primary management, and referral.



METHODOLOGIES

- Presentation
- Case study / Skills practice
- Discussion



MATERIALS NEEDED

- Flipchart and markers
- Trainer PPT Slide Deck 2
- Participant manual for each participant



ADVANCE PREPARATION

- Review slides and training content
- Review Case Study / Skills Practice 8: Aklima

Session 4-A: Legality, Protecting Confidentiality, and Reporting GBV



45 MIN.

Activity 1: Presentation

Learning Objectives, Legality, Confidentiality, and Reporting (10 min.)

STEP 1

Present **SLIDES 31–32**, highlighting what participants can expect to learn from this session:

- Gain an understanding of the legality and reporting aspect of a GBV case identification, notification to primary management, and referral.

STEP 2

Present **SLIDES 33–35**.

DEFINING “LEGALITY”

Legality is an act, agreement, or contract that is consistent with the law or state of being lawful or unlawful in a given jurisdiction, and the construct of power. Legal assistance describes a range of legal services, from the provision of generic legal information and advice to representation by a legal professional in court.

LEGAL CONSIDERATIONS FOR FP AND SRH PROVIDERS AROUND GBV

- Health care providers do not have a legal mandate to report GBV. You should only report cases to judicial authorities if and with a client’s written consent.
- Documentation of disclosure, injuries, or other medical records may become evidence in the event a survivor chooses to file a legal complaint and prosecution follows.
- The universal provision of referral options and GBV services available is not legally required but is ethically mandated.

Emphasize the following to participants:

How, what, and when you document matters!



TRAINER NOTE

Tell participants that while they now know how to solicit and receive disclosures of violence and make referrals to additional services, there is one more critical piece of providing GBV-responsive services: **Documentation and reporting**. Reiterate that this does not refer to legal reporting, but rather to service provision reports just as for any other services given at the facility. BUT – there are unique considerations for GBV.

INTEGRATING GBV DISCLOSURE AND RESPONSE REPORTING INTO AN FP AND SRH VISIT

- Use separate forms provided. GBV disclosures should NOT be noted in the regular FP register.
- Immediately following the visit, place your documentation form in an assigned, locked storage space.
- Document in three places: confidential client record, referral slip, and anonymized facility log.

What to Include in Your Report

- Basic demographic information
- Consents obtained
- History
- Account of the assault
- Results of the physical examination
- Tests and results
- Treatment plan medication provided or prescribed
- Referrals provided
- Anonymous code for use in referral communication
- Information shared by client
- Provider observations

Activity 2: Presentation, Skills Practice, and Discussion

GBV Referral and Report (35 min.)

STEP 1

Project **SLIDE 36**, featuring a sample facility register for recording cases of GBV. Note the following to participants:

Referral completion should be marked Y or N based on completion status at time of one week follow-up.

STEP 2

Project **SLIDE 37**. Ask participants to turn to **Case Study 10: Aklima on page 78 of their Participant's Manual** (page 132 in this Trainer's Manual).

STEP 3

Ask participants to please work on their own or with a partner. Take the next five minutes to read Aklima's story.

Then, using the sample referral and GBV record forms in their manual, fill out the documentation needed based on the information in Aklima's study. Everyone has **10 min.** to fill out the forms before coming together again for reflection and plenary discussion.

STEP 4

During the plenary, ask the following questions to generate discussion:

- What was the hardest pieces of the form to complete?
- Do you think you will be able to do this during a normal day of work?
- Do you have any questions on how to fill out a certain portion of the forms?

Module 4 Tools and Handouts

Tool G: Sample GBV Disclosure Client Report Form

Client Name:	Age:	Sex:	Case Code:
Forms of GBV disclosed (circle all that apply):			
Physical abuse	Sexual abuse (partner)	Contraceptive sabotage	Sexual assault (stranger)
Attempted assault (stranger)	Threat-based reproductive coercion		
Client consents to be contacted for follow up: Y/N	By phone:	By SMS:	Other:
Okay to leave voice mail: Y/N			
Any observed marks or injuries:			
Referrals offered (circle all that apply):			
Clinical management of rape	Other emergency medical treatment	Psycho-social support/ case management	Legal services
Referral location:	Date referral issued:		
Referral completed: Y/N/Unknown	Date referral completed:		
Provider signature:			

Tool H: Sample Facility Register

Source: Pathfinder International

Date of visit	Date of incident	Case Code	Client sex	Client age	Type of GBV					Response				
					Physical	Contraceptive Sabotage	Emotional	Sexual (IPV)	Sexual (non-IPV)	Treatment (first aid)	LIV(ES)	Referral Issued	Referral Completed*	Police Report Made
23/9/2022	19/9/22	922-05	F	22		X		X			X	X		N

Case Study 10: Aklima

Referral and Report Skills Practice

Aklima, age 28, is a married, mother of three. She has been using a Copper-T intrauterine device (IUD) for two months. Aklima's husband, Rahim, is very strict and beats her when he is not pleased with her housework, the children's behavior, Aklima's appearance, or her way of speaking in front of his friends. During her last pregnancy, Aklima was very worried the beating would hurt her child, and she ended up delivering early. The baby was very small, and the child tends to be sickly. Aklima wants to avoid another pregnancy for the sake of her children and to be able to carry out her duties in a way that is pleasing to her husband.

During the visits to the clinic to receive her Copper-T, Aklima shared that she wanted to prevent another pregnancy so she could better please her husband. The FP counselor offered her information about feeling safe in one's home and gave her the national hotline number, but Aklima did not call. Aklima felt this would only make her situation worse. And she knew her husband would be very angry if he found out she had complained about him. The FP counselor also gave Aklima information about the Copper-T, its safety, and that it had no impact on hormones or future fertility.

One night, Rahim came home late. He seemed upset and impatient, criticizing dinner and the children's cleanliness. In the marriage bed that night, Rahim became very angry. He blamed Aklima and the Copper-T on not being able to perform, and he beats her very badly. In the morning, Aklima has a black eye, is missing a tooth, and is afraid her wrist may be broken. As soon as the children go to school, Aklima rushes to the health center to have the Copper-T removed.

The nurse assistant in the waiting area notices Aklima's appearance and goes to fetch a GBV counselor to join the appointment. Once in the exam room, Aklima states that she would like the Copper-T removed. The counselor asks why and if she would like another method. Aklima bursts into tears and shares her whole story. The counselor provides psychological first aid and recommends that Aklima be seen at the OCC help center where she can get treatment for her injuries, find a new FP method, and receive other GBV services all in one place. The counselor assures Aklima that she can be seen today and that there will be no open record of the referral or where she goes.

Aklima agrees. The counselor completes the client record card and tells Aklima it will go into a private, locked storage box. She also completes the OCC referral slip and gives Aklima directions to the nearest MCH unit. The FP provider completes the FP register noting that no method was given and also completes the anonymized GBV register.

Later that day at the end of her shift, the FP provider calls the OCC to inquire which case codes have come in and can be marked as completed referrals.

Using the sample referral and GBV record forms, fill out the documentation needed based on the information from Aklima's story.



For Reflection and Group Discussion

1. What was the hardest pieces of the form to complete?
2. Do you think you will be able to do this during a normal day of work?
3. Do you have any questions on how to fill out a certain portion of the forms?

Tool I: Sample Facility Report of Services for GBV

Individual disclosure forms must be kept confidential and only accessed as needed for case management, clinical follow-up, and/or legal inquiry. However, anonymized aggregate reporting is critical for facility and health system management. This type of reporting will help facility, upazila, and district managers appropriately allocate staff, forecast and order necessary supplies and equipment, and plays a role in sensitizing policy makers on the prevalence and severity of GBV faced by their constituents. Participants may share this sample form with their ward head and/or facility manager if they are not participating in this training.

SI #	Facility name	Total no. GBV client identified			Total no. GBV client managed			Total no. GBV client referred			Total no. GBV client followed			Total		
		Male	Female	Others	Male	Female	Others	Male	Female	Others	Male	Female	Others	Male	Female	Others
	UH&FWC total															
	Health post total															
Reporting month/year:																
Union					Upazila					District						

Module 5: Closing



TOTAL MODULE TIME: 1 H. 30 MIN.

- Session 5-A: Closing and Post-test



LEARNING OBJECTIVES

Participants will be able to:

- Be able to provide feedback on this training
- Share what they learned
- Find additional resources



METHODOLOGIES

- Presentation
- Assessment



MATERIALS NEEDED

- Flipchart and markers
- Trainer PPT Slide Deck 2
- Tool A: Pre- and Post-Test Assessment
- Tools K and L: Competency Assessment Checklists
- Tool M: Training Evaluation
- Participant's Manual for each participant



ADVANCE PREPARATION

- Review slides and training content
- Be sure to read all instructions for Module 5 carefully. Multiple closing activities are intended to be managed simultaneously by the facilitation team.
- Print enough copies for of the Tool B: Post-test Assessment for all participants, plus 2-3 extra copies.
- For each participant, print Tools K and L—the competency assessment checklists.
- Print sufficient copies of Tool M: Training Evaluation for all participants.

Session 5-A: Closing and Post-Test



1 H. 30 MIN



TRAINER NOTE

As a facilitation team, plan in advance who will give instructions and guide the main group during the closing session and who will be taking participants aside for skills evaluation. During periods when participants are engaged in independent work, e.g.: the post-test and training evaluation, all facilitators should be engaged in skills assessment.

To complete assessments for each participant in the available time, it is important to keep the simulation brief. Be sure to set expectations that these are mini scenarios and not full role plays.

Activity 1: Presentation and Discussion

Wrap-up (20 min)

Step 1

Present **SLIDE 38** and **SLIDE 39**.

Congratulate the group on reaching the end of the training. Review key messages:

- ✓ FP/SRH providers have a critical role to play in first line response for violence against women and girls.
- ✓ Basic services such as GBV-responsive FP method counseling, psychological first aid, and appropriate activation of a referral chain can have significant impact on the trajectory of care for people living with GBV.
- ✓ FP/SRH providers have a significant role to play in safe, confidential reporting and documentation of GBV prevalence and incidence.

STEP 2

Direct participants attention to the wall and/or flip chart of expectations from the opening session on Day 1. Review expectations and how various activities or discussion highlights from the past two days met these expectations.

STEP 3

Ask for a few volunteers to share 1 thing they will be taking away from this training.

STEP 4

Project **SLIDE 40** and introduce the final elements: a self-reflected action plan; post-test and training evaluation, and a skills assessment.

Tell participants that facilitators will be pulling them aside throughout this session for their skills assessment. They will have plenty of time for the other activities, regardless of when they are pulled for their assessment.

Send the first participant over to the assessing trainer.

Activity 2: Presentation and Reflection

Individual Action Plan (35 min)

Step 1

Ask participants to turn to the **Individual Action Plan on page 81 of their Participant's Manual** (page 138 of this Trainer's Manual).

Emphasize that these plans are individual and based on their own work context, stage of professional development, and typical clients. FP and RH providers working in FP clinics, versus those working in referral hospitals, are likely to have different goals.

Tell participants that you are available if they have questions as they work on their plans and need only raise their hand.

Activity 3: Assessment

Post-Test and Training Evaluation (35 min)

STEP 1

Distribute **Tool A: Pre- and Post-Test Assessment** (see page 26 of this Trainer's Manual) for participants to complete.

Remind participants to write the same 3- or 4-digit number or code that they wrote on their Pre-test. This is very important.

STEP 2

While everyone is completing their Post-test Assessment, begin pulling individual participants aside to complete their **Skills Assessment** using the following tools:

- **Tool K: GBV-Responsive FP Counseling Competency Checklist** (see page 139 of this Trainer's Manual)
- **Tool L: Responding to Disclosures of Violence - LIV - Competency Checklist** (see page 140 of this Trainer's Manual)

Set the stage by telling the participant that, in this final role play, they are taking the role of FP provider during a routine FP visit. The consult room has a fabric partition between two service spaces. They are sharing the room with another provider.

Scenario information for the assessor to use during the role play:

You are a 24-year-old married woman. You have completed three years of university and have one young child who is now six months old. Your husband was supportive of you completing your university degree, and you have been planning on returning to complete your final year when the next semester begins—now that your baby has started eating solid foods.

However, since the baby arrived, life has become much harder. Your husband is always finding fault with the housework and often yells at you and even smacks you because there are nights when you are busy with the baby and don't go to your husband's bed. Your

husband has told you he will just use condoms for a few months because he wants another baby as soon as you finish your degree so you can become pregnant in a few months.

You are very worried about how hard life will be if you become pregnant again. You worry about whether you can even go back to university without making your husband angrier and getting beaten more often.

When first asked what brings you in to the clinic, you simply tell the FP provider that you have heard there are ways to make sure you do not get pregnant for a few years that a husband would not notice. If the provider makes you feel comfortable, you may choose to disclose additional information about your home troubles.

STEP 3

Distribute **Tool M: Training Evaluation** (see page 141 of this Trainer's Manual) for each participant to complete by walking around and placing the evaluation facedown by participants approximately **15 min.** after they start their knowledge Post-test Assessment.

Module 5 Tools and Handouts

Tool J: Individual Action Plan: Improving GBV-Sensitive FP Service Provision

I understand that to provide GBV-sensitive FP services, I need to:

- ✓ Support GBV-sensitive communication.
- ✓ Promote reproductive agency by encouraging clients, whether men or women, to make their own reproductive choices, regardless of their age, marital status, or consent by a spouse or family members.
- ✓ Engage men and boys as supporters and users of FP.
- ✓ Facilitate positive couple’s communication and cooperative decision-making.
- ✓ Respond to GBV through empathetic counseling and referrals, and respect and maintain confidentiality on a woman or couple's use of a FP method.

Name			
Specific action you can implement immediately	Why you want to make this change	Challenges you might encounter	Strategies to overcome challenges
1.			
2.			
3.			
Notes			

Tool K: GBV-Responsive FP Counseling Competency Checklist

GBV-Responsive FP Counseling		Participant Code
Competency	Meets	Not Observed
Begins the appointment by asking if the client is comfortable with the people present or would like to have their appointment in private.		
Inquiries about the client's current needs and priority concerns. Uses open-ended questions to inquire if the client has any safety concerns.		
Contraceptive method counseling includes information on visibility and risk of tampering by method.		
Total competencies met:		
<i>Participants should meet 3/3 competencies. If a participant meets 0/3 or 1/3 competencies, they should be referred for further coaching and on-the-job support to their clinical supervisor.</i>		

Tool L: Responding to Disclosures of Violence - LIV – Competency Checklist

Responding to Disclosures of Violence - LIV		Participant Code
Competency	Meets	Not Observed
Listens to information shared with open body language and without interrupting		
Does NOT ask about curiosity details (e.g.: why did that happen?)		
Validates client experience and feelings. Example responses include: <ul style="list-style-type: none"> ✓ That must have been scary. ✓ I can hear how hard that was. ✓ You are not alone. Many women struggle with such things. 		
Assures the client the violence is not their fault.		
Informs the client that help, and support are available nearby. Offers to share referral options.		
Total competencies met:		
<p><i>Participants should meet 5/5 competencies. If a participant meets fewer than 3 competencies, they should be referred for further coaching and on-the-job support to their clinical supervisor.</i></p>		

Tool M: Training Evaluation

Instructions: Please evaluate the training by responding to the statements below. Kindly score each statement from 1 to 5, with **1 being the poor** and **5 being excellent**. Where the statement does not apply to the session, please note N/A in the comments column. The final score should be indicated, with the exclusion of the statements marked as N/A. This is an anonymous process.

Province: _____ Venue: _____ Date: _____

Content Evaluation	1	2	3	4	5	Comments
The content was presented clearly.						
The standard of the content presented was of high quality.						
The content was relevant to the training.						
The information is up to date and well researched.						
I gained new knowledge and skills.						
The session that was of most value (give the session a score and write which session in the comments column).						
The session that was of least value (give the session a score and write which session in the comments column).						
Adequate time was allocated for all the sessions of the day.						
Presentation/Organization/Preparation	1	2	3	4	5	Comments
The training schedule was well prepared.						
The flow/transition between sections/topics was logical and easy to follow.						
All topics presented were linked to real-life situations/experiences/current events.						
Activities conducted were relevant to the topic and allowed participants to reflect on what was being discussed.						
Handouts were prepared and distributed when they were to be used.						

Delivery of Content	1	2	3	4	5	Comments
The trainers/facilitators maintained a level of Professionalism throughout in a nonthreatening manner.						
The trainers/facilitators were confident about presenting the topics.						
The trainers/facilitators spoke clearly and projected their voices.						
All participants were engaged in the activities and listening.						
The trainers/facilitators encouraged participation throughout.						
The trainers/facilitators responded knowledgeably and appropriately to questions.						
The trainers/facilitators did a summary at the end of all sessions and activities.						
The session was concluded with a summary that reflected valuable information.						
Distractions and interruptions were managed appropriately.						
Overall rating of the training						
Overall time management rating:						

General comments on how to strengthen the training, if any

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Shukhi Jibon

PATHFINDER



Integrating Gender-Based Violence Response into Family Planning and Reproductive Health Service Delivery

—Day 1—



পরিবার পরিকল্পনা অধিদপ্তর

Module 0

Introduction to Training

MODULE 0 | SESSION A

Introductions, Group Norms, and Pre-Test

Overall Goal of Training

Advance knowledge and skill set of family planning (FP) and sexual and reproductive health (SRH) service providers to address gender-based violence (GBV) and provide GBV-responsive care within FP/RH service interactions.

Learning Outcomes

- Gain greater understanding and knowledge of gender norms, dynamics, equity, and their role in GBV.
- Gain a greater understanding of how GBV manifests in FP and SRH service provision and uptake.
- Increase knowledge of how GBV is relevant to FP services, including GBV risk identification and analysis.
- Gain skills to mitigate and respond to GBV threats within the context of FP and sexual and reproductive health and rights (SRHR) activities.
- Master skills required to deliver the first three steps of the LIVES mnemonic for disclosure response.
- Gain knowledge on how to refer GBV survivors to appropriate service providers/facilities in a safe and ethical way.
- Develop skill sets to manage GBV case recording and reporting during FP and SRH service provision.

Module 1

Understanding Gender and GBV

MODULE 1 | SESSION A

Understanding Gender in FP Services

What You Can Expect to Learn

Gain clear concepts of gender, gender equity and equality, and their impact on power and violence.

What Does Gender Mean to You?

Turn to a person near you and share reflections based on these three questions:

- 1. Share a time when you became aware of your gender.**
- 2. Describe a time when you felt happy about your gender.**
- 3. Has there been a time when you felt scared, discriminated against, or sad because of your gender?**

Definition of Gender

Gender is about the roles, norms, and behaviors that society consider appropriate for women, men, girls, boys, and those with diverse gender identities, such as transgender. These are socially constructed and vary widely within and across cultures, religions, class, and ethnicity. For example, in many societies a common gender norm is that women and girls should do most of the domestic work.

Source: Pathfinder International

It's not fair or equal...

WOMEN ARE **HALF** THE WORLD'S POPULATION.

YET, WOMEN LIVE WITH A **3X GREATER** LIFETIME EXPERIENCE OF GENDER-BASED VIOLENCE. IN LOW AND MIDDLE INCOME COUNTRIES, GENDER DISCRIMINATION RESULTS IN AN ESTIMATED **3.9 MILLION EXCESS DEATHS** AMONG WOMEN AND GIRLS BY THE AGE OF 60.

Source: World Bank

Let's Try a Gender Quiz

Please read each statement below carefully. Then check the appropriate box to answer the question:

Does this issue relate to sex or does it relate to gender?

	Tick the correct box	
	Gender	Sex
Women must consume extra calories and safe water during lactation.		
It is a man's responsibility to protect his family's honor.		
Female-bodied people will need resources and space to enable optimal menstrual hygiene.		
Women and girls have a responsibility to ensure they don't get pregnant or have sex before they are married.		

Understanding the Difference Between Sex and Gender

Gender	Sex
Socially constructed roles, responsibilities, and attitudes (e.g. <u>division of labor</u>)	Physically, biologically defined
Gender rules and regulations are learned/imposed; we build it in our own minds	Determined by birth; we are born with it
Differences in dress and behavior	Determine our physical functions
Differences between and within cultures, includes variables identifying differences in roles, responsibilities, attitudes, opportunities, expectations, needs, and constraints	Same throughout the world
Changeable over time	Generally unchangeable

Key Terms

Gender Norms

What society considers male and female behavior, leading to the formation of gender roles, which are the roles men and women, and boys and girls, are expected to take in society.

Gender Awareness

An awareness of the differences in roles and relations between women and men. It recognizes that the life experiences, expectations, and needs of women and men are different, varying across the culture and society.

Gender Equity

The absence of discrimination based on a person's sex or gender. Gender equity means providing the same opportunity to each person, including access to and control of social, economic, and political resources, including protection under the law, such as health services, education, and voting rights.

Key Terms *continued*

Gender Discrimination

Any distinction, exclusion, or restriction made on the basis of socially constructed gender roles and norms, which prevents a person from enjoying full human rights.

Gender-Related Barriers

Obstacles to access and use of health services, which are related to deep-rooted social and cultural norms about the roles of women, men, and those with diverse gender identities.

Gender-Based Violence (GBV)

Any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. This includes threats or acts of coercion, arbitrary deprivation of liberty, neglect, or discrimination, whether occurring in public or in private life. GBV encompasses physical or sexual assault, emotional or psychological harm, denial of resources or access to services, and denial of legal self-autonomy.

Understanding Gender and Power

Power is the capacity or ability to direct or influence the behavior of self, others, or the course of events.

Power Over: an individual or institution's degree of power translates to their capacity to exploit others, *regardless of intention or action to do so.*

Power To: an individual or institution's capacity to create without using relationships of domination. The capacity to act and to exercise agency and realize the potential of goals, rights, or aspirations.

Power Within: a person's sense of their own capacity and self-worth. It is related to the productive sense of 'power to' and a prerequisite to holding or increasing one's 'power to.'

Power With: collective power within, to, or over that comes from intentional solidarity amongst individuals or groups. This collective power can be mobilized both within and across class, caste, religious, gender and age differences.

Power and GBV



Case Study 1: Rahima



For Group Discussion

- What elements of Rahima's story demonstrate the common gender norms and expectations in your communities?
- Do you see examples of the men and women in Rahima's story having different levels or different types of power?
- Do you think that gender norms and gender-specific power influences the FP choices in Rahima's story? Why or why not?
- Do you see examples of GBV in Rahima's story? Why or why not?

Gender Relevance in FP Success and Failure

What You Can Expect to Learn

- Gain insights into gender role in FP success and failure, including how failure can be transformed into a success story.
- Be able to articulate the relevance of gender discrimination and GBV to optimize FP and SRH services.

Questions to Assess How Gender Affects FP and RH Outcomes

Question	Answer
Are there gender constraints around who has the authority to access FP/RH services?	
Who in the couple makes FP decisions?	
Do women need permission from husbands/in-laws to seek an FP method for themselves?	
Are there gender norms that affect men's or women's perception of using FP?	
Are there gender norms that affect men's or women's use of FP and RH services?	
Are there unequal decision-making abilities between men and women about whether and when to seek FP and RH services?	
Are there gender differences in who is accessing FP and RH services?	
Are there broader, systematic barriers affecting men and women accessing FP and RH services?	
Is there accessible, relevant, and accurate information about FP and RH tailored to young men?	
Do FP and RH service providers treat men and women equally?	
Do FP and RH facility- and/or community-based providers facilitate male involvement?	

The Power of FP for Women and Development

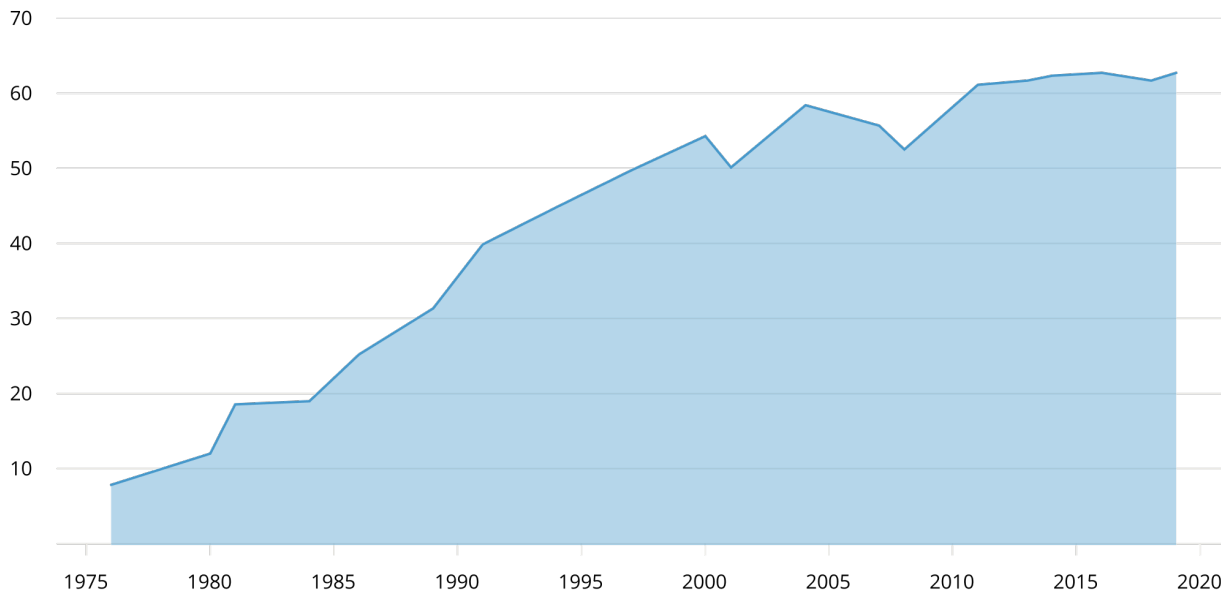


“Investing in family planning is a development ‘best buy’ that can accelerate achievement across the 5 Sustainable Development Goal themes of People, Planet, Prosperity, Peace, and Partnership.”

Source: Ellen Starbird, Maureen Norton, and Rachel Marcus. “Investing in Family Planning: Key to Achieving the Sustainable Development Goals,” *Global Health: Science and Practice*, 2016 Jun 20; 4(2): 191–210.

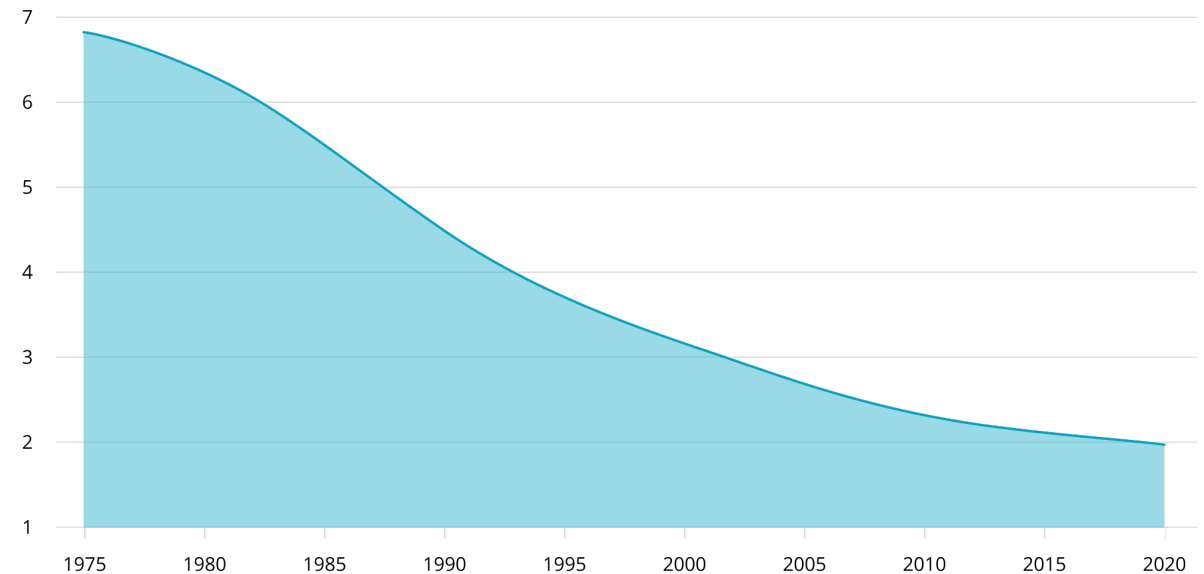
Bangladesh has achieved historic progress in expanding access to voluntary contraception for nearly half a century.

Increase in Contraceptive Use



Sources: Household surveys, including Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys, largely compiled by United Nations Population Division.

Decrease in Total Fertility Rate



Sources: (1) United Nations Population Division, World Population Prospects: 2019 Revision; (2) Census reports and other statistical publications from national statistical offices; (3) Eurostat: Demographic Statistics; (4) United Nations Statistical Division, Population and Vital Statistics Report (various years); (5) U.S. Census Bureau: International Database; and (6) Secretariat of the Pacific Community: Statistics and Demography Programme.

Bangladesh's Historic FP Progress

- One of the **oldest family planning programs** in the world (launched 1953).
- In less than 50 years, **percentage of married women** of reproductive age who are **using family planning increased sevenfold**.
- Today, **contraceptive prevalence rate is 62 percent**, and 52 percent of women are using modern contraceptive methods.*
- GOB and DGFP has **strong commitment** and **farsighted vision** for FP program.

Source: BDHS 2017–2018

Opportunities for Progress

- **Address high rates of discontinuation:** 37% of contraceptive users stop their selected method within 12 months.
- **Improve service quality and method mix:** only 9% of currently married women are using a long-acting or permanent method.
- **Address unmet need among adolescents:** 16% of adolescents ages 15–19 have an unmet need for FP, compared to 5% among women at the end of their childbearing years (45–49)
- **Improve services offered to women who were or are child brides:** Nearly one-third (31%) of women ages 20–49 report that they had married by age 15.

Source: BDHS 2017–2018

Case Studies 2–5: Hena, Nazma, Rani, and Mr. Hossain



For Group Discussion

- How does gender influence the power of the people in the story?
- Where do you see gender and power helping achieve good FP and SRH?
- Where do you see gender and power being a barrier to good health?

Other Relevant Barriers

- Stock outs
- Lack of funding
- Lack of skilled service providers
- Distance to health service point
- Misinformation in communities
- Opportunity costs
- Service provider bias
- Legislative and legal barriers
- Cultural norms and traditions

Module 2

Foundations in GBV

MODULE 2 | SESSION A

Understanding and Conceptualizing GBV

What You Can Expect to Learn

- Be able to articulate the many different forms and manifestation of GBV.
- Understand how GBV is an intersectional issue that can affect anyone regardless of age, marital status, or economic class.
- Be able to communicate the health risks and impacts suffered by those living with GBV.

Unpacking GBV

Gender-Based Violence (GBV)

Any act perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses:

- Threats of violence and coercion
- Physical or sexual assault
- Emotional or psychological harm
- Denial of resources or access to services
- Denial of legal self-autonomy
- It inflicts harm on women, girls, men and boys.

Violence Against Women & Girls (VAWG)

Any act based on gender norms or unequal power dynamics that results in, or is likely to result in, physical, sexual, or mental harm to *women*, including threats, coercion, or arbitrary deprivation of liberty—whether occurring in public or in private life. It includes:

- Intimate partner violence
- Sexual assault and rape
- Female genital cutting
- Reproductive coercion
- Forced marriage
- Trafficking
- Denial of education, financial, and legal services

Forms and Manifestations of GBV

PHYSICAL

Hitting, beating, burning, cutting

Trafficking

Acid attacks, honor killings

SOCIAL

Discrimination, and/or denial of opportunities

Denial of education

Denial of inheritance and/or property rights

EMOTIONAL/PSYCHOLOGICAL

Abuse, Humiliation

Confinement/Isolation

Intimidation/Threats

Blame for uncontrollable outcomes

SEXUAL

Forced Marriage

Sexual Exploitation/Forced Prostitution

Rape*

Harassment

Female Genital Cutting

Reproductive Coercion

A complex form of VAWG that can be perpetrated using physical, sexual, psychological and/or social violence—most commonly perpetrated through a combination of these forms.

Examples:

- › Repeated shaming and blaming of a woman until she gives birth to a son
- › Forcing a women or girl to undergo menstrual regulation to avoid pregnancy
- › Throwing away contraceptive pills or condoms
- › Using a pin to put holes in condoms
- › Denying a women freedom of movement and/or access to resources to access family planning

National GBV Prevalence

VAW in Bangladesh Facts

2017 study | A total 1,143 victims

- 63.78% belonged to the age group of 16–30 years, 19.16% belonged to the age group of 1–15 years.
- 71.91% were married, and 25.63% were unmarried.
- 60.37% were housewives, followed by others (11.46%), students (11.11%) and maid servants (10.85%).
- Most of the perpetrators were husbands (64.65%), followed by the known person (14.00%), neighbors 26 (13.30%), lovers (3.15%), house master and mistress (2.62%), in-laws and others (2.27%).

Report on VAW Survey 2015

- 72.6 % of ever-married women experienced violence by their husband at least once in their lifetime.
- 27.8% of women reported lifetime physical violence by someone other than their husband.
- The lifetime rates of emotional and sexual violence are 28.7% and 27.2%, respectively.

UN Special Declaration

Article 1: For the purposes of this Declaration, the term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Article 4: States should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence

National Laws and Commitments

- In 2014, Bangladesh committed to ending child marriage in the country by 2041.
- Multiple facets of the penal code provide for severe punishment in cases of specific forms of GBV, including acid attacks, femicide to gain new or increased dowry, and denial of child custody.
- Signatory to international conventions include ICPD and the UN Special Declaration against Violence against Women.
- Marital rape is exempt from legal prosecution excepting cases where the wife is below age 13.

MODULE 2 | SESSION B

GBV Risk Analysis in FP and SRHR

What You Can Expect to Learn

- Recognize and communicate GBV impacts across the life cycle.
- Identify verbal and non-verbal cues that an FP and SRH client is high risk for current GBV.



0–2 years



4–10 years



Adolescent
10–14 years



Adolescent
15–19 years



Newly married
couple



Couple who have
completed family



Postpartum couple



Pregnant woman

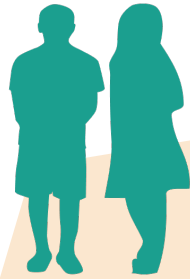
LIFE CYCLE APPROACH



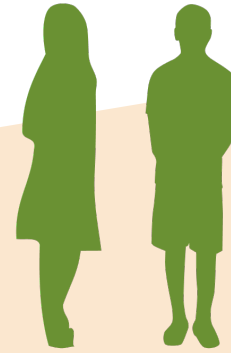
0–2 years



4–10 years



Adolescent
10–14 years



Adolescent
15–19 years



Newly married
couple

- Denial of access to education
- Sexual violence
- Restriction on movement to reach services
- Reproductive coercion
- CEFMU

- Son preference
- Contraceptive sabotage
- Other repro coercion
- Restriction of movement
- Coercion to prove fertility



Couple who have
completed family

- Intimate partner violence
- Denial of resources to access care
- Reproductive coercion



Postpartum couple



Pregnant woman

- Obstetric violence
- Intimate partner violence
- Denial of resources to access care
- Forced repeat pregnancy
- Forced menstrual regulation

GBV IN FP AND SRH ACROSS THE LIFE CYCLE

GBV Impacts Across the Life Cycle

- **Mental health impacts:** e.g., depression, anxiety, flashbacks, substance abuse, suicide ideation
- **Sexual and reproductive health impacts:** e.g., unintended pregnancy, HIV, STIs, cervical cancer, miscarriage, pre-term labor, stillbirth
- **Physical impacts:** e.g., broken bones, contusions, internal bleeding, malnourishment, death
- **Social impacts:** e.g., school dropout, unemployment, isolation, limited contribution to civil society, poverty

Women living with intimate partner violence are:

TWICE as likely
to experience depression

16% more likely
to have a low-birth-weight baby

1.5x more likely to acquire chlamydia, gonorrhea, and HIV

38% of all murders of women were committed by their intimate partners

Source: WHO, *Caring for women subjected to violence: a WHO curriculum for training health-care providers, revised edition* (Geneva: 2021).

What Can GBV Look Like in FP and SRH?

- A woman in the postpartum ward who waits until her mother-in-law has gone outside to ask about PPF
- A FP client who frequently has bruises on her face or wrists when she comes for refill appointments
- An adolescent girl who doesn't speak for herself when brought by a parent for MR
- A FP client who asks if there are options that her husband cannot throw away
- An IUD client who returns with her partner soon after insertion asking for removal

Living with GBV is different for everyone! Never force a disclosure. Never assume someone is immune to GBV.

MODULE 2 | SESSION C

Male Engagement in GBV Prevention Awareness

What You Can Expect to Learn

- Clarify concepts around male engagement in GBV prevention awareness, including pros and cons, challenges and successes, and evidence.

Male Engagement in GBV Prevention

“Engaging men and boys as users, supportive partners, and agents of change improves health outcomes. More specifically, engaging men in FP/RH programs has been successful in decreasing unintended pregnancies, improving maternal health, reducing sexually transmitted infections (STIs) and HIV/AIDS, and better meeting the needs of youth.”

Source: Breakthrough ACTION

Potential Role of Male Engagement to Improve Women's FP and SRHR Status



Benefits of Male Engagement in SRHR

- Male engagement can reduce the spread of STIs, HIV and AIDS.
- Male engagement can lessen the ill effects of men's risky sexual behavior on the health of women and children.
- Men and husband, in most cases, approve of FP.
- Men make decisions that affect women's and men's health.
- Men can gain awareness that gender affects sexual behavior, reproductive decision-making, and reproductive health.
- Male engagement can help meet demands from women for more involvement.
- It provides opportunities for men to promote better RH, and they can play a role.
- As individuals, men benefit from intentional family building and chosen timing and spacing of children.
- As family members, men honor their responsibilities to care for their wives and children by only having children and when safe and healthy for the family.
- As community leaders and policymakers, men support strong, thriving communities by encouraging intentional FP and health timing and spacing of pregnancies.

Risks of Male Engagement in SRHR

- Already imbalanced power over fertility and health decisions
- More attention to men in limited resource setting (human resource, logistics, and client time) can result in unintentional pulling of resources away from women- and girl-centered outreach and services.

Key Things to Learn about Involving Men in FP

- Engaging men in FP is a personal issue.
- Check your assumptions.
- Understand power dynamics.
- Own the reality: for better or for worse, men are involved.
- Men are underserved, yet many want to be engaged fathers and supportive partners.
- Men are FP clients and users in their own right.
- Don't count men out of health services.
- Providers need to think about social norms too.
- Address men even when they are not present.
- Reach men where they are, through their networks.
- Men can and do participate positively in FP.
- When done right, involving men in FP can yield significant benefits for women and families.

In Safe Motherhood and SRHR,

Men play many key roles, their decisions and actions make a difference during

- Pregnancy
- Delivery
- Postpartum period

Men: Full Partners and Advocates for Good Reproductive Health

- Reaching men is a winning strategy. **Yes / No**
- To encourage sexual responsibility. **Yes / No**
- To foster men's support of their partners' contraceptive choices. **Yes / No**
- To address the reproductive health care of couples. **Yes / No**
- Men play dominant roles in decisions. **Yes / No**
- Men are more interested in family planning than assumed. **Yes / No**
- Need communication and services directed specifically to them. **Yes / No**
- Understanding-and influencing-the balance of power is important. **Yes / No**
- Couples who talk to each other reach better, healthier decisions. **Yes / No**

MODULE 2 | SESSION D

Understanding GBV in FP and SRH for Adolescents and Youth

What You Can Expect to Learn

- Be able to articulate the risks and impacts of child, early, and forced marriage and unions (CEFMU) and GBV among young people.
- Understand how national laws impact FP and RH service provision for CEMFU-involved clients.

Basic Concepts

Adolescent and Youth SRHR and CEFMU

Terms and Definitions

Adolescents: 10–19 years

Youth: 15–24 years

Young People: 10–24 years

Child, Early, and Forced Marriage and Unions (CEFMU)

Child and early marriage is any marriage in which one of the parties involved is below the age of 18. Forced marriage and unions refer to any union in which one party did not consent—regardless of their age. This term includes both formal, legal marriages, and as well informal union and cohabitation.

Comprehensive SRHR Services for Young People

- Provision of a full range of contraceptive information and supplies, including emergency contraceptives
- Counseling and information services on FP, pregnancy, and the prevention and treatment of STIs and RTIs
- Basic equipment for provision of reproductive health services (e.g.: FP, antenatal care, laboratory testing for STIs/RTIs)
- Services that cater to interrelated issues, such as mental health, nutrition, sexual abuse, and GBV
- Capacity to accommodate the needs of young people with special needs
- Referral system

Concept of Child Marriage

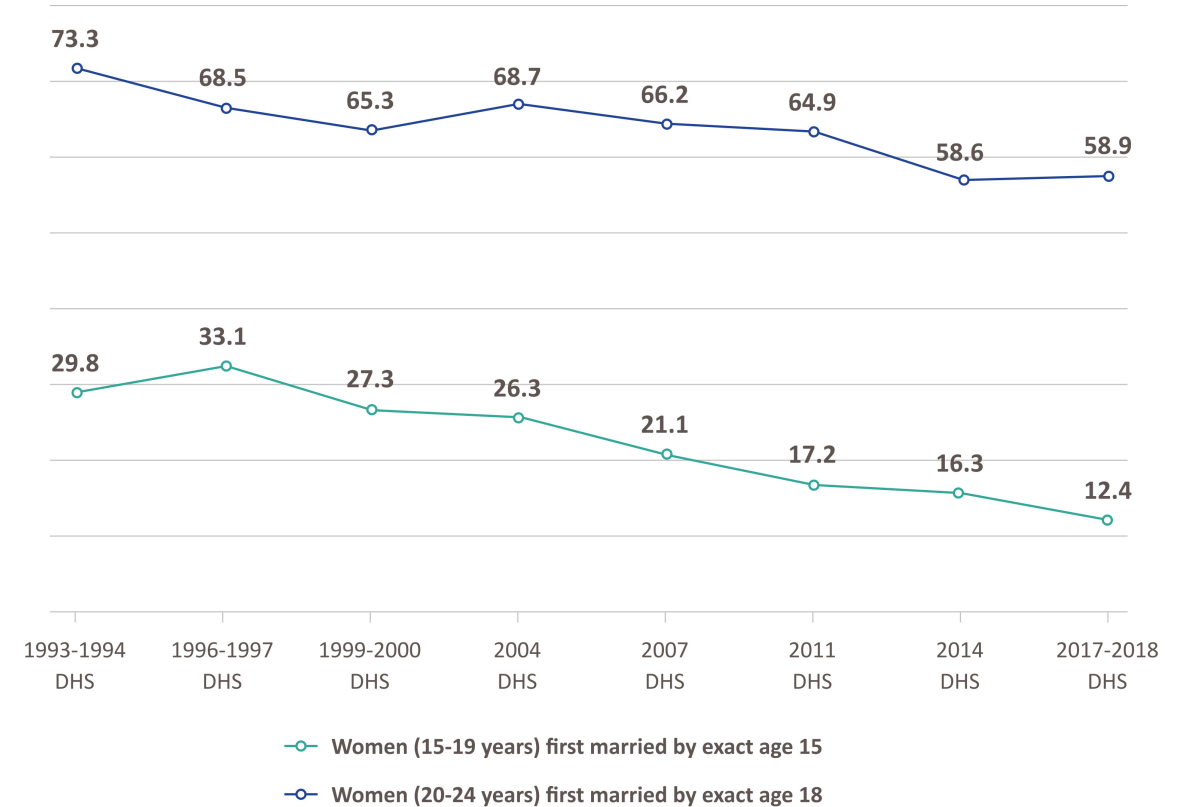
According to BDHS 2017–18, 71% of women ages 20–49 were married by age 18, and nearly one-third (31%) of women 20–49 reported that they had married by age 15.

Bangladesh's Child Marriage Restraint Act, 2017 (CMRA) repealed the earlier British law of 1929. The Act sets the minimum age of marriage for a male as 21 years and for a female as 18 years. This refers to both formal marriages and informal unions in which children under the age referred with a partner as if married.

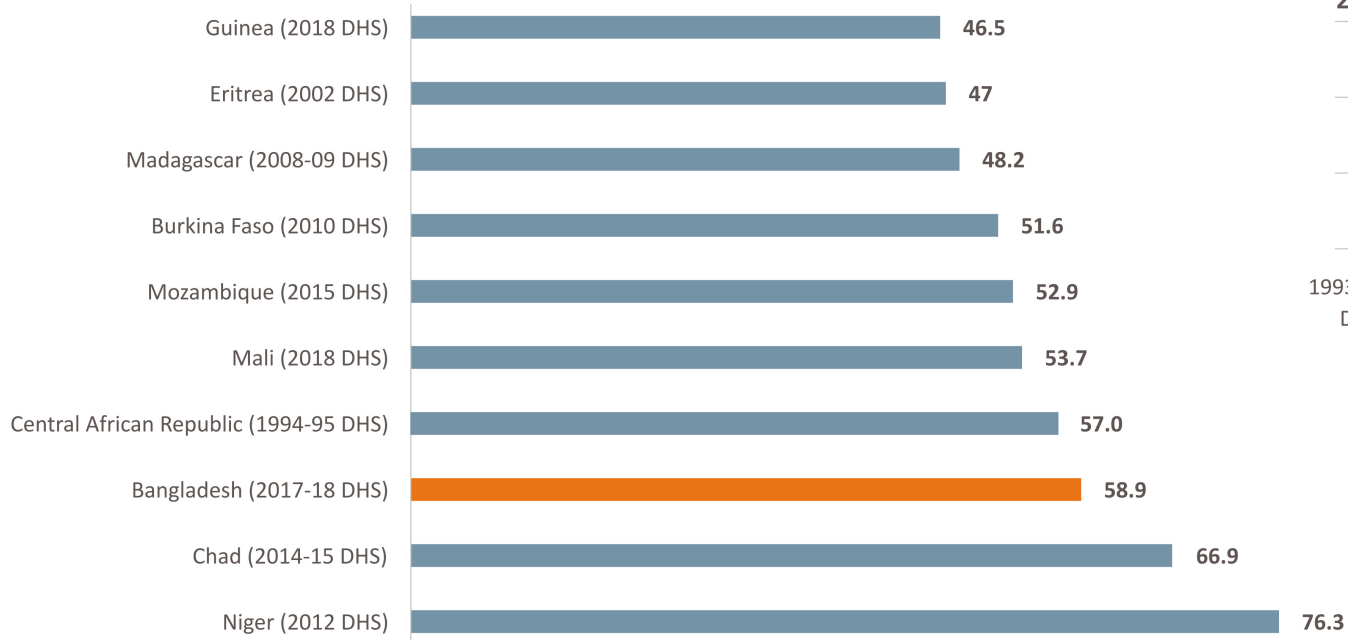
To address the child marriage situation of the country, the Honorable Prime Minister of Bangladesh made the following commitments in July 2014:

- Create a National Plan of Action by the end of 2014 (prepared in 2018);
- Revise the Child Marriage Restraint Act 1929 (revised in 2017);
- End the marriage of under 15-year-olds and reduce by one third child marriage under 18 years by 2021
- Eradicate child marriage from the country by 2041.

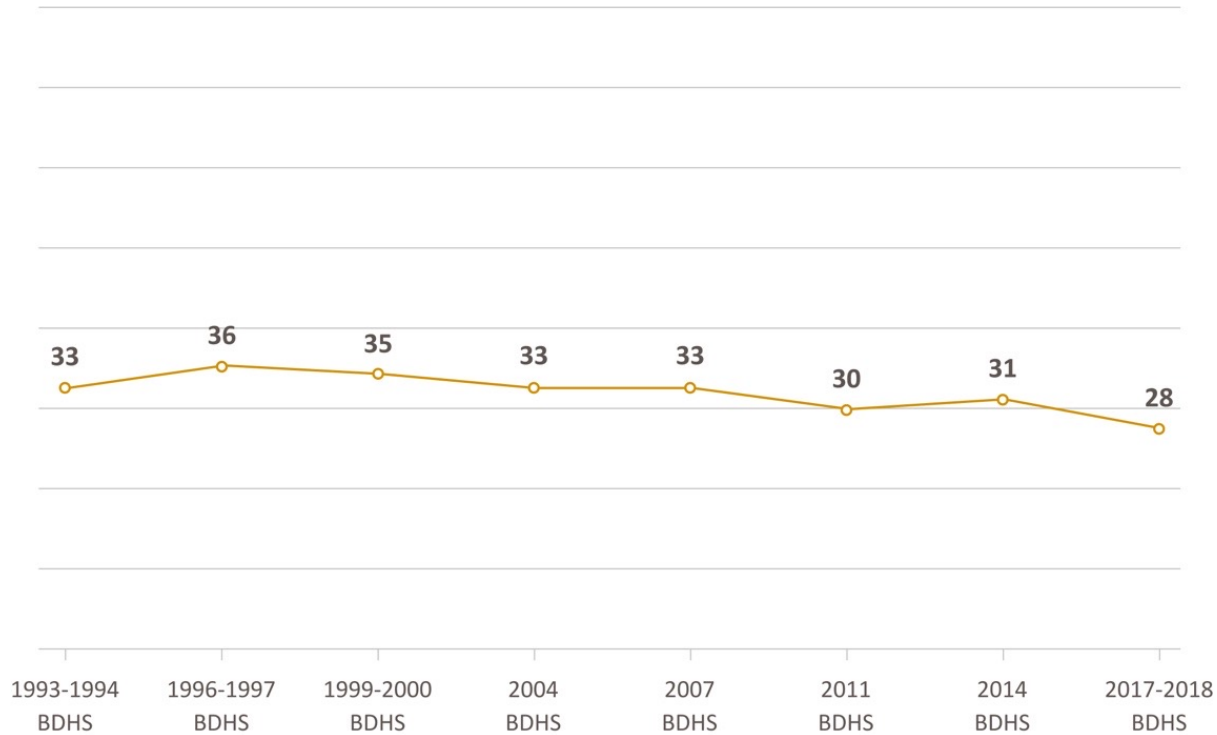
Trends (%) of Child Marriage in Bangladesh, 1993–2017



% of Women (20–24 years) First Married by Exact Age 18: Top Ten Countries



Teenage Childbearing in Bangladesh



Drivers of Adolescent Childbearing

- Social stigma and poverty.
- After giving birth, the status of girls' and boys' (wife and husband) may improve.
- Lack of girls' individual identity/ empowerment/agency.
- Barriers to contraceptive access and use among adolescent girls (unmet needs).
- Misconceptions around contraception.
- Familial and social pressure, and insecurity.
- Presumptions of infidelity and/or extra marital relationship.

Let's make a list of the SRHR service needs of adolescents and youth

Type of service needs	Most common	Sometimes	Rare Need	GBV as Driver — Y/N
Malnutrition				
General health problems (e.g.: viral infection, bacterial illness, asthma, UTI)				
Menstrual problems				
Mental health issues (e.g.: depression, anorexia, sexual identity questions)				
Contraception				
Emergency contraception & menstrual regulation				
Sexually transmitted infection				
Addictive behaviors				
Physical trauma (e.g: broken bones, contusions, lacerations)				
Sexual abuse and assault response				

Case Studies 6–8: Meena, Parvin, and Khadija



To Present in Plenary

- Key facts of the vignette
- How was the case first noticed in the FP/SRH clinic?
- What are your gender- and GBV-relevant observations?
- What are the solution points you considered—to handle the case?



Values Clarification

Vote with Your Feet

- There is no right answer
- Be prepared to share why you have placed yourself where you have
- Power dynamics, values, and beliefs are complicated

Key Takeaways

- Gender is socially constructed and gives everyone habits, values, biases, and assumptions.
- GBV affects 2 in 3 women in Bangladesh and has significant impacts on FP and SRH outcomes.
- People from all walks of life and of all ages experience GBV.
- Reproductive coercion is GBV.
- Addressing GBV is something men and women can and should tackle together.



Questions?



Thank you!



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FROM THE AMERICAN PEOPLE

Shukhi Jibon

PATHFINDER



Integrating Gender-Based Violence Response into Family Planning and Reproductive Health Service Delivery

—Day 2—



পরিবার পরিকল্পনা অধিদপ্তর

Welcome Back

TODAY'S OBJECTIVES

- Develop foundation skills in GBV-responsive FP and SRH service provision, disclosure response, and referrals to comprehensive GBV services.
- Develop knowledge and foundation skills on GBV case recording, reporting, and referral confirmation.

Module 3

GBV-Responsive FP and SRH Service Provision

MODULE 3 | SESSION A

GBV-Responsive Counseling in FP and SRH

What You Can Expect to Learn

- The difference between universal counseling versus selective screening for GBV.
- The pros and cons of different FP methods for clients living with intimate partner violence (IPV) and/or reproductive coercion.
- How to demonstrate active listening during client-centered counseling.

Concept of Counseling

- A two-way interaction between a client and a provider.
- An interpersonal, dynamic communication process that involves a kind of contractual agreement between a client and a counselor who is trained to an acceptable standard and who is bound by a code of ethics and practice.
- A process of dialogue and mutual interaction between counselor and counselee aimed at facilitating problem-solving, motivation, and decision-making of the counselee
- Requires empathy, genuineness, and the absence of any moral or personal judgment.

Principles of Client-Centered Counseling

- Privacy; ensure audio and visual privacy.
- Take sufficient time.
- Maintain confidentiality.
- Ask the client about their priorities. Listen to their answer.
- Keep it simple; use common language. Avoid overly scientific/technical words.
- First things first: do not cause confusion by giving too much information.
- Say it again; repeat the most important information at the beginning, in the middle, and the end.
- Use available visual aids, like posters and flip charts, etc.
- Seek feedback from the client.

Counseling with Active Listening

IT IS IMPORTANT TO:

- Use eye contact, as long as this is culturally acceptable in your particular setting. It shows interest.
- Use open-ended questions. They allow clients to express themselves.
- Check your understanding by summarizing (paraphrasing).
- Nod and use acknowledgment sounds that convey your interest and keep the conversation flowing, but avoid unnecessarily interrupting your client.
- Use a tone of voice that shows interest.
- Listen for feelings as well as facts.
- Limit active note taking and verbally communicate to the client why you are writing things down as they speak.



Counseling with Active Listening



DO NOT:

- Interrupt the client unnecessarily.
- Finish the client's sentences.
- Let your mind wander and spend listening time formulating your responses or thinking about your dinner!

GATHER Approach in FP Counseling

G Greet

A Ask

T Tell

H Help

E Explain

R Return

- **Greet** the client respectfully.
- **Ask** them about their FP needs. Ask if they have any other concerns about their health or safety.
- **Tell** them about different contraceptive options and methods, including information on the FP method's vulnerability to sabotage and degree of partner involvement needed for proper use.
- **Help** them to make decisions about choices of FP methods.
- **Explain** and demonstrate how to use the FP methods.
- **Return**, referring, and scheduling an appropriately timed return visit. Ask the client for their preferred method of follow up communication and seek consent to send texts or make phone calls. Offer information on GBV services and referral availability.

IPV/ Reproductive Coercion Considerations in FP Counseling

Adapted from WHO's
Caring for Women
Subjected to Violence
curriculum.

Method	Pros	Cons	Discussion Points
Injectable Contraceptive	<ul style="list-style-type: none"> • Does not leave any signs on the skin • No supplies to store 	<ul style="list-style-type: none"> • With two- and three-month types, monthly bleeding often stops after time • Another injection is needed every one, two, or three months, depending on type 	<ul style="list-style-type: none"> • Are you concerned that your partner may track your periods? • Do you think you could go for re-injection visits without fail?
Implant	<ul style="list-style-type: none"> • Works well for several years • Usually, no follow-up required • No supplies to store 	<ul style="list-style-type: none"> • Sometimes can be felt and seen under the skin of arm • May cause spotting or changes in menstrual bleeding (often improves after three months) 	<ul style="list-style-type: none"> • Are you concerned that your partner may track your periods?
Copper or LNG IUD	<ul style="list-style-type: none"> • Remains out of sight in the uterus • Copper IUD works well for at least 12 years; LNG-IUD, for 3–5 years • Usually, no follow-up required • No supplies to store 	<ul style="list-style-type: none"> • Copper IUD often increases menstrual flow • Hormonal IUD can make period lighter or stop • Caution if women has current STI or high STI risk • Partner may feel ends of strings in cervix 	<ul style="list-style-type: none"> • Are you concerned that your partner may track your periods? • Do you think you may have an STI or are likely to get an STI?
Pill	<ul style="list-style-type: none"> • Does not leave any signs on skin • Little effect on menstrual bleeding 	<ul style="list-style-type: none"> • Must be taken every day • Pills/packaging must be kept in safe place 	<ul style="list-style-type: none"> • Do you have a safe place to keep the pills?

GATHER Skills Practice: Role Plays 1–3



Observers should provide feedback on:

- Did the provider follow the steps and use active listening?
- Did the provider follow client cues to guide discussion and selection of methods?
- Did the provider give information that was GBV-responsive?

Clients should give feedback on:

- Did you feel listened to? Why or why not?
- What did the provider do that was helpful?
- What could the provider have done to make you feel more comfortable?

MODULE 3 | SESSION B

Responding to Disclosures of GBV

What You Can Expect to Learn

- Explain the purpose and value of psychological first aid
- Understanding the role of quality disclosure response in FP settings
- Deliver the first three steps of the LIVES approach to first-line response

Responding to Disclosures

As FP providers, you may be the first and/or only person this woman has been able to tell about what she is dealing with. **Your response matters.**

Remember:

- It is never the survivor's fault.
- Everyone deserves to feel and be safe.
- Services and support are available in your district.

LIV(ES)

Listen, Inquire, Validate, Enhance safety, and Support

The LIV(ES) mnemonic was developed by the World Health Organization to ensure first line response to violence against women in primary and preventative health care settings.

- **Listen** – Listen closely with empathy, no judgment.
 - **Inquire** – Assess and respond to the client’s needs and concerns – emotional, physical, social, and practical.
 - **Validate** – Show the client you believe and understand them.
- Psychological First Aid**
- **Enhance Safety** – Discuss how to protect the client from further harm.
 - **Support** – Help connect the client to appropriate resources and services, including social support.

LIV(ES) Step	Sample Phrases to Use
<p>L - Listen</p>	<ul style="list-style-type: none"> • I hear you. • I'm listening. • We have time if you there is anything else you want to tell me.
<p>I - Inquire</p>	<ul style="list-style-type: none"> • What can I do to help? • Are you worried about your safety if you tell your partner? • How are you feeling? Are you in pain?
<p>V - Validate</p>	<ul style="list-style-type: none"> • That must have been very difficult. • I'm so sorry this happened to you • You did not/do not deserve this • Thank you for telling me. • Sadly, this happens to many women. You are not alone.

LIV(ES) Skills Practice: Role Plays 4–6



Reflection Questions:

- How did it feel just to listen and not offer “advice” or solutions?
- What did the provider do that was helpful?
- What could they have done differently?

Risk Identification

The following may be signs that your client is in immediate danger. Should you see these signs or behaviors, you may wish to fetch a GBV specialist colleague and have them join you in the appointment room:

- The client tells you she is afraid she will be killed if she returns home.
- A client is accompanied by a partner or family member and not allowed to answer questions for themselves.
- A child under 13 is seeking MR or emergency contraception.

MODULE 3 | SESSION C

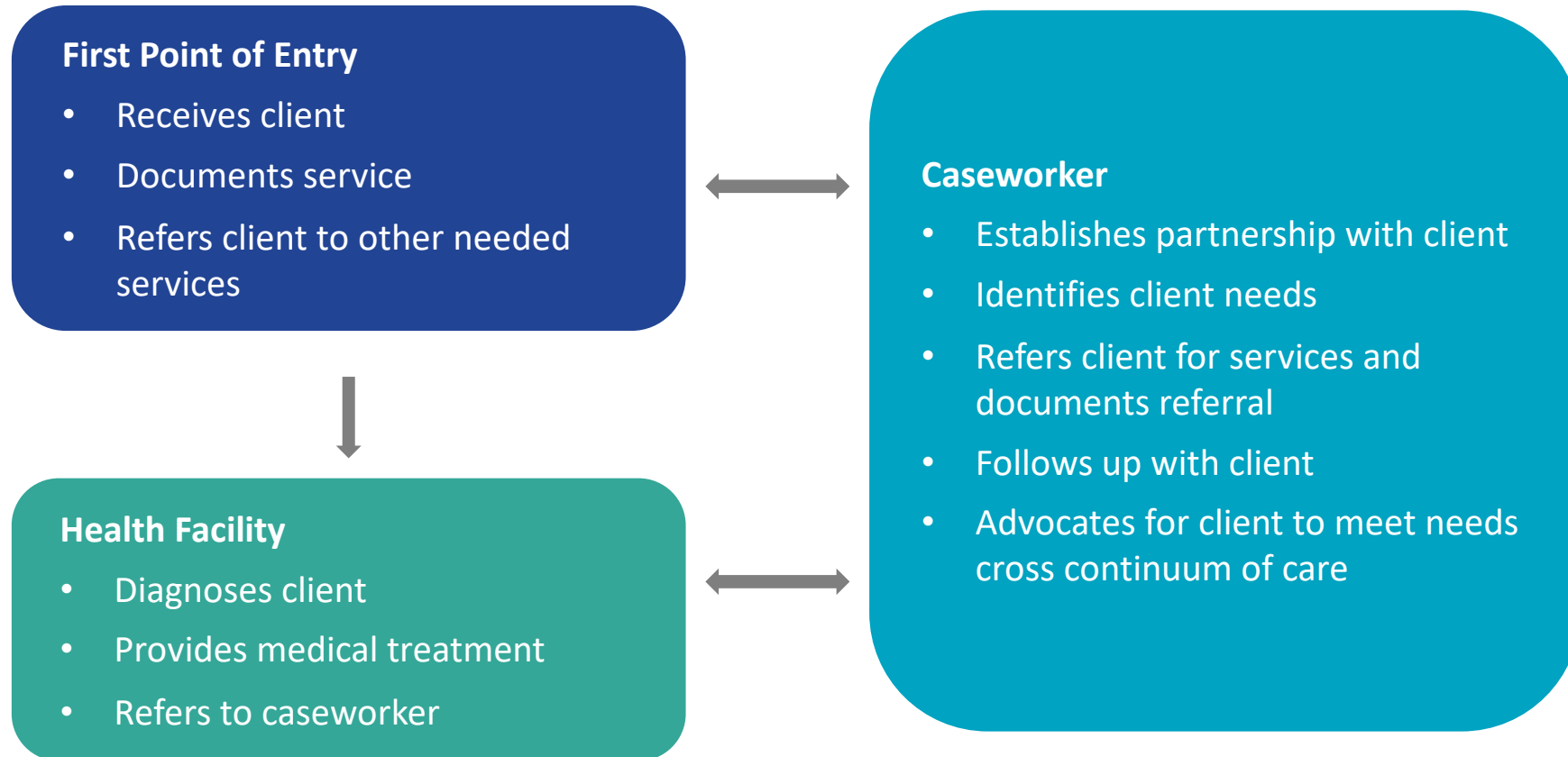
Making GBV Referrals

What You Can Expect to Learn

- Know when and how to provide referrals for comprehensive first line response to GBV

Effective Referral Pathway

Case Management Referral System



Case Study 9: Lovely



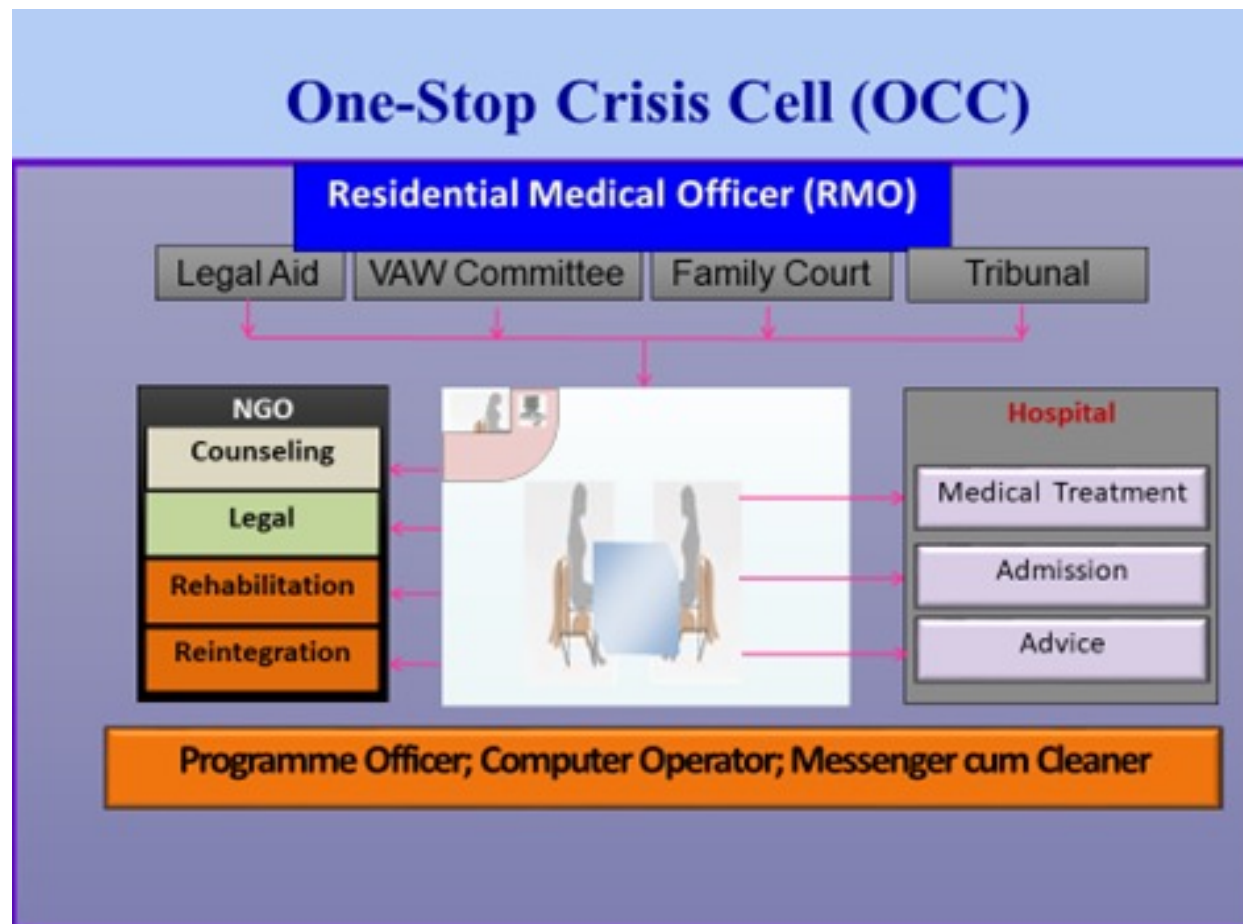
For Group Discussion

- What are the steps you will follow to counsel her in a real situation?
- In what way you will support the case so she can continue her pregnancy?
- What kinds of referrals might you want to make for this case?

One-Stop Crisis Cell

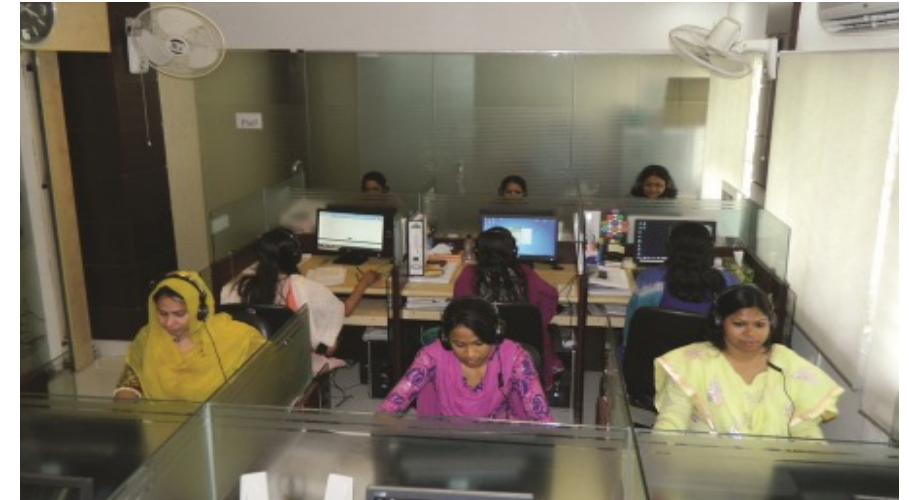
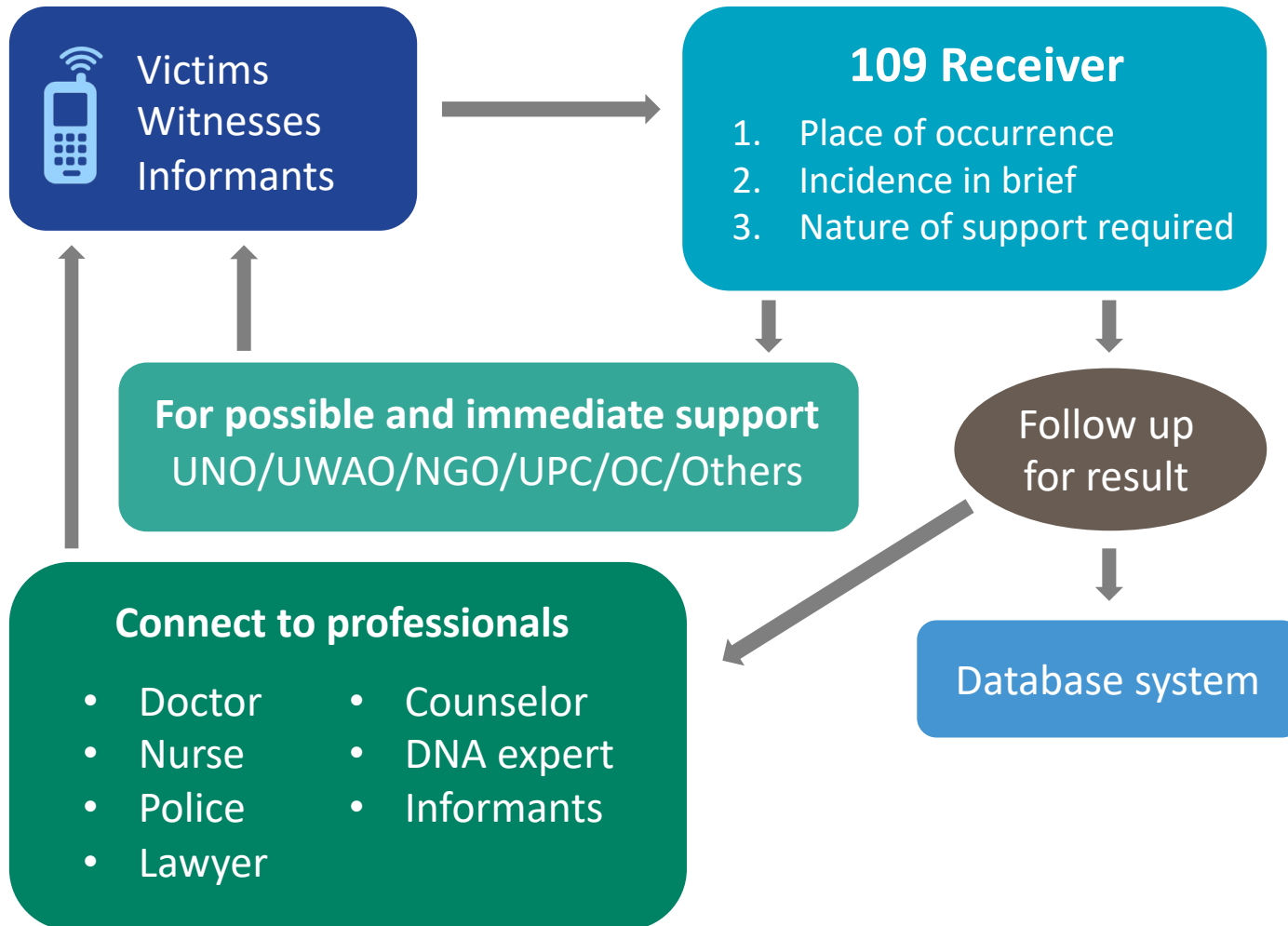
Services of OCC at MCHs

- Medical treatment
- Social reintegration
- Safe custody/shelter home
- Rehabilitation
- Psychosocial counseling
- Social welfare services
- Legal support
- Police assistance
- Forensic DNA test










National Helpline Center as a Referral Way Out

National Helpline Center for VAWC



Important GBV Referral Centre Locations in Bangladesh



-  One-Stop Crisis Center at MCH
-  One-Stop Crisis Cell at District
-  One-Stop Crisis Cell at Upazila
-  National Trauma Counseling Center (NTCC)
-  National Forensic DNA Profiling Laboratory
-  National Helpline Center for Violence Against Women and Children
-  Regional Trauma Counseling Center (NTCC)

Helplines for the Prevention GBV (VAW) and Child Marriage

109	National Helpline Centre for Violence against Women and Children	Offering multisectoral referral and psychosocial support, this is the main helpline number to call and is circulated nationwide. It is a 24-hour-per-day, 365-days-per-year, free emergency phone service for women and children in need of aid and assistance.
333	National Hotline Number	Immediate reports/help for any social problems, from queries related to COVID-19 to child marriage and sexual harassment cases.
10921	National Helpline Center for Violence against Women	Immediate service for victims, offering links to relevant agencies, including doctors, counselors, lawyers, DNA experts, police officers.
16767	DGFP Call Center	Call center that is available 24 hours per day, seven days per week for any information on FP, maternal and child health, and nutrition.
999	National Emergency Service Bangladesh	A centralized 24-hours-per-day, seven-days-per-week emergency support service allowing any citizen within the country border to directly connect with the police, fire, and ambulance emergency responding teams on the ground to get aid in an emergency state.

Where to Report

There are several places where we can report:

- One-Stop Crisis Center
- Trauma Counseling Center
- Forensic DNA Laboratory
- National Help Line for Violence Against Women
- Legal Aid Center
- Legal Action Center/Police Station
- Social Support Center/rehabilitation center
- Safe Custody/Shelter Home
- Rehabilitation Center

National Trauma Counseling Center (NTCC)

Objective of NTCC

- Provide psychosocial counseling support in NTCC, OCC, and safe home to those experiencing violence against women and children.
- Conduct different types psychosocial counseling training for Human Resource Development.
- Organize awareness-raising program for changing mindsets.
- Establish a strong network among organizations/stakeholders who work on GBV issues.

Psychosocial Counseling Services

NTCC provides psychosocial counseling support for those experience VAWC free of cost. NTCC provides a wide range of counseling support including:

- Individual face-to-face counseling
- Individual tele-counseling
- Couple counseling
- Family counseling
- Group counseling
- Online Counseling

Intra-Facility versus Inter-Facility Referral

Intra-Facility

Facility has an emergency department, GBV specialist, and/or other needed services.

Client has declined legal referral and is seeking medical aid only.

Inter-Facility

Client has need and desire for full case management and the full scope of an OCC cell.

FP service facility does not house:

- GBV subject matter expert
- Necessary equipment and/or commodities for treatment
- Capacity to protect confidentiality of the client

Role Play 7: Web of Referrals

Let's better understand and gain empathy for how uncoordinated systems and too much specialization can make referrals burdensome for a survivor of GBV.

Forms and Formats of GBV Recording and Reporting

REFERRAL SLIP

Client number (as recorded):

Name of client (first name only/optional):

Age:

Gender:

Immediate management given (if any): first aid / LIV / Helpline info

Cause of referral:

Place of referral:

Date referral completed:

Source: Pathfinder International

Case Study 9: Lovely

Lovely Begum (*pseudonym*) is only 16 years old. Her parents had arranged to have her married to a nearby acquaintance when she turns 18, but a jealous cousin abducted her and forced her into wedlock. She tried to escape to her parents' home after that the cousin made her isolated from everyone in the family, but her parents explained that because the marriage had been consummated, her previous betrothed will not take her anymore and told her she needed to go back to her husband.

Lovely returns to her husband's house. Her husband continues to keep her at home and does not allow her to visit her parents anymore. He is angry that she tried to stay at her parents. He yells at Lovely and beats her frequently. He accuses Lovely of not getting pregnant on purpose.

Finally, after six months of life as a wife, Lovely discovers she is pregnant and goes to the SRH service center to get help for continuing her pregnancy. She is very worried about protecting her precious child in her womb and concerned that the beatings she is receiving at home will harm her child

Module 4

Foundational Knowledge of GBV Case Recording, Documentation, and Record Keeping

MODULE 4 | SESSION A

Legality, Protecting Confidentiality, and Reporting GBV

What You Can Expect to Learn

- Gain an understanding of the legality and reporting aspect of a GBV case identification, notification to primary management and referral

Defining “Legality”

Legality is an act, agreement, or contract that is consistent with the law or state of being lawful or unlawful in a given jurisdiction, and the construct of power. Legal assistance describes a range of legal services, from the provision of generic legal information and advice to representation by a legal professional in court.

Legal Considerations for FP and SRH Providers Around GBV

- Health care providers do not have a legal mandate to report GBV. You should only report cases to judicial authorities if and with a client's written consent.
- Documentation of disclosure, injuries, or other medical records may become evidence in the event a survivor chooses to file a legal complaint and prosecution follows.
- Universal provision of referral options and GBV services available is not legally required but is ethically mandated.

Integrating GBV Disclosure and Response Reporting into an FP and SRH Visit

What to Include in Your Report

- Basic demographic information
- Consents obtained
- History
- Account of the assault
- Results of the physical examination
- Tests and results
- Treatment plan medication provided or prescribed
- Referrals provided
- Anonymous code for use in referral communication
- Information shared by client
- Provider observations

- Use separate forms provided. GBV disclosures should NOT be noted in the regular FP register.
- Immediately following the visit, place your documentation form in an assigned, locked storage space.
- Document in three places: confidential client record, referral slip, and anonymized facility log.

Facility Registers for Recording Cases of GBV

Date of visit	Date of incident	Case Code	Client sex	Client age	Type of GBV					Response				
					Physical	Contraceptive Sabotage	Emotional	Sexual (IPV)	Sexual (non-IPV)	Treatment (first aid)	LIV(ES)	Referral Issued	Referral Completed*	Police Report Made
23/9/2022	19/9/22	922-05	F	22		X		X			X	X		N

Source: Pathfinder International

Case Study 10: Aklima

Using the sample referral and GBV record forms, fill out the documentation needed based on the information from Aklima's story.



For Reflection and Group Discussion

- What was the hardest pieces of the form to complete?
- Do you think you will be able to do this during a normal day of work?
- Do you have any questions on how to fill out a certain portion of the forms?

Module 5

Closing

Key Messages

- ✓ FP/SRH providers have a critical role to play in first line response for violence against women and girls.
- ✓ Basic services such as GBV-responsive FP method counseling, psychological first aid, and appropriate activation of a referral chain can have significant impact on the trajectory of care for people living with GBV.
- ✓ FP/SRH providers have a significant role to play in safe, confidential reporting, and documentation of GBV prevalence and incidence.

Wrap Up

You have three final steps in this training:

- 1) Complete your individual action plan
- 2) Take the post-test
- 3) Meet with a trainer for clinical competency assessment



Questions?



Thank you!



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