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An interactive session for participants of an Integrating GBV in SRHR training in Dhaka.  
Photo: Dr. Rubana Rashid/USAID Shukhi Jibon Project

# Shukhi Jibon Learning Lab: Integrating Gender-Based Violence Response into Sexual and Reproductive Health Service Delivery

## SUMMARY

Through the USAID Accelerating Universal Access to Family Planning Project, locally known as Shukhi Jibon, Pathfinder supported Bangladesh's Directorate of Family Planning (DGFP) to train providers, orient health facility staff, and collaborate with health facility managers to strengthen gender-based violence (GBV)-responsive sexual and reproductive health (SRH) services. Building upon Shukhi Jibon's gender-transformative work, including the development and rollout of a training on Gender Integration in Family Planning (FP) Services for providers and clinical managers, the new pilot intervention for GBV-responsive FP and SRH care aimed

to strengthen the health sector's response to GBV and adapted FP service provision to meet the multifaceted needs of clients experiencing GBV.

## BACKGROUND

### GENDER-BASED VIOLENCE: A SYMPTOM OF GENDER DISPARITY IN BANGLADESH

In 2015, the Bangladesh Bureau of Statistics conducted its second Violence Against Women Survey, interviewing 22,775 women from households spanning urban, peri-urban, and rural communities.<sup>1</sup> The survey revealed that 73% of ever-married women in Bangladesh had experienced at least one instance of GBV in their lifetimes. Half of ever-married women reported having experienced physical violence, 29% emotional violence, 27% sexual violence, and 11% economic violence during their lifetimes. Fifty-five percent of respondents reported being subject to controlling behavior, such as restrictions on working or leaving the home, during their lifetimes. The second-most common form of controlling behavior (after "anger for no reason") was a husband's expectation that his wife seek permission before accessing health services (36% of ever-married women experienced this during their lifetime and 23% in last 12 months). Nearly 8% of women reported being forced to use contraception in their lifetime, and 5% reported being forbidden to use contraception.

## A NOTE ABOUT BANGLADESH'S BIFURCATED HEALTH SYSTEM

Bangladesh's Ministry of Health and Family Welfare (MOHFW) has a split public-sector health service delivery system. The **Directorate General of Family Planning (DGFP)** provides district-, union-, and community-level FP, maternal and child health, and nutrition services, whereas the **Directorate General of Health Services (DGHS)** provides district-, union-, and community-level curative and preventive services through higher level health facilities.

DGFP and DGHS staff work independently at health care facilities and in the community.

The perception among many Bangladeshis that GBV—particularly intimate partner violence in the context of marriage—is normal is driven by patriarchal norms and reinforced by the country's legal structure. Many view use of violence as part of a husband's traditional role in disciplining his wife. In Bangladesh, marital rape is not criminalized if a wife has reached the age of 18, the legal age for marriage.<sup>2</sup> The prevalence of GBV underscores Bangladesh's enduring gender inequality and women's limited agency and decision-making power, including whether and when to access FP. Gender inequality and pressure on young women to prove their fertility soon after marriage contribute to high fertility rates among girls ages 15 to 19 (24% have begun childbearing)<sup>3</sup> and high maternal mortality (196 deaths per 100,000 live births).<sup>4</sup>

### GAPS AND OPPORTUNITIES IN BANGLADESH'S FP PROGRAMMING

GBV in all its forms directly affects women's ability to exercise their sexual and reproductive health and rights (SRHR). Women who have experienced GBV are more likely to experience sexually transmitted infections and miscarriages and less likely to be able to make their own decisions on FP use.<sup>5</sup> Supporting women in fulfilling their SRHR intentions—including the right to practice FP—is an essential part of promoting gender equality and women's empowerment. Yet many FP service providers in Bangladesh still do not make a clear connection between GBV and FP.

In Bangladesh's FP service system, staff from the Directorate General of Family Planning (DGFP) focus on FP and SRH, and there are no provisions to serve clients experiencing GBV. Though the health system does not systematically address violence against women, its FP and SRH infrastructure is strong. Counseling is built into all DGFP services, providing an opportunity for providers to address violence against women and provide client-centered psychosocial SRH counseling. Yet, currently, FP providers, regardless of cadre, rarely receive training around the drivers, impacts, and manifestations of GBV, nor how GBV affects FP and SRH outcomes.

“It is imperative to take action to reduce the gender gap as well as gender-based violence. This requires addressing the underlying factors—for example, strengthening facility readiness and building workforce capacity in responding to gender- and gender-based violence-related issues.”

—Director General, DGFP



Training on GBV-Responsive FP and SRH Services in Dhaka.  
Photo: Dr. Shamima Parveen/USAID Shukhi Jibon Project

“No woman dares to take a family planning method without her husband’s permission. We often [counsel women on alternatives to the contraceptive pill], but they refuse because they feel afraid their husbands would kick them out of house!”

–Upazila Family Planning Manager, DGFP

## SHUKHI JIBON’S LEARNING LAB FOR STRENGTHENING GBV-RESPONSIVE FP AND SRH SERVICES

From 2018 to 2023, Shukhi Jibon supported Bangladesh’s Ministry of Health and Family Welfare (MOHFW) to strengthen national health systems and reduce inequities to broaden access to and use of quality voluntary FP services. Led by Pathfinder, Shukhi Jibon took a systems-strengthening approach to providing adaptive, needs-driven technical assistance at the national, divisional, district, and upazila (sub-district) levels within four focus divisions—Chattogram, Dhaka, Mymensingh, and Sylhet.

### SHUKHI JIBON’S INTEGRATION OF GBV RESPONSE INTO FP AND SRH SERVICES

Shukhi Jibon initially provided technical support to both the DGFP and Directorate General of Health Services (DGHS) to develop and roll out provider training on gender-responsive SRH care in 2019. The process of developing the training package on gender integration in FP services illuminated the need to increase the competency of providers in GBV-responsive FP counseling, GBV risk mitigation, and GBV disclosure response, and to create opportunities for women experiencing GBV to disclose incidents and request support.

In 2020, Shukhi Jibon conducted a desk review on Bangladesh’s GBV-related national sociocultural context and the FP and SRH service delivery context to inform approaches to strengthen GBV response within FP and SRH services. To complement the desk review and better understand the immediate effects of the COVID-19 pandemic, which exacerbated GBV in Bangladesh as it did in many countries,<sup>6</sup> Shukhi Jibon conducted a brief survey of 31 FP service providers between July and August 2020 to learn what they were seeing in their services related to GBV and to formulate recommendations for DGFP on addressing GBV. For example, service providers stressed their need for clear guidelines and skills-building to effectively respond to clients experiencing GBV or facing the potential of GBV as a consequence of FP use. Providers also noted the need to raise awareness of the availability of GBV-responsive services and increase knowledge about where and how clients can access these services.

#### The Shukhi Jibon intervention involved the following key components:

**Advocacy and collaboration:** The project team advocated for the integration of GBV-responsive services into public-sector FP and SRH provision and into DGFP operational plans. In partnership with the DGFP, Shukhi Jibon formed a GBV working group, whose members included representatives from the Multi-Sectoral Program on Violence Against Women (MSPVAW), DGFP, DGHS, the National Institute of Population Research and Training (NIPORT), UNWomen, the World Health Organization (WHO), and other nongovernmental organizations (NGOs) working on gender and GBV. The working group developed an action plan, assessed health facility readiness, and selected 16 facilities in Faridpur, Sylhet, Cox’s Bazar, and Dhamrai for tailored implementation of the intervention to strengthen GBV response within FP and SRH services. The selected facilities had high levels of facility readiness to provide gender-sensitive FP services and included 16 union health and family welfare centers (UH&FWC), one upazila health complex (UHC), and one mother and child welfare center (MCWC).



**Facility readiness:** Shukhi Jibon provided a whole-site orientation to all staff of participating facilities on adolescent-friendly health services, gender, GBV and its relevance to SRH and FP, and the integration of GBV response into FP services. To increase access to information among clients, all participating facilities were equipped with information, education, and communication (IEC) materials about SRH and FP-related violence as well as referral points and contacts. The Shukhi Jibon team worked with the MSPVAW project of the Ministry of Women and Child Affairs (MOWCA) to include a list of public-sector one-stop crisis cells and centers (OCCs) in the project's GBV leaflet and established cross-ministry collaborations with MOWCA to use the OCCs as referral points for clients in need of support.

**Demand generation:** In addition to the provision of IEC materials at facilities, Shukhi Jibon organized radio programs in collaboration with MSPVAW and the USAID-funded Ujjiban project to share messages about integrated GBV services at the primary health care level.

**Strengthening provider capacity for effective counseling:** Between December 2022 and April 2023, the Shukhi Jibon project trained 83 community-based service providers [mostly family welfare visitors (FWVs) and sub-assistant community medical officers (SACMOs) and managers at the union and upazila levels (FP inspectors, upazila FP officers, and medical officers) from the 16 participating health facilities.\* Shukhi Jibon developed a trainer's manual and a participant's manual to guide provider interactions with clients who have faced GBV related to their FP and SRH choices. The 13-hour training module aimed to advance the knowledge and skills of FP and SRH service providers to address GBV with responsive care, strengthening the following:

- Knowledge of gender norms, dynamics, equity, and their role in GBV;
- Understanding of how GBV manifests in FP and SRH service provision and uptake;
- Skills in GBV risk identification and analysis in FP services;
- Ability to mitigate secondary risk and respond to GBV disclosures within the context of FP and SRH activities;
- Mastery of the first three steps of the LIVES<sup>7</sup> approach for disclosure response: listening, inquiring, and validating (see box);
- Skills to manage GBV case recording and reporting during FP and SRH service provision;
- Ability to provide timely psychological first-aid; and
- Knowledge of proper mechanisms to refer GBV survivors to appropriate service providers or facilities, maintaining client privacy and confidentiality.

This training was not intended to develop providers' skills in delivering comprehensive medical care for GBV nor clinical management of rape. Rather, it aimed to strengthen FP and SRH providers' capacity to integrate GBV-responsive care into their routine work through appropriate identification of cases of GBV, counseling, first-aid (if needed), and referral for further support.

Shukhi Jibon also developed and provided job aids, field tested and finalized through the GBV working group and approved by DGFP, which focused on do-no-harm principles, best practices to prevent unintended secondary violence in response to GBV, and general gender integration and awareness for quality service provision.

\* This activity was conducted in collaboration with the Cox's Bazar Sexual and Reproductive Health and Rights project, led by Pathfinder and supported by the David and Lucile Packard Foundation.

Bangladesh's one-stop crisis cells and centers (OCCs) within district hospitals and some upazila health complexes (UHCs) are a key component of the Multi-Sectoral Program on Violence Against Women (MSPVAW). OCCs provide people experiencing GBV with free, round-the-clock access to services and consultation, including the following:

- Police assistance
- Medical treatment
- Legal support
- Psychosocial counseling
- Forensic DNA testing
- Safe shelter
- Social welfare services & reintegration
- Rehabilitation

Shukhi Jibon used the **LIVES** approach, developed by WHO,<sup>7</sup> to guide primary health care providers to counsel women who have experienced GBV. LIVES helps empower clients by acknowledging their autonomy and dignity and supporting them in making their own decisions.

**Listen** closely with empathy and without judgment.

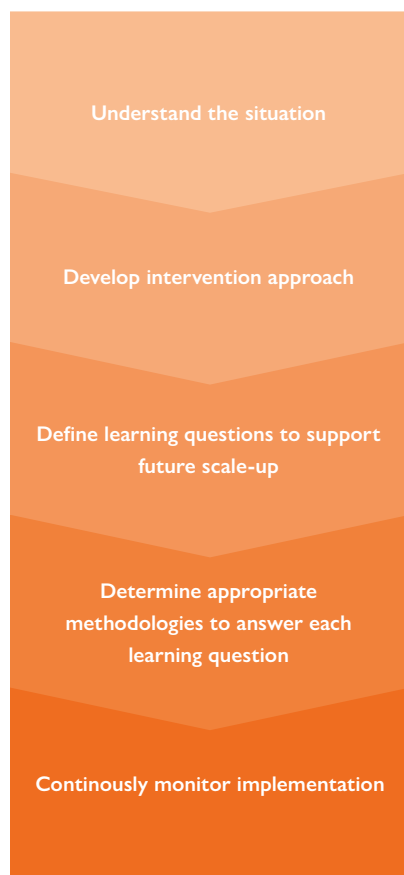
**Inquire**, assess, and respond to clients' needs and concerns, whether emotional, physical, social, or practical.

**Validate** clients by showing them you believe and understand them.

**Enhance** safety by discussing plans to protect clients from further harm if violence occurs again.

**Support** clients by helping them connect to information, services, and social support.

**Figure 1. Shukhi Jibon Learning Lab approach**



**THE LEARNING LAB MODEL**

Shukhi Jibon used a Learning Lab approach based on USAID’s Collaborating, Learning, and Adapting (CLA) framework, and with strong commitments from the Government of Bangladesh (GOB) and USAID, to implement innovative interventions—including strengthening GBV-responsive FP and SRH services—in 39 test sites across 6 learning districts. The project team formulated the following key learning questions about the implementation of GBV-responsive FP and SRH services:

1. To what extent did service providers’ knowledge change regarding GBV in the context of FP as a result of the intervention?
2. How well do service providers identify clients who have experienced GBV-related to FP issues?
3. To what extent do managers feel this pilot initiative is feasible to scale within the DGFP system?
4. To what extent are providers able to make appropriate referrals?
5. To what extent do service providers record the provision of GBV services?

**DATA INFORMATION AND COLLECTION PROCESSES**

Shukhi Jibon employed mixed data collection methods, triangulating the results of regular monitoring data and additional observations and data collected by project staff to answer the five interrelated learning questions following six months of implementation—June to September 2023. All 83 training participants (22 from Faridpur, 16 from Dhamrai, 26 from Sylhet, and 19 from Cox’s Bazar) were given pre- and post-training assessments, and 25 participants were observed and scored in 12 role-play sessions.

The project developed a DGFP-approved format for FWVs to use to record and report GBV cases to upazila managers and the Shukhi Jibon team each month. To maintain client confidentiality and safety, all recordings were anonymous. The project began collecting GBV identification reports in June 2023. Trained service providers from 13 of the 16 implementation sites reported 51 different types of GBV cases between June and September 2023 (Figure 2). FWVs from the other three sites did not identify any GBV cases during this time period.

The Shukhi Jibon team continuously monitored FWVs at Learning Lab sites to identify, counsel, and manage referral and reporting of GBV cases within FP and SRH visits to gauge the effectiveness of the intervention. In-depth interviews with the respective managers of

**Figure 2. Types of GBV cases reported at Learning Lab sites, June to September, 2023 (n = 51)\***

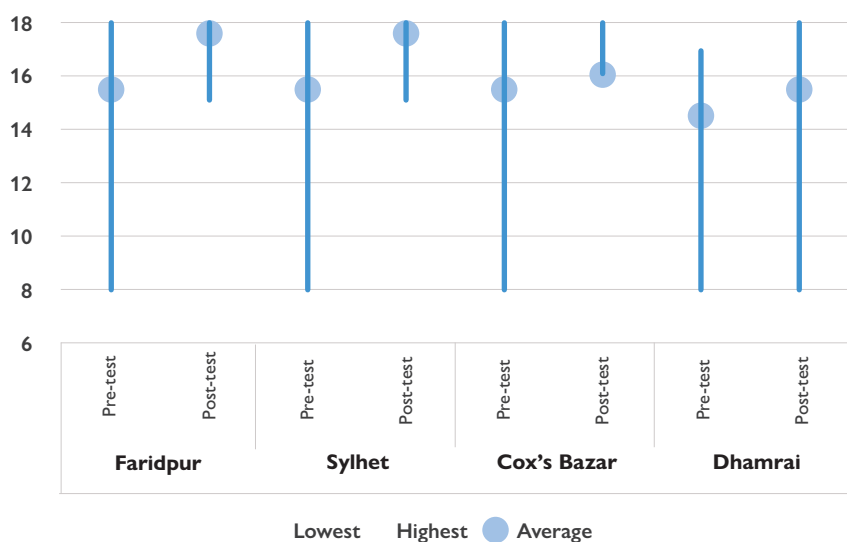


service providers in October 2023 helped the Shukhi Jibon team understand providers' experience with the GBV intervention, recognizing the work it added to FWVs' existing responsibilities.

### LEARNINGS REGARDING PROVIDER KNOWLEDGE AND COMPETENCE

**Training improves consistency of knowledge when conducted well.** After the training, the average knowledge scores of providers on integrating GBV response into FP and SRH services (in which the maximum score was 18) improved by 11% between the pre- and post-training assessment across the 16 intervention sites in 4 regions (Figure 3). Observation of the 12 role-play sessions during training helped the team understand how well service providers were able to identify clients who experienced GBV. Role-play scores averaged 11.2 out of a maximum of 16—fair to good—and reflected providers' lack of familiarity with the LIVES approach to counseling. Noting the need for additional practice, the Shukhi Jibon team revised the training content by carefully selecting role-play scenarios that reinforce the LIVES approach for use in future trainings.

**Figure 3. Ranged (line) and average (dot) of pre-test and post-test scores (0–18 points) of GBV training participants (n=70)\***



\* Though 83 participants total were trained, data was only available for 70 of the participants

**In some cases, providers' fear of harassment and secondary violence from perpetrators constrains service provision.** In-depth interviews with five upazila-level managers, who are direct supervisors of FWVs, from the four implementation regions revealed that Shukhi Jibon's training supported frontline FP providers' awareness of the potential for GBV related to clients' selection of particular contraceptive methods. These managers reported the training also improved providers' ability to identify cases of GBV, respond appropriately to disclosures, provide psychological first-aid, and refer clients to OCCs, which offer comprehensive, multisectoral safety, care, and protection. However, the managers felt FP and SRH service providers were not equipped or positioned to provide comprehensive, confidential GBV response services themselves. Some managers mentioned that service providers may be vulnerable to violence themselves if they cannot maintain the privacy of the survivors, so FWVs avoid dealing with certain types of cases.



Service provider presentation during a training session.

Photo: Marufa Aziz

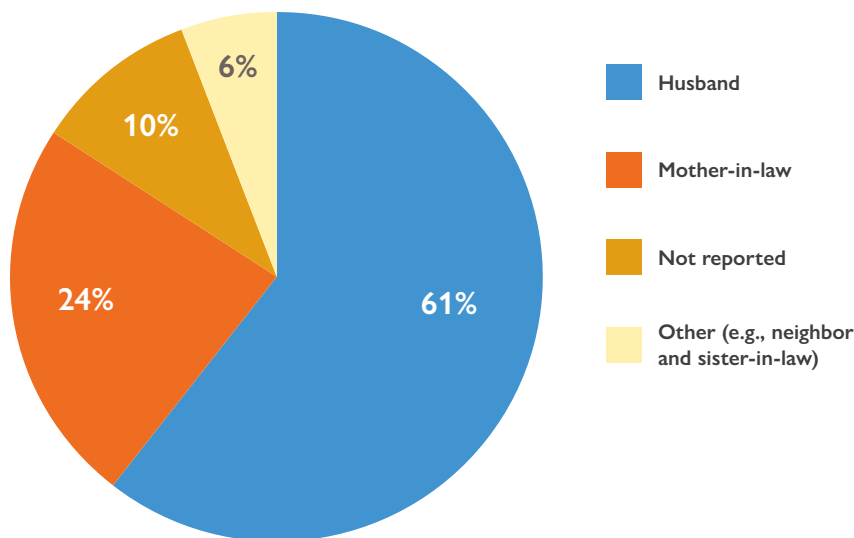
“This is a very timely initiative by the Shukhi Jibon project. With implementation findings, we can scale up the program. The manual is the pioneer of GBV with SRHR and FP services, which will help us reduce drop-out, discontinuation, and increase CPR, and as a result maternal health will improve.”

-Line Director, Field Service Delivery, DGFP

An upazila FP officer in Faridpur noted, “An FWV is mostly alone at UH&FWCs. If any incident happened [and went to prosecution, everyone would know about] her involvement, [which] would increase her personal risk.” A medical officer in maternal and child health in Sylhet observed, “FWVs should not risk handling cases of extreme violence like rape. They do not have those skills, and UH&FWCs [are not equipped]. These cases should always be referred to the OCC.”

Almost all managers agreed that GBV hinders providers’ ability to provide comprehensive FP services that meet their clients’ needs and preferences. In 61% of the cases of GBV recorded at Learning Lab facilities, clients’ husbands were the perpetrators (Figure 4). Most GBV incidents disclosed during FP and SRH visits were directly linked to the clients’ desire and/or action to seek FP services: 61% were attributed to accessing FP methods, such as implants, IUDs, and oral contraceptive pills, and an additional 24% were attributed to accessing antenatal care and delivery services at the health facility. All managers agreed that FWVs were aware that some of their clients faced GBV but were not properly equipped to systematically address these cases. The managers felt that the training increased efficiency of FP services but agreed on the need for a strategy to protect frontline service providers from violence within their communities.

**Figure 4. Perpetrators in GBV cases reported at Learning Lab facilities (n=51)**



**GBV-responsive FP and SRH services need to be complemented by increased access to comprehensive GBV response care.**

The project learned that appropriate referral facilities (OCCs) are needed in all locations to ensure referral from UH&FWCs. Only one referral to the OCC was reported out of 52 cases in the 4 months of data collection (June to September 2023). FWVs explained that the distance from the FWCs to the OCCs caused clients to decline a referral. In addition, most clients feared breaches of confidentiality. Managers suggested integrating the GBV reporting system that Shukhi Jibon developed into DGFP’s main reporting system to help service providers avoid disruption of FP services by violence. However, they noted the need for service providers to be careful about recording such cases, which might create community pressure and security concerns for providers.

“FWVs should not risk handling cases of extreme violence like rape. They do not have those skills, and UH&FWCs [are not equipped]. These cases should always be referred to the OCC.”

—Medical Officer, Maternal and Child Health, Sylhet



Group work during a training on GBV-Responsive FP and SRH in Sylhet.  
Photo: Sumon Kumar

“A husband brought his [pregnant] wife to the service center and openly scolded the woman and was about to beat her. He held her throat brutally!”

—Family Welfare Visitor, shared during training

## RECOMMENDATIONS

### FP service providers need rigorous practice counseling with the LIVES approach.

Role play revealed that listening was challenging but necessary for providers to build rapport with clients to recognize instances of GBV in relation to SRH and FP. In addition, facilities must be ready to provide the necessary privacy, monitoring, and supervision to ensure effective GBV-responsive counseling.

**Robust sensitization, training, and quality assurance are critical to ensure appropriate confidentiality processes and controls.** According to upazila managers, recording and reporting GBV incidents, such as rape, can pose a security concern for community-level service providers, who need additional training to safely and effectively handle these cases. Shukhi Jibon trained providers to keep records secure and refer rape cases to the nearest OCC. IEC materials for clients reinforced this process by providing relevant emergency numbers, including for the OCC. However, the persistent and common concerns cited by key informants about confidentiality highlights the importance of reviewing, updating, and enforcing confidentiality procedures.

### Providers and managers need to receive both general gender-responsive service provision training and GBV-responsive FP and SRH service provision training.

The general gender-responsive service provision training provides essential foundational knowledge that helps participants comprehend and incorporate the GBV-specific training. These complementary trainings can be delivered sequentially as was done under Shukhi Jibon, or via a combination training.

“We never got this kind of training before; it is a very useful training for us. Now we can relate to the gender issues we see.”

—Family Planning Inspector



## SUGGESTED CITATION

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