



Islamic Republic of Afghanistan  
Ministry of Public Health  
GD of Preventive Medicine  
PHC Directorate  
**Mental Health & Substance Abuse Dep.**

## **Gender Based Violence-Psychosocial Counseling Training Packages**





**Ministry of Public Health  
Directorate of policy and plan  
Directorate of Gender**

**MODULE 1: UNDERSTANDING GENDER-BASED VIOLENCE**

## MODULE 1: UNDERSTANDING GENDER-BASED VIOLENCE

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## **Introduction to Module 1**

Understanding Gender-Based Violence (GBV), a complex issue.

## **Contents of Module**

This module provides information on the nature of gender-based violence as well as its many types and causes. These understandings form the foundation for the rest of the course.

### **The module covers:**

- Understanding what we mean by “GBV”
- Prevalence and types of GBV
- Causes, contributing factors and consequences of GBV

## **Module Objectives**

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

- Define gender-based violence
- Describe basic concepts related to GBV (such as violence, harm and power)
- List common categories of GBV
- Identify the root causes of GBV
- Identify potential consequences of GBV

## **Context**

GBV prevention and response involves a specific set of interventions that must be well planned and well-coordinated. Before you can establish those interventions, however, you must understand the problem well, and you must have reflected on your own knowledge, attitudes and beliefs about issues of gender, human rights, discrimination and gender-based violence.

This module will help build your knowledge and understanding of gender-based violence, its causes, and its consequences so that you can begin to use your knowledge to develop effective interventions for preventing and responding to GBV in emergencies.

## **Self-Reflection**

In order to begin to effectively address this issue, we must first be aware of our own preconceived ideas about women, girls, men, and boys in the context of emergencies. Before we begin, take a minute to reflect on your own attitudes.

Read each of the statements below and tick whether you agree, disagree or are unsure about what is written.

- Men are better than women at making important decisions during times of crisis.

- Men are responsible for protecting their wives and children from harm during emergencies.
- In case of emergency, women should always defer to the decisions of their husbands or other male relatives regarding when it is safe to return home or resettle.
- Men should be the primary income earners of the family in regular situations and especially during displacement.
- A man should always know what to do and should never show his weakness, even if he has experienced traumatic events during the crisis.
- The focus of our prevention programmes with men, as the primary perpetrators of GBV, should be on attitude and behaviour reform.

## **Topic 1: Overview of Core Concepts**

### ***Overview***

In nearly every modern day conflict and disaster, reports of gender-based violence have revealed the various ways in which emergencies can increase vulnerabilities to abuse amongst populations already deeply disadvantaged by the effects of the crisis. Every day the media reports on gender-based violence happening on a scale that seems unimaginable.

### ***Core Concepts***

In order to begin addressing this issue effectively and sustainably, we must first explore the core concepts that make up our definition of gender-based violence.

Gender-based violence is a complex issue, and even the words “gender-based violence” involve a complex set of concepts and terms. It is important to develop a basic understanding of these terms and concepts so that you can conduct assessments, design programmes, deliver services, coordinate with others, and monitor and evaluate your GBV interventions.

A thorough understanding of these core concepts will also enable you to help others understand the issues, and will help you to talk about GBV with care and respect, and without using confusing words.

We will now explore each of the core concepts listed here, which will lead us to a working definition of gender-based violence.

### ***Gender and Sex***

“Gender” refers to the social differences between males and females in any society. Although the words “sex” and “gender” are often used interchangeably, the differences between these two terms must be well understood.

- Gender - Is defined by social differences between males and females| Sex – Is defined by physical or biological differences between males and females
- Gender – Is determined by social factors—history, culture, tradition, societal norms, religion | Sex - Is determined by biology, nature

## **Gender**

“Gender” Refers to the social differences between males and females that are learned. Though deeply rooted in every culture, social differences are changeable over time, and have wide variations both within and between cultures. “Gender” determines the roles, responsibilities, opportunities, privileges, expectations, and limitations for males and for females in any culture.

## **Human Rights**

The concept of human rights acknowledges that every single human being is entitled to enjoy his or her human rights without distinction as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Human rights are founded on respect for the dignity and worth of each person. Human rights are universal, meaning that they are applied equally and without discrimination to all people. Human rights are inalienable, in that no one can have his or her human rights taken away other than in specific situations.

## **Violence**

### **Violence, Use of Force, Abuse, Coercion**

Many people associate the word “violence” with physical force and physical violence, but there are many other forms of violence. For example, consider this: Violence = the use of some type of force, coercion (When force or coercion is used, there can be no consent.), or pressure.

**Violence:** The use of force to control another person or other people. Violence can include physical, emotional, social or economic abuse, coercion, or pressure. Violence can be open, in the form of a physical assault or threatening someone with a weapon; it can also be more hidden, in the form of intimidation, threats or other forms of psychological or social pressure.

**Force:** To cause to do through pressure or necessity, by physical, moral or intellectual means.

**Abuse:** the misuse of power. Abuse prevents persons from making free decisions and forces them to behave against their will. Children are especially vulnerable to abuse due to their extremely limited power in any given situation. Children are also more easily confused and tricked due to their limited life experience.

**Coercion:** Forcing, or attempting to force, another person to engage in behaviours against her/his will by using threats, verbal insistence, manipulation, deception, cultural expectations or economic power.

**Consent:** Refers to approval or assent, particularly and especially after thoughtful consideration. "Informed consent" occurs when someone fully understands the consequences of a decision and consents freely and without any force. The absence of informed consent is an element in the definition of GBV. There can be no consent in situations where any kind of force (physical violence, coercion, etc.) is used. "She didn't say no" is a common defence for acts of GBV. In many cases, she might say "yes" or would not say "no" because she feels threatened and fears for her own safety, her social status, or her life. It is further assumed that children (under age 18) are unable to fully understand and make informed choices/give consent about such issues as education and marriage.

To ensure consistency in the understanding of the different forms of gender-based violence by health care professionals in Afghanistan, the following WHO definitions will also be used.

**1. Sexual Violence:** According to WHO; sexual violence is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including, but not limited to home and work.

**2. Sexual Assault:** A sub-category of sexual violence, sexual assault usually includes the use of physical or other force to obtain or attempt sexual penetration. It includes rape.

#### **a. Rape**

According to the Rome Statute ratified by Afghanistan, rape can be defined<sup>1</sup>:

1. The perpetrator invaded the body of a person by conduct resulting in penetration, however slight, of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body.

2. The invasion was committed by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person or another person, or by taking advantage of a coercive environment, or the invasion was committed against a person incapable of giving genuine consent.

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<sup>1</sup> The Elements of Crimes are reproduced from the Official Records of the Assembly of States Parties to the Rome Statute of the International Criminal Court, First session, New York, 3-10 September 2002 (United Nations publication, Sales No. E.03.V.2 and corrigendum), part II.B.



### **3. Physical Assault**

Physical assault involves<sup>2</sup> intentionally using or threatening to use physical force, strength, or a weapon to harm or injure the woman. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.

### **4. Forced Marriage**

Forced marriage is defined as the marriage of an individual against her or his will. Apart from being a form of violence, forced marriage can further increase the risks of physical, sexual and psychological abuse.

### **5. Denial of Vital Resources, such as Nutrition and Shelter**

This category covers the acts of deliberate deprivation from nutrition and shelter as means of punishment or discipline.

### **6. Psychological/Emotional Abuse**

Psychological or emotional abuse are defined as infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

In Afghanistan, most healthcare workers need to be prepared to treat survivors of domestic violence, including burnings and assault and sexual assault, including rape.

<b>CATEGORY</b>	<b>EXAMPLE</b>	<b>POSSIBLE OFFERED TREATMENT</b>
<b>Sexual assault</b>	- Rape, including gang rape	Rape management – First-line support – referral mental health support
<b>Sexual violence</b>	- sexual assault including rape - unwanted sexual comments or advances - acts to traffic	First-line support Referral for mental health support
<b>Physical assault</b>	- Beating - Kicking - Biting - Hair pulling - Strangling - Causing injury - Causing disability - Burning	First-line support Wound management Burn management Referral to next level of care Referral Mental health support

<sup>2</sup> Standard Operating Procedures for Healthcare Sector response to Gender-Based Violence, MoPH, 2013

<b>Forced marriage</b>	<ul style="list-style-type: none"> <li>- Selling/buying women for marriage</li> <li>- Giving baad</li> <li>- Forced marriage</li> <li>- Under-aged marriage</li> </ul>	Referral to women's organization and other services for such cases
<b>Psychological/emotional abuse</b>	<ul style="list-style-type: none"> <li>- Verbal abusing/ humiliating / intimidating</li> <li>- Harassment / persecution</li> <li>- Forcing to burn</li> <li>- Forcing to suicide</li> <li>- Forcing to use poison</li> </ul>	First-line support Wound management Burn management Referral to next level of care Referral mental health support

### ***Gender-Based Violence***

Gender-based violence is a violation of universal human rights protected by international human rights conventions, including the right to security of person; the right to the highest attainable standard of physical and mental health; the right to freedom from torture or cruel, inhuman, or degrading treatment; and the right to life.

Globally, GBV has a greater impact on women and girls than on men and boys. The term "gender-based violence" is often used interchangeably with the term "violence against women". The term "gender-based violence" highlights the gender dimension of such acts of violence; in other words, the relationship between a female's subordinate status in society and her increased vulnerability to violence. It is important to note, however, that boys and some men may also be victims of sexual violence.

The IASC Guidelines<sup>3</sup> on "Gender-based Violence Interventions in Humanitarian Settings" (2005) describe GBV as "an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females" (p.7).

The following definitions are taken from Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan published in 2014. They in turn have used internationally approved definitions from the Inter-Agency Standing Committee and Afghanistan's Law on the Elimination of Violence against Women (LEVAW)<sup>4</sup>.

According to LEVAW in Afghanistan the following acts shall be deemed as violence against women:

- Sexual assault;
- Forced prostitution;

<sup>3</sup> Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, Inter-Agency Standing Committee, 2005.

<sup>4</sup> Law on Elimination of Violence against Women (EVAW), MINISTRY OF JUSTICE, ISLAMIC REPUBLIC OF AFGHANISTAN, 2009.

- Recording the identity of the victim and publishing it in a way that damages her personality;
- Burning, using chemicals or other dangerous substances;
- Forcing one to burn herself or to commit suicide or using poison or other dangerous substances;
- Causing injury or disability;
- Beating;
- Selling and buying women for the purpose of or on the pretext of marriage;
- Giving baad<sup>5</sup>;
- Forced marriage;
- Prohibiting from the right of marriage or right to choose spouse;
- Underage marriage;
- Abusing, humiliating, intimidating;
- Harassment/persecution;
- Forced isolation;
- Forced addiction;
- Depriving from inheritance;
- Prohibiting to access personal property;
- Prohibiting from the right to education, work and access to health services;
- Forced labour;
- Marrying more than one wife without observing Article 86 of Civil Code; and
- Denial of relationship.

At present, there are no clear statutory definitions to define at law the various GBV concepts listed above.

### ***Checking Your Knowledge - Violence***

In the following lines you will be asked to apply what you have just learned about violence and its related terms. There are three questions.

(Answers are available in the Answer Key at the end of the module)

1. In situations where armed people take advantage of the chaos of conflict to rape women indiscriminately, they are usually coercing women into performing sexual acts against their will.

This is an example of (check all that apply)

- a) Violation of human rights
- b) Abuse
- c) Informed consent

2. True or False: When we refer to violence, we are referring only to physical violence.

- True
- False

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<sup>5</sup> The selling/trading of girls/women to settle debts.

3. Violence can be manifested in many different ways, including (check all that apply):
- a) Physical assault
  - b) Emotional or psychological abuse
  - c) Social or economic abuse.

### **Power**

Gender-based violence involves the abuse of power.

To understand GBV risks and vulnerabilities, it is important to understand the power dynamics in the communities we serve.

To address GBV effectively, you must understand and analyse the power relations among men and women, women and women, men and men, adults and children, and among children.

### **Power**

Power involves the ability, skill or capacity to make decisions and take action; physical force or strength. The exercise of power is an important aspect of relationships. All relationships are affected by the exercise of power. The more power a person has, the more choices are available to that person. People who have less power have fewer choices and are therefore more vulnerable to abuse.

REMEMBER: Similar to “violence”, “power” is not always physical.

### **Harm**

Gender-based violence causes harm. Physical injuries, including sexual injuries, often occur. Other harmful consequences can include:

- Emotional and psychological trauma
- Economic hardship
- Rejection and social stigma

Any of these can lead to the most harmful of all consequences – death due to injuries, from suicide or murder.

REMEMBER: Every survivor of GBV is an individual, and will experience harm in different ways.

**Stigma:** Severe disapproval for behaviour that is not considered to be within cultural norms. Social stigma often causes rejection by families and/or communities.

### **Core Concepts and the Definition of GBV**

Put together, these core concepts form the basis for our working definition of gender-based violence.

**Gender** – Acts of GBV are based on gender; that is, the socially defined roles, expectations, rights, and privileges of males and females in any society or community.

**Violence** – GBV involves the use of force – which includes threats, coercion, and abuse.

**Power** – Gender-based violence is the abuse of some type of power over another person.

**Harm** – All forms of GBV are harmful to individuals, families, and communities. Each survivor of GBV is an individual, and each will experience harm differently.

**Human Rights violation**– Acts of GBV are violations of basic human rights

### ***Definition of Gender-Based Violence***

“Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many — but not all — forms of GBV are illegal and criminal acts in national laws and policies.”

### ***More About the Definition***

As you saw, the definition brings together the key concepts. Acts of GBV are based on gender, are harmful, violate human rights, and involve the abuse of power and the use of force.

### ***An International Perspective***

#### **GBV Definition**

The definition we used is the official and agreed-upon definition of gender-based violence in the context of humanitarian emergency situations. The definition was developed by a team of GBV experts in 2005 when the Inter-Agency Standing Committee Guidelines on GBV Interventions in Emergencies were developed. Because it is an IASC-endorsed definition, this is the agreed definition for use by UN agencies, most international NGOs, the Red Cross/Red Crescent movement, and most other international organizations involved in emergency response.

#### **Men and Boys and GBV**

Around the world, GBV has a greater impact on women and girls than on men and boys. It is important to note, however, that men and boys may also be victims of gender-based violence, especially sexual violence. While there is some evidence that sexual violence against boys occurs more often than previously known, we do not yet know enough about sexual violence against men and boys in any setting, including in emergencies.

Although men and boys can often be seen as either perpetrators or victims of GBV, men and boys are often also critical change agents in GBV prevention efforts.

### ***Checking Your Knowledge – GBV Concepts and Terms***

Review what you know about GBV concepts and terms by answering the following questions.

A displaced woman fleeing with three children from armed conflict approaches an armed person at a checkpoint. The woman has been separated from the rest of her family and community; she is seeking refuge at a town on the other side of the checkpoint. The armed person asks the woman to give him some money to go through the checkpoint (there is no fee - he is asking for a bribe). The woman explains she has no money and nothing of value to offer. The armed person tells the woman that he will let her through if she has sex with him. The woman agrees. The man is very rough and the woman feels pain while he is inside of her. She tries not to cry in front of her children.

1. Did the woman consent to sex?
  - Yes
  - No
2. Is this an incident of gender-based violence?
  - Yes
  - No
3. Why is this an incident of gender-based violence? Check all that apply:
  - a) It was based on an unequal balance of power between the armed person and the woman
  - b) It was harmful to the woman
  - c) It violated the woman's human rights
  - d) She gave her consent to have sex
  - e) It involved the use of force

### **Topic 2: Prevalence and Types of GBV**

Now that we have looked at the core concepts that make up our definition of gender-based violence, let's look at the many types of GBV and their prevalence throughout the world, whether in a stable setting or in an emergency.

It is important to note that we usually only know the number of individuals who report GBV, not all of the individuals who have experienced GBV. Prevalence of gender-based violence is extremely difficult to obtain due to its hidden nature and do to the fact that it is under reported.

Prevalence: The prevalence of an event or act is defined as the total number of cases (of GBV) in the population at a given time.

## ***NOT JUST A LOCAL ISSUE***

### ***Prevalence of GBV Worldwide***

It is well documented that GBV is a widespread international human rights and public health issue, and that appropriate, good quality, and effective prevention and response are inadequate in most countries worldwide.

Although in most countries little research has been conducted on the problem, available data provide a rough estimate of the prevalence of GBV worldwide.

### ***GBV Across the World***

Note: Given the ethical and safety difficulties in collecting data on this sensitive topic, these facts and figures are accepted estimates that demonstrate the widespread nature of the problem and highlight specific trends in crisis/post-crisis settings. This information may be useful in efforts to bring GBV to the attention of stakeholders in the absence of reliable data from any one specific setting.

### ***GBV in All Settings***

Around the world at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime. Most often the abuser is a member of her own family.

- 48% of girls surveyed in the Caribbean reported their first sexual intercourse experience was forced.
- More than 90 million African women and girls are victims of female circumcision or other forms of genital mutilation.
- In South Africa, it is estimated that a woman is raped every 83 seconds, and only one in 20 of these cases are ever reported to the police.
- In the Midlands Province in Zimbabwe, 25% of women reported attempted or completed rape by an intimate partner.
- More than 70 million girls/women have suffered FGM/C worldwide. Every year more than 2 million girls suffer this practice.

### ***Populations Affected by Armed Conflict***

Multinational peacekeepers and humanitarian aid workers have been found to sexually abuse and exploit refugee and internally displaced women and children in Guinea, Sierra Leone, Liberia, the Democratic Republic of Congo, Nepal, and other countries.

**Cambodia:** 75% of women who participated in a study conducted in the mid-1990s were domestic violence survivors, often at the hands of partners who kept small arms that they used in the war.

**Liberia:** Overall, the proportion of women who reported violence, perpetrated by non-family members, was over 10 times greater during the conflict period (1999-2003), compared with violence reported during the post conflict years.

### ***Following Natural Disasters***

#### **Sexual Violence**

Indian Ocean tsunami, 2004: Sexual assaults were widely reported to increase in the aftermath of the tsunami.

#### **Intimate partner violence/ Domestic violence**

Indian Ocean tsunami, 2004: Domestic violence was widely reported to increase in the aftermath. One NGO reported a three-fold increase in cases brought to them.

#### **Trafficking**

Women, girls, and boys “disappear” from populations affected by natural disaster. The extreme circumstances of disaster, poverty, dependence, and hopelessness provide an opportunity for traffickers to trick and exploit women and children.

#### ***Death Due to GBV***

Some victims of GBV die in the aftermath of the incident as a result of illness, murder or suicide, although statistics on deaths due to GBV are rarely kept.

Many survivors of rape during the Rwandan genocide are now HIV+ or already dead due to complications of AIDS.

More than 5 million women die each year as victims of honour killings

Some women, suffering from unrelenting emotional, psychological, and social distress, commit suicide. In Thailand, UNHCR monitors the numbers of suicides, among other protection incidents in the Burmese refugee population. According to UNHCR, “2 in 3 suicide victims are women, compared to a national ratio in Thailand of 3 males to every 1 female. Most suicides involve victims of rape or domestic violence.”

#### ***Prevalence of GBV in Afghanistan***

According to the 2013 annual report of the United Nations Assistance Mission in Afghanistan (UNAMA) and the United Nations High Commissioner for Human Rights, an estimated total of 1,669 incidents of violence against women were registered with



the Department of Women's Affairs, police and prosecutors in the 16 concerned provinces. The report also highlighted that of those 1,669 registered incidents of violence against women, only 109 cases (seven percent) were processed by the formal justice system through the implementation of the Law on the Elimination of Violence Against Women (LEVAW). The crime of battery and laceration was the most prevalent form of violence against women among the registered cases documented in the said period.

The Global Rights' 2008 "National Report on Domestic Abuse in Afghanistan" reported that 87% of the women interviewed in 4,700 households in 16 provinces experienced at least one form of domestic violence and 62% experienced multiple forms of violence. Seventeen% reported sexual violence (11% experienced rape), 52% were victims of physical violence, 59% were forced to marry and 74% were victims of psychological violence.

The Afghan Independent Human Rights Commission (AIHRC) reported that 4,154 cases of violence against women were registered by 1179 complainants at several AIHRC offices during the first six months of 2013. The majority of cases (1249 cases, 30%) were related to physical violence, 976 cases (24%) were related to verbal and psychological violence, 862 (21%) were forms of economic violence, 262 (6%) of cases were related to various forms of sexual violence and 805 cases (19.4%) were forms of other types of violence against women.

### ***GBV and Healthcare***

In mid-2013, a Knowledge, Attitudes and Practices (KAP) study relating to health personnel working in GBV case management was carried out by UN Women and WHO in six provinces for the purpose of acquiring a better understanding of healthcare provider capacity to identify, treat, document and refer GBV survivors. According to the results of the study, an average of 22 GVB survivors had visited the health facility during the month prior to investigation (77 percent were victims of physical violence, 83 percent of emotional violence and 29 percent of sexual violence). Half of the healthcare personnel interviewed were well-informed about the health consequences of GBV. Slightly more than half of the respondents said they have asked patients on the possibility of being a survivor of GBV, but highlighted that several barriers to a proper consultation existed, including time limitations, lack of space in the clinic to ensure privacy, little or no service facility for GBV victims in the facility, greater emphasis on other health issues, fear of police proceedings, lack of training to handle such issues, and a lack of referral facility in the province for GBV victims.

The results of the KAP study showed that there is an urgent need to include GBV into health sector policies, develop guidelines to handle GBV cases and strengthen the capacity of health professionals on managing GBV cases. There results also pointed to a need to strengthen coordination and linkages with other non-health service providers, properly equip and organize health facilities and addressing cultural and social barriers to GBV.

### ***Humanitarian Emergencies and fragile environments***

Sexual and other forms of gender-based violence can escalate in many humanitarian emergencies. Humanitarian emergencies are a complex mix of occurrences that may be the result of natural forces (extreme weather or geological activity) or human activity (conflict, social upheaval and environmental degradation). During emergencies, women and adolescents especially can be separated from their families and communities, increasing their vulnerability to attack. Breakdowns in law and order and in protective societal norms also contribute to this abuse.

### ***Phases of Emergency Response***

Emergencies can have a wide range of impacts and effects on both the human and physical environments.

One way to organize our response to emergencies is by phases.

#### **Phase 1: Prevention and Mitigation**

This phase may be characterized by deteriorating economic and social circumstances, civil disturbance, and growing instability. Activities in this phase contribute to outright avoidance of a crisis and/or minimize its adverse impacts. Prevention and mitigation can include:

- Monitoring and information gathering to support early detection of coming crises
- Engagement and consultation with those at risk
- Information campaigns to help communities respond when a crisis hits
- Contingency or preparedness planning
- Developing the response capacity of all key actors, including the communities that may be affected
- Stockpiling supplies

#### **Phase 2: Acute Response**

This phase is often chaotic, with people fleeing for safety and families and communities separating. Interventions during this phase focus on saving lives and meeting the basic needs of affected communities.

#### **Phase 3: Protracted Relief**

In this phase, the initial crisis has passed or subsided. People have reorganized themselves into families and communities. There is less chaos, and basic needs are met. Interventions at this phase may focus on capacity development of civil society and the affected populations, (re)establishment of systems for healthcare, rule of law, protection, etc., and conflict resolution and/or reconstruction.

#### **Phase 4: Recovery and Rehabilitation**

During this phase, those communities that have been displaced by the crisis may be returning to their country or area of origin or seeking asylum in a new country, either spontaneously or as part of a planned settlement. This phase may be characterized by wide scale community reconstruction and reintegration of returnees into communities. Interventions at this phase might support the transition of actions away from international actors to government and civil society.

#### ***GBV in Emergencies and fragile environments***

The following information demonstrates the types of GBV that often occur during the various stages of an emergency, whether due to armed conflict or natural disaster.

Types of GBV present during crisis, prior to flight

- Abuse by persons in power
- Sexual bartering
- Sexual assault, coercion by combatants

Types of GBV present during flight

- Sexual attack, coercion by bandits, border guards, pirates
- Capture for trafficking
- Capture by armed person for sexual assault, slavery

Types of GBV present in displacement setting

- Sexual attack, exploitation, abuse by persons in authority
- Child sexual abuse
- Domestic violence
- Sexual assault when collecting wood, water, etc.
- Sex for survival
- Harmful traditional practices may resume in displacement settings

Types of GBV present in repatriation

- Sexual abuse, separated children
- Sexual abuse by persons in power
- Sexual attack

Types of GBV present in reintegration

- Abuse by persons in power
- Sexual bartering
- Sexual assault, coercion by combatants

#### ***GBV across Life Stages***

Even without any type of humanitarian emergency in their community, women and girls are at high risk for many forms of GBV at all stages of their lives. The following

shows a sampling of the types of gender-based violence that commonly occur at the various life stages of women and girls.

It is important to note that younger girls will not be able to understand and communicate on the situation they may be facing and that the elderly may also not have all their capacities maintained.

#### Types of violence present in pre-birth

- Sex-selective abortion
- Battering during pregnancy, which can result in negative emotional and physical effects on the woman and effects on birth outcome
- Coerced pregnancy (for example, in the context of genocide)

#### Types of violence present in infancy

- Female infanticide
- Emotional abuse
- Physical abuse
- Differential access to food and medical care

#### Types of violence present in girlhood

- Forced marriage
- Sexual abuse by family members and strangers
- Unequal access to food and medical care
- Forced prostitution
- Rape
- Trafficking

#### Types of violence present in adolescence

- Forced marriage
- Dating and courtship violence
- Sex in exchange for goods and services (example: "sugar daddies")
- Sexual abuse by family members, strangers, acquaintances
- Rape
- Sexual harassment
- Unequal access to food and medical care
- Forced prostitution
- Trafficking

#### Types of violence present in reproductive age

- Intimate partner abuse
- Marital rape
- Dowry abuse and murders
- Sexual abuse in the workplace
- Sexual harassment
- Rape
- Abuse of women with disabilities

Type of violence among the elderly

- Abuse of widows
- Elder abuse

**Discussion:** Which of them may have broader MHPSS impact? With which other areas do they interact? On MHPSS which level of specialization will be required in the different cases? Should we ask for additional support? When?

### **Topic 3: Causes and Contributing Factors of GBV**

Now that we have explored the meaning of gender-based violence as well as types and prevalence of GBV across settings and across the lifespan, we will look at the root causes and factors that contribute to GBV.

#### **The GBV Tree**

One way of demonstrating - and understanding - gender-based violence is to illustrate the issues using a drawing of a tree. This method is useful with communities in the field, and is a simple way to understand GBV.

The entire tree represents gender-based violence. The roots are the root causes. Weather and temperature are the contributing factors - they make the tree grow bigger and the roots grow stronger. The branches stand for the different categories of GBV that can occur. The leaves are the consequences of GBV for survivors, their families, and communities.

#### **Roots**

The roots are the root causes.

The root causes of gender-based violence are a society's attitudes towards and practices of gender discrimination. Typically, these place women and men in rigid roles and positions of power, with women in a subordinate position in relation to men. The accepted gender roles and lack of social and economic value for women and women's work strengthen the assumption that men have decision-making power and control over women. Through acts of gender-based violence perpetrators seek to maintain privileges, power, and control over others. This disregard for or lack of awareness about human rights, gender equality, democracy and non-violent means of resolving problems help continue the inequality that leads to GBV.

#### **Weather / Temperature**

Weather and temperature are the contributing factors - they make the tree grow bigger and the roots grow stronger.

While gender inequality and discrimination are the root causes of all forms of gender-based violence, various other factors will influence the type and extent of GBV in each setting. During crises and in fragile environments, there are many such factors that can increase risk and vulnerability to GBV. Examples include:

- Community and family support systems have broken down
- Families are often separated
- Institutions such as health facilities and police are under-staffed or non-existent
- There is a prevailing climate of human rights violations, lawlessness, and impunity
- Displaced populations are dependent on aid and vulnerable to abuse and exploitation
- Temporary communities and shelters may not be safe, may be overcrowded, may be in isolated areas, or could lack sufficient services and facilities

### **Branches**

The branches stand for the different categories of GBV that can occur.

Acts of gender-based violence can be grouped into four general categories:

- Sexual abuse
- Physical abuse
- Emotional and psychological abuse
- Economic abuse

### **Leaves**

The leaves are the consequences of GBV for survivors, their families, and communities.

The consequences of GBV for individuals and communities are far reaching. Keep in mind the physical consequences like sexually transmitted diseases and unwanted pregnancy, emotional and psychological consequences like guilt and shame, and social consequences like isolation and rejection, to name but a few. Each of these types of consequences of GBV will be discussed at greater length in Module 4: Responding to Gender-based Violence in Emergencies, and additional resources will be dedicated to the psychosocial support and mental health components.

### **Module 1 Case Study**

Let's apply some of the concepts from this module by examining a case study. It is tempting to immediately move to thinking of ways to address the GBV. But as you read the case study and complete the activities, first try to understand the dynamics of the situation for Azadah and her family in light of what you have just learned.

#### **Azadah and Family**

Azadah is 17 years old. Until recently, Azadah was living with her parents and younger siblings in an unsafe environment. Azadah's family is a patriarchal family with traditional gender roles – her mother is responsible for the house, cooking, and child care, and her father is the decision-maker and primary income earner. Although the family is poor, Azadah used to attend the local school along with other IDP children. Three weeks ago Azadah's father told her that he could not afford to take care of her anymore and that he had arranged for her to go live with his cousin's family in a relatively stable area of the country.

The 42-year-old father of the family had recently lost his wife, and they needed someone who could help take care of the children and the home, and be a comfort to the father. Azadah was quickly married to the man and he brought her to his home, three hours away from her own family members. The first night, the man raped Azadah. He raped her again the next morning, again that night and again every day after that. After two weeks of suffering, Azadah wrote to her father and pleaded with him to let her come back to the camp. Azadah has just received a response from her father:

My dear Azadah. I was greatly distressed to receive your letter. Please do not write such things to me again – you know how the mail can go missing here and end up in others' homes. The matter that you shared with me is between you and your husband; you are a wife now, Azadah, with responsibilities that only a wife can meet. He is a good man and can provide a home for you and some money for us so we can survive. You have helped your family by marrying this man, Azadah. Please do not dishonour your family by reacting in this way.

Azadah is sad and scared. She feels trapped in the man's home and does not know what to do. She does not feel that she has any options left.

### **Module 1 Quiz - Analysing the Case Study**

1. Let's begin analysing Azadah's case study considering the concepts we reviewed at the start of this module. In this case study, which of the following GBV concepts were evident? Check all that apply:

- a) Respect for Azadah's human rights
- b) Social pressure
- c) Abuse of power
- d) Harm

2. Next, consider the categories of GBV that have been discussed in this scenario. Please select all of the categories of GBV that apply to Azadah's story:

- a) Sexual abuse
- b) Physical abuse
- c) Emotional and psychological abuse
- d) Economic abuse

3. What do you think are the principal root causes of Azadah's abuse?

- a) Azadah 's religious background and lack of appropriate health education
- b) Gender inequality and lack of respect for Azadah's human rights
- c) Displacement and poor schools

4. The leaves on the GBV tree symbolize the consequences of GBV. Identify all possible consequences of Azadah's abuse in this case:

- a) Negative health outcomes
- b) Economic dependence on her husband
- c) Early pregnancy
- d) Depression

5. In the case study, there were contributing factors (symbolized in the GBV Tree by weather, temperature, etc.). Refer to the case study and select all that apply to Azadah's situation:

- a) Azadah's attractive appearance
- b) The family's dependence on aid from organizations
- c) The family's unsafe environment
- d) The man's alcoholism
- e) Azadah's lack of knowledge about her human rights (and her lack of skills in advocating on behalf of her rights)

### **Congratulations!**

You have now completed this module.

You should now be able to...

- Define gender-based violence
- Describe basic concepts related to GBV (such as violence, harm, power)
- List common categories of GBV and the ones most affecting Afghanistan
- Identify root causes of GBV
- Identify potential consequences of GBV

You may now proceed to Module 2.



## MODULE 1 ANSWER KEY

### ***Checking Your Knowledge - Violence***

1. In situations where armed people take advantage of the chaos of conflict to rape women indiscriminately, they are usually coercing women into performing sexual acts against their will. This is an example of (check all that apply):
  - a) Violation of human rights
  - b) Abuse
  - c) Informed consent

Answer: a – This is an example of a violation of human rights and abuse.

2. True or False: When we refer to violence, we are referring only to physical violence.

Answer: False – Violence can include physical, emotional, social or economic abuse, coercion, or pressure. Violence can be open, in the form of a physical assault or threatening someone with a weapon; it can also be more hidden, in the form of intimidation, threats or other forms of psychological or social pressure.

3. Violence can be manifested in many different ways, including (check all that apply):
  - a) Physical assault
  - b) Emotional or psychological abuse
  - c) Social or economic abuse

Answer: a, b, c — All of these are examples of way that violence can be manifested.

### ***Checking Your Knowledge – GBV Concepts and Terms***

Review what you know about GBV concepts and terms. Read the following scenario and answer the questions below.

*A displaced woman fleeing with three children from armed conflict approaches an armed person at a checkpoint. The woman has been separated from the rest of her family and community; she is seeking refuge at a town on the other side of the checkpoint. The armed person asks the woman to give him some money to go through the checkpoint (there is no fee - he is asking for a bribe). The woman explains she has no money and nothing of value to offer. The armed person tells the woman that he will let her through if she has sex with him. The woman agrees. **The man is very rough and the woman feels pain while he is inside of her. She tries not to cry in front of her children.***

1. Did the woman consent to sex?

Answer: No – The woman did not consent. There can be no consent in situations where any kind of force (physical violence, coercion, etc.) is used.

2. Is this an incident of gender-based violence?

Answer: Yes – This is an example of gender-based violence. The man abused his power to force the woman to have sex so she could get through the checkpoint.

3. Why is this an incident of gender-based violence? Check all that apply:
- a) It was based on an unequal balance of power between the armed person and the woman
  - b) It was harmful to the woman
  - c) It violated the woman's human rights
  - d) She gave her consent to have sex
  - e) It involved the use of force

Answer: a, b, c, e – This incident is based on an unequal balance of power between the armed person and the woman, causes harm to the woman, violated the woman's human rights, and involved the use of force. The woman did not consent to have sex.

### **Module 1 Quiz - Analysing the Case Study**

1. Let's begin analysing Azadah's case study considering the concepts we reviewed at the start of this module. In this case study, which of the following GBV concepts were evident? Check all that apply:
- a) Respect for Azadah's human rights
  - b) Social pressure
  - c) Abuse of power
  - d) Harm

Answer: b, c, d – Azadah's human rights are not being respected in this scenario. Azadah is experiencing social pressure to marry the older man. Azadah is also facing an abuse of power by her father and her new husband. Finally, Azadah is experiencing physical, emotional and psychosocial harm due to the rapes.

2. Next, consider the categories of GBV that have been discussed in this scenario. Please select all of the categories of GBV that apply to Azadah's story:
- a) Sexual abuse
  - b) Physical abuse
  - c) Emotional and psychological abuse
  - d) Economic abuse

Answer: a, c – Rape is a form of sexual abuse. Azadah is being raped every day by her new husband. Azadah is also experiencing emotional and psychological abuse: she did not want to marry the man, is sad and scared, and now feels trapped in the man's home. Although we might assume that Azadah was also experiencing physical abuse, this type of GBV was not described in the case study. Although Azadah was sent to the man to help fix her family's financial problems, there is no indication from the case study that she is experiencing economic abuse herself.

3. What do you think are the principal root causes of Azadah's abuse?

- a) Azadah 's religious background and lack of appropriate health education
- b) Gender inequality and lack of respect for Azadah's human rights
- c) Unsafe environment and poor schools

Answer: b – Gender inequality and lack of respect for Azadah's human rights are the principal root causes of Azadah's abuse.

4. The leaves on the GBV tree symbolize the consequences of GBV. Identify all possible consequences of Azadah's abuse in this case:

- a) Negative health outcomes
- b) Economic dependence on her husband
- c) Early pregnancy
- d) Depression

Answer: all – All of these are possible negative consequences of Azadah's abuse.

5. In the case study, there were contributing factors (symbolized in the GBV Tree by weather, temperature, etc.). Refer to the case study and select all that apply to Azadah's situation:

- a) Azadah's attractive appearance
- b) The family's dependence on aid from organizations
- c) The family's unsafe environment
- d) The man's alcoholism
- e) Azadah's lack of knowledge about her human rights (and her lack of skills in advocating on behalf of her rights)

Answer: b, c, e – Contributing factors that were mentioned in this case study include: the family's dependence on external support; the family's unsafe environment; and Azadah's lack of knowledge about her human rights (and her lack of skills in advocating on behalf of her rights).



**Ministry of Public Health  
Directorate of policy and plan  
Directorate of Gender**

**Module 2: FRAMEWORK FOR ADDRESSING GBV**

## Module 2: FRAMEWORK FOR ADDRESSING GBV

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## **Introduction to Module 2**

### **Module 2: Framework for Addressing Gender-Based Violence in Emergencies**

Now that we have reviewed the core concepts that make up our understanding of GBV in emergencies, let's begin to explore a framework and some key approaches we need to understand in order to design appropriate and effective gender-based violence prevention and response interventions.

#### **Contents of Module**

The module describes three core approaches for effective interventions: the rights-based, community-development and survivor-centered approaches.

Next this module presents an overview of multi-sectoral interventions with focus on the role of the health sector in general and on Mental Health (MH) and Psychosocial Support (PSS) in particular, looking at systems and standards for intervention and inter-agency coordination, as well as expectations for minimum actions as set out in the IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings and other available instruments in Afghanistan, that will be further developed at a later stage.

Finally, this module looks briefly at people as a key resource in creating the change necessary to protect women and girls from gender-based violence, with an emphasis on strengthening local leadership and ownership.

#### **Module 2 Objectives**

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

- Identify the core approaches that influence our work to prevent and respond to GBV at every level and in all phases of emergency response and in fragile contexts
- Explain the purpose of GBV coordination and utility of the IASC GBV Guidelines to support inter-agency action
- Apply an understanding of this framework and approaches to a real-life case study

#### ***Context***

##### **International**

Since the early 1990s, with reports of mass rape in Bosnia, Rwanda and Kosovo, the international community has been actively responding to gender-based violence as a component of humanitarian response efforts. As a result, there have been significant developments in both policy and practice in the field. Many actors have contributed

resources to research, advocacy, identification of good practices and standards, and the creation of guidelines and tools to support effective prevention and response.

## **Afghanistan**

For women living in Afghanistan, the numbers are difficult to confirm but most research agrees that gender-based violence (GBV), particularly violence against women and girls (VAW/G), is widespread in Afghanistan and impacts all segments of Afghan society. GBV may take on different forms, including physical, mental and sexual violence, sexual exploitation, domestic violence as well as traditional harmful practices and is often condoned by and founded on deeply-entrenched norms that dictate a subservient status for women at the societal level.

Worldwide these efforts have resulted in frameworks, approaches and models that provide guidance for good practices in addressing gender-based violence in emergencies and fragile contexts and are dependent on effective multi-sectoral collaboration and coordination. The frameworks are based on the rights of individuals and communities and on their meaningful participation any efforts to defend and promote their rights.

### **Topic 1: Framework for Intervention**

Effectively addressing gender-based violence in emergencies requires actors to:

- Promote and protect the rights of affected populations (especially women and girls)
- Intervene when those rights are violated
- Provide services and assistance to both meet the needs of and realize the rights of those who have experienced violence

### ***A Rights-Based Approach***

Underpinning our ecological framework are a series of approaches to prevention and response programming that are relevant at each level of intervention and during all phases of emergency response.

The first of these approaches that we will discuss is the Rights-based Approach.

A rights-based approach to addressing gender-based violence in emergencies recognises women's and girls' rights as human rights and obliges all stakeholders to:

- Keep the rights of women and girls in all circumstances on the international agenda (including their right to live free from gender-based violence)
- Promote, protect and fulfil the rights of women and girls

A rights-based approach:

- Is based on standards of international human rights and humanitarian law
- Involves many actors and stakeholders
- Requires working with and addressing the political, legal, social and cultural norms and values in a country or community

- Seeks to empower survivors and communities

### ***A Community Development Approach***

The next approach we'll discuss is the Community Development Approach

A community development approach seeks to empower individuals and groups by providing the knowledge, resources and skills they need to effect change in social and gender relations in their own communities to more effectively address gender-based violence.

The key purpose of a community development approach is to collectively bring about social change and justice by working with communities to:

- Identify their needs, opportunities, rights and responsibilities in relation to addressing gender-based violence
- Plan, organise and take action to address gender-based violence
- Evaluate the effectiveness and impact of action taken

### ***A Survivor-centered Approach***

The final approach we'll discuss is the Survivor-centered Approach to GBV.

A survivor-centered approach to GBV seeks to empower the survivor by putting her or him in the centre of the helping process. A survivor-centered approach embraces each individual survivor's physical, psychological, emotional, social and spiritual aspects. This approach also considers a survivor's cultural and social history as well as what is happening in her or his life that could support and facilitate recovery.

The survivor-centered approach recognizes that:

- Each person is unique
- Each person reacts differently to gender-based violence and will have different needs as a result
- Each person has different strengths, resources and coping mechanisms
- Each person has the right to decide who should know about what has happened to them and what should happen next

### **The Survivor-centred Approach and the Guiding Principles**

The survivor-centred approach means ensuring survivors can access appropriate, accessible and good quality services including:

- health care
- psychological and social support
- security
- legal services

Competent service delivery requires that those who engage directly with survivors have the appropriate attitudes, knowledge and skills. Implementing a survivor-centred



approach involves applying the guiding principles of safety, confidentiality, respect and non-discrimination.

### **Safety**

The safety and security of the survivor and others, such as her children and people who have assisted her, must be the number one priority for all actors. Individuals who disclose an incident of gender-based violence or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them.

### **Confidentiality**

Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment.

### **Respect**

All actions taken will be guided by respect for the choices, wishes, rights, and dignity of the survivor.

### **Non-Discrimination**

Survivors of violence should receive equal and fair treatment regardless of their age, race, religion, nationality, ethnicity, sexual orientation, or any other characteristic.

### **Checking your Knowledge - Approaches to Addressing GBV**

In a conflict-affected area, media reports came out that two young girls had been raped near the water point outside of a major IDP (Internally Displaced Person) camp. The four UN (United Nations) agencies most engaged in GBV work in and around the IDP camp immediately rushed in to support the girls. Each agency went to interview the girls and each spoke to them at length about what had happened. They then met together to develop a plan of action that would ensure both immediate assistance and long-term, holistic care for the girls in all relevant sectors of response: health, psychosocial, security and legal.

In this scenario, which of the following approaches to addressing GBV in emergencies were violated:

1. Rights-based approach
2. Community-development approach
3. Survivor-centered approach

(Answer: All three approaches)

In this scenario, the UN agencies did not consider the rights of these girls, but rather assumed that they already knew their needs. Similarly, no one consulted with local women's groups or other community-based actors to consider sustainable action to address this situation as a way to both protect and care for the girls and empower the communities. Finally, asking the girls to tell their story multiple times is a clear violation of their confidentiality and demonstrates a lack of respect for their autonomy, thereby undermining the core elements of a survivor-centred approach.

## **Topic 2: Prevention and Response**

### Prevention and Response in Multi-Sectoral Interventions

Addressing gender-based violence is complex and multidimensional.

Effective GBV programming involves:

- Preventing violence through addressing the causes, contributing factors and risks
- Responding to violence and its consequences to meet the needs of survivors

Best practice in this area calls for multi-sectoral action where all actors have a clear understanding of their specific roles and responsibilities towards GBV prevention and response. Health actors play a key role in the prevention, and also in response, including identification, support and referral of victims.

### **Minimum Response - IASC GBV Guidelines**

In the early stages of a humanitarian emergency, interventions to prevent gender-based violence and provide appropriate assistance to survivors are based on the IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention and Response to Sexual Violence in Emergencies, that have previously been mentioned. The Guidelines outline a set of minimum required actions to enable all actors responding to an emergency to plan, establish, and coordinate multi-sectoral interventions to prevent and respond to sexual violence during the early phase of any emergency. These guidelines can be used in broader contexts, not just in emergency scenarios. They can also be used as a preparedness check in emergency prompt settings.

The Guidelines:

- Focus on sexual violence
- Emphasise both prevention and response
- Build on existing good practices
- In general, can be done without extra staff, training or funds

The Guidelines integrate interventions into the day-to-day emergency work of all sectors and actors involved in protection, water and sanitation, shelter, site planning

and non-food item distribution, health (including PSS and MH) and community services and education.

### **A Closer Look at the IASC GBV Guidelines in Action**

Within a few days after a devastating earthquake in a small island nation, a large emergency response is underway. UN agencies and international NGOs arrive to assist the government and local civil society to provide emergency humanitarian services.

Let's explore a few of the minimum actions from the GBV Guidelines that should be integrated into standard practices and immediately undertaken by the various emergency actors to both prevent and respond to sexual violence.

#### ***Health***

At health clinics and hospitals, ensure protocols, medications, supplies, and trained staff are available for the clinical management of sexual violence survivors  
Provide information and education to communities about sexual violence and available health services  
The availability of basic mental health care at all general and reproductive health services.

#### ***Community Services***

Provide psychological "first aid" for survivors of sexual violence.  
A functioning referral system between health services and individuals/organisations providing  
Psychological support.  
Produce information, education, and communication materials to mobilise communities for GBV prevention and referral to services

#### ***KEY ACTIONS for health and community services as per the IASC GBV guidelines***

The following actions apply to the health and community services sectors; that is all organizations implementing health, psychological, and/or social services. The health and community services sectors each identify a focal point who participates regularly in the GBV working group, and reports on the health/community services sectors' achievement of the key actions in this Action Sheet. The focal points also participate in cross-cutting functions led by the GBV coordinating agencies and working groups, as described in Action Sheets for  
Coordination, Assessment and monitoring, Human resources, and Information education communication.

1. Identify and mobilise appropriate existing resources in the community, such as TBAs, women's groups, religious leaders, and community services programmes.

- Discuss issues of sexual violence, survivors' needs for emotional support, and evaluate the individuals, groups, and organisations available in the community to ensure they will be supportive, compassionate, non-judgmental, confidential, and respectful to survivors.

- Establish systems for confidential referrals among and between community-based psychological and social support resources, health and community services, and security and legal sectors.

- Establish coordination mechanisms and orient partners.

2. At all health and community services, listen and provide emotional support whenever a survivor discloses or implies that she has experienced sexual violence. Give information, and refer as needed and agreed by the survivor.

- Listen to the survivor and ask only non-intrusive, relevant, and non-judgmental questions for clarification only. Do not press her for more information than she is ready to give

(e.g. do not initiate a single-session psychological debriefing). Note that she may describe the event out of sequence, and details may change as her emotional state changes. This does not indicate that she is lying but rather that she is emotionally upset.

- If the survivor/victim expresses self-blame, care providers need to gently reassure her that sexual violence is always the fault of the perpetrator and never the fault of the victim/survivor.

3. Assess her needs and concerns, giving careful attention to security; ensure that basic needs are met; encourage but do not force company from trusted, significant others; and protect her from further harm.

- Ensure safety; assist her in developing a realistic safety plan, if needed.

- Give honest and complete information about services and facilities available.

- Do not tell the survivor what to do, or what choices to make. Rather, empower her by helping her problem-solve by clarifying problems, helping her identify ways to cope better, identifying her choices, and evaluating the value and consequences of those choices. Respect her choices and preferences about referral and seeking additional services.

- Discuss and encourage possible positive ways of coping, which may vary with the individual and culture. Stimulate the re-initiation of daily activities. Encourage active participation of the survivor/victim in family and community activities. Teach relaxation techniques.

Discourage negative ways of coping; specifically discourage use of alcohol and drugs, because trauma survivors are at high risk of developing substance abuse problems.

- **When feasible, raise the support of family members.** Families (those who are not the perpetrators) can play a key role in supporting victims/survivors emotionally and practically. For example, they may help victims/survivors to return to usual daily activities (e.g. child care, job, household work, school) after physical recovery of sexual violence. Conversely, families can contribute to increased emotional trauma if they blame the survivor for the abuse, reject her, or are angry at her for speaking about the sexual violence.

#### **4. Address the special needs of children.**

- Persons interviewing and assisting child/adolescent survivors should possess basic knowledge of child development and sexual violence.
- Use creative methods (e.g. games, storytelling, and drawing) to help put young children at ease and facilitate communication.
- Use age-appropriate language and terms.
- When appropriate, include trusted family members to ensure that the child/adolescent is believed, supported, and assisted in returning to normal life.
- Do not remove children from family care in order to provide treatment (unless it is done to protect from abuse or neglect).
- Never coerce, trick, or restrain a child whom you believe may have experienced sexual violence. Coercion, trickery, and force are often characteristics of the abuse, and “helpers” using those techniques will further harm the child.
- Always be guided by the best interests of the child.

**4. [For health care providers only] Regarding psychotropic therapy for adult victims/survivors, provide medication only in exceptional cases. See** Chapter 6 of Clinical Management of Survivors of Rape for guidance. Of note, benzodiazepines—which may quickly lead to dependence in trauma survivors—are often over-prescribed. Caution is required.

#### **5. Organise psychological and social support, including social reintegration activities.**

- **Always adhere to the guiding principles for action:**

- ✓ Ensure safety and security.
- ✓ Guarantee confidentiality.
- ✓ Respect the wishes, choices, and dignity of the survivor/victim.
- ✓ Ensure non-discrimination.
- ✓ Any training in psychological support/counselling should be followed by supervision.
- ✓ Advocate on behalf of the victim/survivor with relevant health, social, legal, and security agencies if the victim/survivor provides informed consent. When appropriate, organize confidential escorting to any service needed.

- ✓ Initiate community dialogues to raise awareness that sexual violence is never the fault of the
- ✓ victim/survivor and to identify solutions to honour killings, communal rejection, and isolation.
- ✓ Inform community about sexual violence and the availability of services.
- ✓ Provide material support as needed via health or other community services.
- ✓ Facilitate participation and integration of survivors in the community. This may be done
- ✓ through concrete, purposeful, common interest activities (e.g. aid projects, teaching children)
- ✓ and activities that enhance self-sufficiency.
- ✓ Encourage use of appropriate traditional resources. If feasible, collaborate with traditional healers or clergy, who, respectively, may conduct meaningful cleansing ceremonies or prayer for sexual violence survivors/victims.
- ✓ *Many such practices can be extremely beneficial; however, ensure that they do not perpetuate*
- ✓ *blaming-the-victim or otherwise contribute to further harm to the survivor/victim.*
- ✓ Link with other sectors.
- ✓ Behaviour change communication information, education, and communication.

### **Water and Sanitation**

Actively engage women and girls in the community to help design and place water points, latrines, and bathing and washing facilities

### **Shelter and Site Planning**

Listen to women and girls and respond to their recommendations for safe, appropriate, and secure shelter and displacement sites

### **Food Security and Nutrition**

Actively engage women and girls in the community to ensure at least 50% women's representation on food committees

Use women as food distributors or to assist with the distribution process

## **Education**

Implement strategies for keeping girls in school

Facilitate Prevention of Sexual Exploitation and Abuse training and develop codes of conduct for teachers

## **Protection**

Include sexual violence issues in security monitoring and implement strategies to respond to security threats

Promote presence of female police and security officers

## **Topic 3: Coordination**

Given the multiple sectors and types of interventions and the diverse actors involved in prevention and response, no single agency, organisation, group of actors or authority possesses the mandate, capacity or resources to address gender-based violence alone. Coordination is critical to effectively address gender-based violence.

Effective overall coordination, local-level coordination of activities and services, and individual case coordination are all essential forms of coordination. Click on each term for a closer look.

### ***Overall coordination***

Overall coordination often focuses on national-level or crisis-wide action and includes:

- Strategic planning
- Facilitating data collection, monitoring, information sharing and advocacy
- Mobilizing resources and ensuring accountability
- Orchestrating a functional division of labour
- Negotiating and maintaining effective action based on standards and good practices
- Providing leadership to design and implement sustainable programming

### ***Local-level coordination***

This is coordination among and between multi-sectoral and interagency GBV actors and includes:

- Clarification of mandates, roles and responsibilities to agree on types of services and to discuss geographical coverage in specific locations.
- Development and implementation of referral protocols for service delivery
- Collection, organisation, analysis and use of service-level and other data for planning, advocacy and prevention initiatives, including by undertaking joint assessments and sharing information and knowledge
- Collective planning, implementation and monitoring of complementary prevention and response activities
- Collective advocacy
- Joint community education and awareness raising

## **Afghanistan Gender Based Violence Sub-Cluster**

The Afghanistan Gender Based Violence Sub-Cluster was established as a national coordinating body to strengthen and enhance the efforts and activities of stakeholders in the country, in the prevention of and response to gender based violence (GBV). The objectives are to consolidate, coordinate, improve and support the activities of all relevant stakeholders in the prevention of and response to GBV within the context of humanitarian action in Afghanistan. Within the humanitarian setting, the AGBV SC shall target and prioritize GBV issues relating to most vulnerable or affected groups. The members of the Sub-Cluster meet both at the national and regional levels.

UNFPA (United Nations Population Fund) is the Sub-Cluster Chair and Oxfam the Co-Chair. Members are:

- ✓ Related government bodies
- ✓ Sub-Cluster's / TF Focal points
- ✓ International NGOs
- ✓ National NGOs/ NGOs in provinces

The Terms of Reference for National GBV Sub-Cluster, are available both in DARI and in English.

The protection of the survivor and the community is understood as an interconnection of psychosocial, health, legal/justice and security areas.

At the prevention stage, Psychosocial and Community Support refer to Awareness Raising and Behaviour Change.

Psychosocial networks and trained professionals are part of the referral pathway in the response phase.

Add slide (available on internet, if not outdated)

[http://www.globalprotectioncluster.org/\\_assets/files/field\\_protection\\_clusters/Afghanistan/files/APC\\_GBV\\_SC\\_Presentation\\_EN.pdf](http://www.globalprotectioncluster.org/_assets/files/field_protection_clusters/Afghanistan/files/APC_GBV_SC_Presentation_EN.pdf)

## **SOPs (Standard Operational Procedures) in Afghanistan**

Add from document repository.

### ***Case coordination***

Case coordination involves ensuring survivor-centered and holistic service delivery based on the needs of individuals who come forward for assistance across agencies and sectors.

### ***Actors Addressing GBV in Emergencies***

The types of GBV prevention and response interventions, timeframe for action, and the actors responsible will depend on the context and phase of the emergency.



The possible actors responsible for GBV prevention and response can be grouped into four major categories. Click on each for a closer look at each group.

### ***International Community***

#### **Actors from the international community include:**

- The United Nations and its entities
- Regional bodies
- Donor and other foreign governments
- The International Committee of the Red Cross and Red Crescent
- International non-governmental organizations (NGOs)
- International civil society

### **The State/Government**

Governing and supportive institutions that have sovereignty over a territory and population.

### **Civil Society**

Civil society commonly includes a diversity of actors and types of institutions, varying in their degree of formality, autonomy and power. Civil societies are often made up of organisations such as registered charities, non-governmental organizations, community groups, women's organizations, faith-based organizations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups.

### **Local Community**

Here, the term community refers to a group of people living in a common location. A rights-based approach reflects the agency and role of individuals and communities in claiming and exercising rights. The community therefore is not a passive recipient or beneficiary of services and assistance, but a key actor in humanitarian efforts to address gender-based violence in humanitarian and regular scenarios.

### **Strengthening Local Leadership and Ownership**

Strengthening and promoting local ownership involves engaging, empowering and building the capacity of local actors to engage in gender-based violence interventions from the very beginning of an emergency. The efforts to address gender-based violence should reflect and support the strengths, resilience, coping mechanisms, and agency of affected individuals and communities.

Strategies for strengthening local leadership and ownership of GBV interventions include:

- Building on and supporting local initiatives and structures, rather than creating parallel initiatives
- Creating genuine partnerships with local actors characterised by transparency and good communication
- Ensuring participation of local actors in all aspects of problem assessment and analysis, programme design, implementation and evaluation.
- Planning strategically with local actors beyond the immediate phase of humanitarian intervention to institutionalise social and political measures that prevent gender-based violence.
- Training and capacity building to develop local competency, including skills for leadership, advocacy, coordination and networking.

### Module 2 Quiz

Amena is a community supervisor with the Ministry of Public Health in Afghanistan in a location where a national NGO that runs a safe house and provides community-based psychosocial support in an area of high return for refugees. A woman has reported to Amena four times about abuse she has suffered by her husband since they returned to the country eight months ago. Each time, Amena gives her information on the local safe house and provides her with information on potential consequences of the abuse on her and her five children, but the woman always chooses to go to her home instead. Amena is deeply distressed about this situation and feels helpless that she cannot do more. Amena's supervisor recently told her about a group that would be meeting once a month to discuss difficult cases and share ideas for action. Amena has never participated in such a coordination group but feels like it could be a good next step in trying to understand how to manage her difficult case.

Now let's look at Amena's situation through the ecological framework. Please select the level that best defines what Amena does in her work to address GBV.

1. Individual
2. Community
3. Society

(Answer: Individual)

Q1: Amena provides direct support to survivors of GBV at the individual level to facilitate their recovery from violence.

Amena's supervisor suggests that she participate in the case coordination group. During her first meeting, Maya hears similar stories from other community supervisors as well as nurses and psychosocial counsellors. Among other things, the group decides to approach local leaders to determine how they can develop and/or support community-based mechanisms that can contribute to domestic violence prevention. Please select the level that best defines this intervention.

1. Individual

2. Community
3. Society

(Answer: Community)

Q2: The group is considering a community-level intervention. At the community level, interventions are focused on developing systems and supporting community mechanisms to monitor, prevent and respond to GBV.

Amena's actions take into consideration approaches to addressing GBV that were discussed in this module. For example, though Amena does not agree with the woman returning to her husband, she does not force her opinion or show judgment of the women's choices. Please select the one approach that is best described by Amena's actions:

1. Rights-based approach
2. Community development approach
3. Survivor-centred approach

(Answer: Survivor-centred approach)

Q3: Amena is taking a survivor-centred approach by showing respect for her client's choices. Although she offers information on her client's options for care, **Maya** does not force her opinion on her client, nor advise her on what she perceives as the best course of action.

During the case coordination meeting, one of the newer participating agencies brings photocopies of case files to share and discuss. Although there are no names on the files, the files do contain information on the survivors' ages, ethnicities, locations of the incidents as well as the dates and times of the incidents. This is a violation of which guiding principle(s)? (Select all that apply):

1. Safety
2. Confidentiality
3. Respect
4. Non-discrimination

(Answer: 1, 2, 3)

Q4: This practice could violate the guiding principles of safety, confidentiality, and respect. Even carrying copies of case files could potentially violate the survivors' safety and confidentiality, for example if the files were misplaced or stolen in transit. Unless the client has told the social worker that it is okay to share this level of detail on her case, it is generally considered bad practice to reveal details of a client's case, and a violation of the client's respect.

## **Congratulations!**

You have completed this module and now should be able to:

- Identify the core approaches that influence our work to prevent and respond to GBV at every level with focus on the health and community services.
- Explain the purpose of GBV coordination and utility of the IASC GBV Guidelines to support inter-agency action
- Identify coordination mechanisms and SOPs in Afghanistan in their correlation to health, MHPSS.
  
- Apply an understanding of this framework and approaches to a real-life case study

# You may now proceed to Module 3.



**Ministry of Public Health**  
**Directorate of policy and plan**  
**Directorate of Gender**

**MODULE 3: THE IMPACT OF GBV – UNDERSTANDING CONSEQUENCES AND  
IDENTIFYING RESPONSES**

## MODULE 3: THE IMPACT OF GBV– UNDERSTANDING CONSEQUENCES AND IDENTIFYING RESPONSES

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**MODULE 3: THE IMPACT OF GBV – UNDERSTANDING CONSEQUENCES AND IDENTIFYING RESPONSES**



# Facilitator guide

## Purpose:

This module will help participants enhance the understanding of the wide range of consequences of GBV –and sexual violence in particular - and its immediate and long-term impact on survivors, their families and communities. Further the Module offers participants a framework for response at the individual, community and services level. Special attention will be given to the considerations towards health professionals.

## Specific Objectives:

*At the end of this Module participants should be able to:*

- Identify the immediate physical and psychological reactions
- Identify the after-effects: The long-term physical and psychosocial effects and the impact on the family and the community
- Identify the survivors’ needs and capacities
- Identify the consequences and needs of children
- Understand, describe and abide by the guiding principles for caring for survivors
- Understand the importance of coping mechanisms and capacities of survivors, factors that promote recovery and obstacles on the path to help; learn what an individual and the community can do to help a survivor
- Describe the relationship between consequences/after-effects, survivor needs, and response services
- Identify the minimum recommended response services that must be available to reduce harmful consequences and prevent further injury and harm
- Identify both formal and informal support services that already exist in the community that can provide support and help to survivors

**Estimated Time:**12.5 hours

## Module 3 at a glance

Session	Time	Handouts
Session 3.1: The physical, emotional and social effects of GBV  3.1.1 Exercise: Just listen  3.1.2 Discussion: Stress, distress and disorder  3.1.3 Lecture: The after-effects	3.5 hours	Tool 3.1.1: Just listen  Handout 3.1.2: Stress, distress and disorder  Handout 3.1.3: The after-effects and outcomes of GBV
Session 3.2: Responding to GBV	4.5hours	Handout 3.2.1: The Guiding

<p>3.2.1 Exercise: The guiding principles for helping survivors</p> <p>3.2.2 Exercise: Factors that promote coping, resilience and recovery</p> <p>3.2.3 Exercise: Obstacles on the path to help</p>		<p>Principles</p> <p>Handout 3.2.2(1): Coping with reactions</p> <p>Handout 3.2.2 (2): Factors that promote coping, resilience and recovery</p> <p>Handout 3.2.3: Obstacles on the path to help, the story of Malalai</p>
<p>Session 3.3: Consequences of GBV, sexual abuse and/or violence for children</p> <p>3.3.1 Discussion: Understanding the consequences and coping mechanisms</p> <p>3.3.2 Lecture: Providing tools to support children</p>	<p>2.5 hours</p>	<p>Handout 3.3.1: Reactions and coping mechanisms of children</p> <p>Handout 3.3.2: Providing comforting tools</p>
<p>Session 3.4: MHPSS as part of a Multi-sectoral response</p> <p>3.4.1 Discussion: Overview of minimum survivor services</p> <p>3.4.2 Demonstration/Discussion: Reinforce Need for Multi-Sectoral Response Services</p> <p>3.4.3 Exercise: Mapping of services in the community</p>	<p>2 hours</p>	<p>/</p>

### **Session 3.1: The Physical, Emotional and Social Effects of GBV**

#### ***Objective:***

- To identify the immediate physical, psychological and social reactions and effects;
- To identify the after-effects: the long-time physical and psychosocial consequences and the impact on the family and the community.
- To agree on common definitions and terms used to describe different levels of stress and of disorder.

#### ***Activities:***

3.1.1 Exercise: Just listen

3.1.2 Discussion: Stress, distress and disorder

3.1.3 Lecture: The after-effects

**Total Time:** 3.5 hours

#### ***Preparations:***

- Prepare the story of the survivor “Rana” in Tool 3.1.1.
- On a flip chart page, draw five columns with the following headings: Body reactions, Emotions, Thoughts, Behaviours, Social Reactions.
- You may want to ask one of the participants to assist you in eliciting discussion and writing down local words and expressions.

#### ***Handouts:***

Tool 3.1.1: Just listen (see end of this Module)

Handout 3.1.2: Stress, distress and disorder

Handout 3.1.3: The after-effects and outcomes of GBV

***Materials: Flip chart and markers***

### 3.1.1. Activity: Just Listen<sup>1</sup>

**Materials:** flip chart and markers

**Preparations:** Prepare a testimony of a survivor Tool 3.1.1

**Handouts:** Tool 3.1.1: Just listen (see end of this Module)

**Group sizes:** Whole group

**Time:** 1 hour

#### 3.1.1. Session: TOOL 3.1.1: Just listen

Testimony from Rana, 16 years old:

*I was hiding in the bush with my parents and two older women when the armed men found our hiding place. I was the only young woman. There were ten armed men, including four children, armed with AK-47. The armed men did not use their real names and covered their heads. The armed men said that they wanted to take me away. My mother pleaded with them, saying that I was her only child and to leave me with her. The armed men said that "if we do not take your daughter, we will either rape her or kill her."*

*The armed men ordered my parents and the two other women to move away. Then they told me to undress. I was raped by the ten armed men, one after the other. One of the armed men was about twelve years. Three were about fifteen. They threatened to kill me if I cried.*

*My parents, who could hear what was happening, cried but could do nothing to protect me. I was physically injured. My mother washed me in warm water and salt but I bled for long. We stayed in the bush until the armed men took over our town. When we came out of the bush, even adults would run away from me and refused to eat with me because I smelled badly. I have nightmares and feel discouraged.*

*Adapted from: IASC Caring for Survivors of Sexual Violence in Emergencies. Training Guide*

1. Prepare participants for the story:

*"Before we listen to the story of Rana, I want you to pay attention to what your body is doing right now. Start at the top of your head and move to your toes. Take an inventory of your muscles, internal body state, feelings and thoughts. What is your posture? How are you sitting in your chair? What is your facial expression?"*

2. Assure participants that you know that listening to the story can be difficult. Explain that it is OK to stop listening to the story, or to leave the room for a few minutes if necessary.
3. Read the story.
4. Allow for a few minutes of silence. Then ask participants to again check in to their bodies, thoughts and feelings and to talk about their reactions. Follow the categories on the flip chart (Body reactions/Emotions/Thought/Behaviours/Social Reactions). Write down the answers on the flip chart in the according column.

---

<sup>1</sup> Exercise based on "Debriefing the Accused" activity.

- Examples of questions to generate responses:

1. Body reactions:

- *"Describe the way your body felt."*
- *"Describe what you felt in your stomach and internal organs." (nausea, pain, etc.)*
- *"Describe what your arms or legs felt." (sweaty palms, tension)*
- *"What was happening to your muscles?" (Tightened throat, tense jaw, etc.)*

- Emotions:

- *"What are your feelings?" (anger, rage, sadness, helplessness, fury)*

- Thoughts:

- *"What were you thinking?" or "What thoughts did you have?"*

- Behavioural response:

- *"What did you want to do right here in this room?" (I.e. get up and run out of the room, hit someone, etc.) or*
- *"What did you do as you were listening to the story?" (Fidgeting, changing positions in their seats, not paying attention, clenching fists, crossing legs, etc.)*

5. Emphasize that there are similarities between the reactions of a survivor and our reactions when listening to the story/watching the movie.

6. Then focus on social reactions.

Social reactions are the reactions of people around the survivor, as well as the changed interactions and relationships between the survivor and her environment. Very often these changes are triggered by emotional, cognitive and behavioural reactions of the survivor (e.g. feelings of shame and guilt, fear, withdrawal), but also by reactions of the environment (e.g. feelings of shame and guilt of the family and/or victim-blaming attitudes, social stigma and rejection by family or community).

Ask:

- *What are the social reactions Rana describing in her story? How do people around her react? How do interactions between her and her environment change?*
- *"Rana says that when she came out of the bush adults would run away from her and refuse to eat with her. How do you think these social reactions have an impact on her situation, on her thoughts, emotions and behaviour?"*  
(Social reactions like avoiding the victim lead to social isolation, increase feelings of shame, guilt, hopelessness, disgust about her own body; She might start to think that it is all her own fault. Relationships with family and the community might change.)
- *"Imagine that the social reactions after the incidents would be different, how would it impact on her thoughts, emotions and behaviour?"*  
If her people around her would show acceptance, understanding and social support, it may be easier for her:

- to express her emotions and thoughts,
- to feel that it is not her fault,
- to ask for help

- to regain self-esteem
  - to deal with feelings of shame and guilt
  - to regain her place in the community
7. Mention also that Rana's capacities and coping mechanisms have an influence on these immediate physical, cognitive, emotional and social reactions. Explain that this will be discussed in detail later in this Module(see 3.2.3).
  8. Conclude by emphasizing the importance of looking at immediate reactions in their social context.

---

**▽ Good to know!**

- In this activity, participants will be confronted with a story of an incident of sexual violence or another story of an extremely stressful event. This can be very confrontational to participants. Listening to the story can provoke intense reactions that might be difficult to handle. Make therefore sure that:
    - You can give participants enough time to express their reactions and emotions;
    - You can build in a break immediately after the exercise, if needed;
    - You can ensure that participants, including possible survivors among participants, have a support system to fall back to (within their organisation, colleagues, or others...) at the end of the training.
  - Make sure you address any expressions of a **victim-blaming attitude** ('it was her fault') that might come up in the discussion.
- 

### **3.1.2. Discussion: stress, distress and disorder**

**Material:** Flip chart and markers

**Preparations:** On a flip chart page, draw five columns with the following headings: Body reactions, Emotions, Thoughts, Behaviours, Social Reactions. You may want to ask one of the participants to assist you in eliciting discussion and writing down local words and expressions.

**Handouts: 3.1.2:** Stress, distress and disorder

**Group sizes:** Whole group

**Time:** 1.5 hour

1. Explain that when we talk about the reactions after sexual violence, we often say that survivors 'have experienced extreme distress'. What do we mean by this? And do these words have the same meaning in different cultures and contexts?  
Now we will look at definitions of stress, distress and disorder and try to find the words that are used in your culture to name or express these conditions.
2. Draw three columns with the headings: Stress – Distress/Extreme Distress –Disorder on a flipchart.
3. Ask participants to give examples of these different conditions. Also ask for local words, expressions, metaphors that describe the different examples and terms. You can start by giving an example yourself.
4. First, look at the word STRESS.  
Give an example:

- "I, as a facilitator of this training, felt stress last night. I was stressed about fulfilling your needs as a trainer. I felt nervous, I slept but I woke up several times during the night."

5. Ask participants:

- *What are the words used in your language(s) to describe this kind of situations or to describe stress?*
- *Do you know any metaphors to describe stress? (e.g.: carrying a heavy burden on your shoulders...)*
- *Do the terms you use in your language describe what is in the definition?*
- *What are possible reactions of your body and mind that you associate with stress?*

6. Read the definition of stress (see Handout 3.1.2)

7. Now look at DISTRESS/EXTREME DISTRESS.

Give the following examples:

- "Imagine that I was so stressed out by this training that I could not eat, I could not sleep, I could not actually stand up here today. I would be distressed."

Point out that the difference between distress and extreme distress lies in the gradation of the severity of the events/stressors and of the reactions to the events/stressors.

8. Ask:

- *What could be some of the reactions of distress and of extreme distress?*
  - Elicit answers that refer to physical, emotional, cognitive, behavioural and social reactions. Refer back to the reactions of survivors described in exercise 3.1.1.
  - Mention:
    - *Physical reactions:* shock symptoms, high blood pressure, headaches, palpitations, startle-reflex, sleeplessness, dizziness or disorientation, fatigue, hyper-arousal.
    - *Emotional reactions:* irritability, feeling overwhelmed, anxiety, fear, sudden mood shifts, denial, isolation or 'numbness', feelings of hopelessness.
    - *Thoughts (Cognitive) reactions:* nightmares, reliving the incident, responses to triggers, dissociation, concentration and memory problems, blaming yourself.
    - *Behavioural reactions:* nervousness, decreased appetite, suicide-attempts.
    - *Social reactions:* changes in the interaction with others, like withdrawal, isolation or fear to be alone, rejection, changes in the relationship with family etc., partly caused by the reactions of people around the survivor, partly caused by the emotional, behavioural and cognitive reactions of the survivor
- *What are some of the words and images you use to describe such experiences in your language? In which context is it used?*
- *Do you know any metaphors to describe distress or extreme distress? (e.g.: I feel like I my body was frozen or numb, as if I am poisoned, as if something broke inside me, ...)*

9. Read and explain the definitions of distress and of extreme distress (see Handout).

10. Then refer to the last column DISORDER.

Explain that some people develop a mental disorder after stressful or extremely stressful events, for instance after sexual violence and in other cases of GBV, both after a single incident and in cases of ongoing stressful situation.

Read and explain the definition of a mental disorder that can develop after extremely stressful or potentially traumatic events (see handout).

Ask:

- *“Why is it important to distinguish between stress, distress/extreme distress on the one side and a disorder on the other side?”*
  - o Point out that it is important to make the distinction distress – disorder because survivors with a disorder will most likely not be able to cope on their own. They need specialised professional help (mental health evaluation and treatment). Survivors suffering from distress or extreme distress will also benefit from emotional and social support, although they can mostly also rely on their own coping mechanisms and capacities.
- *“What can be examples of mental disorders in cases of GBV, including sexual violence?”*
  - o Survivors can develop depression, anxiety, panic attacks, Post-Traumatic Stress Disorder, psychosis and other syndromes, which may continue long after the situation is over. (See also Handout 3.1.3)

**Remember:**

- ***Stress is a normal response to a physical or emotional challenge and occurs when demands are out of balance with resources for coping.***
- ***We all have ways of coping with stress in our daily lives.***
- ***However, sometimes people’s coping mechanisms get overwhelmed by certain situations and they require some extra assistance.***

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### ∇ Good to know!

- You can ask one of the participants to assist you in eliciting discussion and writing down local words and expressions.
  - Be attentive for local words or expressions that describe ‘insanity’ or ‘being crazy’, point out that this is a common association that is made in many cultures. Stress that in fact most people react normally to abnormal events and manage to overcome their reactions in a health way. Explore how using terms like insanity or being crazy are disrespectful towards the survivor.
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### 3.1.3. Lecture: *The After-Effects*<sup>2</sup>

**Materials:** /

**Handouts:** Handout 3.1.3: The after-effects of GBV

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<sup>2</sup> Adapted from: Heise L, Ellsberg M, Gottemoeller M. (2002) *Reproductive Health and Rights: Reaching the Hardly Reached Article 10: Victims of Gender-based Violence*. In: PATH Series: Reproductive Health and Rights: Reaching the Hardly Reached, Article 10. Available at: <http://www.path.org/publications/pub.php?id=513>

Ward, J., ‘An introduction to basic issues and concepts related to gender-based violence prevention and response’, UNFPA Afghanistan (slides)



**Group sizes:** Whole group

**Time:** 1 hour

1. Explain that critical incidents of GBV, such as sexual violence causes very strong immediate reactions, but also has a wide range of after-effects or consequences which impact on the survivor, his/her family, community and society.
2. Draw a table with three headings (Physical/Health – Emotional/Psychological – Social/Socio-economic). Ask participants what they think the after-effects of critical incidents could be. Classify the answers under the three headings.
3. Distribute Handout 3.1.3. Give an overview of all after-effects; highlight those which have not been mentioned by participants.
  - Emphasise also:
    - the wide range of after-effects
    - the large economic and social costs
    - the fact that many effects are hidden (e.g. chronic physical effects, psychological effects like depression, shame...)
    - that GBV very often leads to changed relationships between the survivor and her husband, children, extended family and community. Very often these changes are triggered by feelings of shame and guilt of the survivor and the family, but also by victim-blaming attitudes, social stigma and rejection. Also if the victim does not react the social environment expects, this may lead to the belief that the victim was complicit in the crime.
    - that the social consequences are very often serious and may lead to further emotional damage, including shame, self-hate and depression. The social need for 'obvious' signs of distress, may mask the severe and chronic, but less 'obvious' internal distress (sense of emptiness or hopelessness, lack of trust, fear for children, future etc....)
    - because of social stigma, most survivors will not report the incident and will not seek help. Rejection and isolation make emotional recovery difficult due to withdrawal from day-to-day activities and from social support. As a result, most after-effects stay hidden and the survivor continues to suffer.
    - Psychological effects should be considered as normal reactions to abnormal events. However, if they continue and become a disorder (and affect and incapacitate the daily life of a survivor), survivors should be referred to specialised professional help.
4. Conclude by explaining that everyone who interacts with survivors of GBV should be aware of the often hidden psychosocial consequences that are usually involved.

## Session 3.2: Responding to GBV

### **Objective**

- To understand, describe and abide by the guiding principles for caring for survivors.
- To understand the link between the guiding principles and survivor-centred skills.
- To understand the importance of coping mechanisms and to learn what an individual and the community can do to help a survivor.

### **Activities:**

3.2.1 Exercise: The guiding principles for helping survivors

3.2.2 Exercise: Factors that promote coping, resilience and recovery

3.2.3 Exercise: Obstacles on the path to help

**Total Time:** 4.5 hours

### **Preparations:**

Exercise 3.2.1: Write the guiding principles on index cards (one principle per card).

Exercise 3.2.2: Make sure the statements are adapted to the local context and are translated precisely. If needed discuss beforehand with the translator and/or resource person. In some cases, may want to look for culturally adapted statements to express certain reactions.

### **Handouts:**

Handout 3.2.1: The Guiding Principles

Handout 3.2.2(1): Coping with reactions

Handout 3.2.2 (2): Factors that promote coping, resilience and recovery

Handout 3.2.3: Obstacles on the path to help, the story of Malalai

### **Materials:**

Index cards

**Note:** focus on the identification and development of coping skills. You can use these presentations, depending on the level of expertise of the participants and how much time you can dedicate to this area:

#### **a) Basic approach.**

Helpful coping skills	Un helpful coping skills
- Sharing with friends and family	- Alcohol and drugs

<ul style="list-style-type: none"> <li>- Religious practices</li> <li>- Daily activities</li> <li>- Playing with children</li> <li>- Getting enough rest and relaxation</li> </ul>	<ul style="list-style-type: none"> <li>- Spending time alone</li> <li>- Aggression (boiling pot)</li> </ul>
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**b) Advanced approach**

<b>Encourage positive coping strategies</b>	<b>Discourage negative coping strategies</b>
<ul style="list-style-type: none"> <li>- Talk and spend time with family and friends</li> <li>- Discuss problems with someone you trust</li> <li>- Do activities that help you relax (pray, sing, play with children, ...)</li> <li>- Do physical exercise</li> <li>- Practice relaxation exercise</li> <li>- Use calming self-talk</li> <li>- Help others</li> <li>- Get enough sleep</li> <li>- Eat as regularly as possible and drink water</li> </ul>	<ul style="list-style-type: none"> <li>- Don't take drugs or narcotics or drink alcohol to cope</li> <li>- Don't isolate yourself from family and friends</li> <li>- Don't sleep all day</li> <li>- Don't over-eat or under-eat</li> <li>- Don't be violent</li> <li>- Don't neglect personal hygiene</li> <li>- Don't work all the time</li> </ul>

Give information and help the person access other services (psychological, social, legal and protection services) that she/he might think helpful, but provide appropriate warnings about taking it home and keeping it in a safe place where others cannot find it as this may further compromise their safety.

- o Give plain and correct information about her/his rights, the importance of security and various available services (psychological, social, legal and protection)
- o Provide contact details for the services with appropriate warnings about taking it home and keeping it in a place where others cannot find it.
- o Refer the survivor directly
  - If possible and appropriate, accompany the person to the service
  - Call the service and make an appointment
- o Provide follow-up for the referral, if needed

**Help the survivor to connect with family/ family networks and other social supports**

GBV survivors who have good social support will cope better.

- o Explain the importance of social support
- o Help her identify people from within her social network with whom she can reach out to and that she trusts in case she wants to talk about her experience.
- o If a survivor lets you know that prayer, religious practice or support from religious leaders might be helpful for them, try to connect them with their spiritual community<sup>3</sup>.

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<sup>3</sup>From Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan. Ministry of Public Health and WHO. Afghanistan 2015.

### 3.2.1. Exercise: The guiding principles for helping survivors

**Materials:** Index cards

**Preparations:** Write the guiding principles on index cards (one principle per card).

**Handouts:** 3.2.1 The Guiding Principles

**Groups sizes:** 4 small groups

**Time:** 1.5 hours

1. Explain that if we want to think about coping mechanisms and possible responses to GBV, we need to know the guiding principles for helping survivors. These principles have been developed to deal with survivors in the best way possible.
2. Divide the group in four small groups. Give each group an index card with one of the guiding principles. Ask the groups to brainstorm for 10 min about:
  - The meaning of this principle,
  - Why they think that this principle is important for dealing with survivors,
  - Examples of what we can do to respect the principle. Everybody should think about concrete actions in his or her own setting or role (nurse, midwife, counsellor, medical doctor, etc.)Remind participants of the after-effects! Refer back to Handout 3.1.3.
3. Each group briefly presents the principle and the examples they found. Ask the presenters also to explain to the group why the principle is important in their view. Elicit discussion.
4. Explain that later in the training we will talk about survivor-centred skills to deal with survivors. By using these skills, we put the guiding principles into practise.
5. Distribute Handout 3.2.1

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#### ▽ Good to know!

- Make sure that the link between the guiding principles and the impact of GBV on the survivor is made explicit. Emphasise that respecting the guiding principles is important for the recovery of the survivor.
    - E.g. '*Ensure physical safety*': GBV very often leads to fear and anxiety. Survivors often do not feel safe anymore; they are scared that it can happen again. Some survivors are also in real danger (e.g. of retaliation).
    - '*Respect the wishes of the survivor*'. In GBV situations the control is often very limited. During sexual violence, the survivor had no control; his/her wishes and rights were denied.
    - *Guarantee Confidentiality*: survivors are often ashamed of what happened; in what is still happening; they tend to blame themselves; if the violence becomes public, the survivor might be blamed for it by the community.
    - *Ensure non-discrimination*: GBV is a violation of human rights. In addition, survivors are often stigmatised by their communities.
-

### 3.2.2. Exercise: Factors that Promote Coping, Resilience and Recovery

**Materials:** flipchart and markers

**Preparations:** Use handout 3.2.2

**Handouts:** 3.2.2(1): Coping with reactions

3.2.2(2): Factors that promote coping, resilience and recovery

**Group size:** Up to 20 participants' maximum, distributed in smaller groups

**Time:** 2 hours

1. Explain that in this exercise, we will first focus on emotional, behavioural, social and cognitive consequences of GBV such as sexual violence for survivors. In a second step we will discuss the way survivors cope with these consequences and be helped to cope.
2. Distribute Handout 3.2.2(1) (Coping with consequences).
3. Divide the group into small groups of maximum 5 people. Give the groups 5 min to connect all the statements of the survivors with the right emotional reaction.
4. Go through the list of statements and check with participants the right consequence.

Corresponding pairs:

1	2	3	4	5	6	7
E Fear	M Anxiety	B Anger/ Hostility	J Alienation/ Isolation	G Powerlessness/ Loss of Control	K Mood Changes	H Denial

8	9	10	11	12	13	14
C Guilt/ Blame	F Embarrassment /Shame	D Loss of Self Confidence	N Stigma and Discrimination	L Relationship Difficulties	I Depression	A Flashbacks &nightmare s

5. Discuss their observations in plenary. Explain the different consequences (see Handout).
6. Explain that the way a survivor is dealing with the consequences of GBV and/or sexual violence, depends of various factors. Some factors can promote coping, resilience and recovery. Explain the definitions (Handout 3.2.2(2)).
7. Ask participants to name factors that in their view (or in their experience) can stimulate coping, resilience and recovery of survivors. Explain that it is important to distinguish between characteristics of a survivor and outside factors (see Handout). Generate discussion; write key words on a flip chart.
8. Ask every group to look again at two statements/reaction-pairs (indicate which ones!) and brainstorm about how a survivor can cope with these reactions and which interventions can help them coping. Remind them to also think about traditional ways of coping with such reactions in Afghanistan, which are nowadays used in our context.

9. Generate discussion. Explain that throughout the training there will be many more examples of how each one of us, irrespective of our professional role, can help survivors to cope with the impact of GBV and/or sexual violence.
10. Distribute Handout 3.2.2(2) (Factors that promote coping, resilience and recovery).

**▽ Good to know!**

- Very often participants find it difficult to connect the statement with the correct reaction. Point out that it is important to recognise statements of survivors as a first step to support survivors.
- Check with the group whether the proposed coping methods, also traditional coping methods, are in line with the guiding principles. Be particularly mindful of coping strategies which could be a breach of one of the 'the right to choose'; in which a survivor 'is advised (or forced) to do something or where he or she is been told 'that this is the best solution'.  
*For example:* survivors should only take part in (cleansing) rituals if they choose to do so, it should never be imposed. Public ceremonies, in which the situation of violence is explained, can be a breach of confidentiality (if the survivor did not consent to it).

**3.2.3 Exercise: Obstacles on the Path to Help**

**Materials:** /

**Preparations:** /

**Handouts:** 3.2.3 Obstacles on the path to help, the story of Malalai

**Group size:** Whole group

**Time:** 1 hour

1. Explain that for some survivors it is very difficult to come forward, look for help and/or benefit from factors that promote coping, resilience and recovery. Some of these obstacles on the path to help are related to the context in which the violence took place.
2. Ask participants to give examples of such factors.

For example:

- In complex environments, there is often no safe place where they can share their concerns or tell their story,
- The survivor doesn't trust the services that are available,
- The survivor knew the perpetrator or is afraid of revenge
- Cultural/societal beliefs: in many societies it is a duty for a woman to have sex whenever the husband asks for it. Sexual violence is often not recognised or not seen as a crime by the community. In some cases, society says it is ok for a man to beat his wife under some circumstances. Women may come to expect it and even rationalize it as a sign of love /caring. Men who do not beat their wives will be marginalized.
- Survivors who come forward are blamed and stigmatised
- The survivor thought that the violence was his/her fault.

3. Explain that:

- Sometimes there are more complex reasons why survivors will not seek help. Some obstacles are so deeply rooted in the mind and heart of the survivor that they are difficult to see or to understand for other people;
- This makes these factors difficult to overcome and it can make caregivers (professionals, but also people close to the survivor) feel frustrated, since there might be situations that they suspect or know that violence takes place but are confronted with a survivor who refuses help or does not take steps to secure his or her own rescue.

4. Read the case study: the story of Malalai (see Handout 3.2.3)

5. Ask participants: *“What are the obstacles that prevent Malalai from accepting help?”*

For example:

- Malalai might be afraid to lose material support she still sometimes got from her ex-husband.
- There might also be issues around the support to and custody over the child.
- The neighbour is making assumptions about what is best for Malalai.
- There is not enough confidentiality.

6. Add that another obstacle might maybe be the survival strategies that Malalai has developed.

Explain:

- In case of long lasting and serious abuse the relationship between the perpetrator and the survivor is often characterized by violence, manipulation, control, exploitation and abuse but also sometimes by an emotional dependency. In these very violent situations survivors sometimes develop so-called ‘survival strategies’ to adapt their behaviour in order to reduce the risk of further incidents or abuse that might be ‘worse’.

7. Distribute the handout 3.2.3

8. Explain:

- The experience of long lasting violence can be very damaging for the survivors. They might withdraw from social relations and the process of isolation and ‘disempowerment’ might be reinforced. The survivor might have internalised shame and stigma and have developed the feeling that ‘it is all her fault’. Recovery might take a long time. Trying to build up a relationship of trust with the survivor, while not judging her behaviour, is often a first step towards assisting the survivor in looking for help.<sup>4</sup>

9. Ask: *What could you do to help if you were the neighbour of Malalai?*

10. Ask: *What could you do to help if you were a health worker attending Malalai?*

Important possible responses:

- Trying to get to know her better, not avoiding her
- Ensuring her physical safety if possible
- Not judging her
- Not telling stories about her to others in the village
- Showing care, helping her with small things
- Listening to her story
- Not telling her what she should do, but informing her about options to find help

<sup>4</sup>adapted from: Fisher, Neue wegen in der Opferhilfe (1998). In: anti-trafficking training manual for Judges and Prosecutors in SEE, International Centre for Migration Policy Development.

- Eventually trying to express your worries and concerns
- Assisting her in finding solutions and assistance, if she wants to.

<b>Session 3.3: Consequences of GBV, including Sexual Abuse and/ or Violence for Children</b>
<b>Objective</b> To understand reactions of children and to identify tools to comfort children.
<b>Activities:</b> 3.3.1 Discussion: Understanding reactions of children 3.3.2 Lecture: Providing tools to support children  <b>Total Time:</b> 4 hours
<b>Preparations: /</b>
<b>Handouts:</b> Handout 3.3.1: Consequences of GBV including violence for children and their coping mechanisms  Handout 3.3.2: Providing support to children
<b>Materials: /</b>

**Note:** when we talk about GBV on children we need to consider not only the violence suffered directly by them but also the situations where children are indirect victims of violence (e.g. in dysfunctional family environments).

### ***3.3.1 Discussion: Understanding the consequences and coping mechanisms***

<b>Materials: /</b>
<b>Preparations: /</b>
<b>Handouts:</b> 3.3.1: Understanding the consequences and coping mechanisms
<b>Group sizes:</b> whole group
<b>Time:</b> 1 hour

1. Start the session by asking participants why they think it is important to look at the psychological and social consequences of GBV, including sexual violence, on children separately.

Make sure you highlight:

- That children react differently than adults;
- That children often express suffering differently than adults;
- That the immediate reactions of children and the possible long-term consequences depend on:
  - the type of the violence,
  - the duration of the violence,
  - the identity of the perpetrator (was it a person close to the child?)
  - the developmental stage of the child (and the ability to understand what happened).



2. Continue by reminding participants briefly the concept of developmental stages:
  - In every phase of its life, a child develops skills in different areas, which are all closely related to each other (motor, emotional, cognitive, social, identity...). One can also say that a child has a number of age-specific developmental tasks, particular things s/he has to learn and develop in a certain phase, in order to grow up in a balanced way. For instance: a very small child will learn to communicate, to express needs and wishes. This capacity helps a child to interact with people, develop friendships and social networks.
  - Important is that the way a child goes through all these stages depends very much on the support s/he gets from its environment: caretakers or other people close to the child. A child practises cognitive and motor skills, emotions and social behaviour through play and in relationship with caregivers.
3. Explain that sexual violence is always a brutal and intrusive act which impacts heavily on children, on their current stage of development, and possibly also on later stages of development. (See Handout 3.3.1).
4. Ask participants to think of examples of possible short-term reactions and longer-term consequences of sexual violence on children. List answers. Give additional examples. Explore with participants why certain reactions and consequences occur (see for examples and explanation Handout 3.3.1).
5. Ask them to also think about coping mechanisms of children. Refer back to activity 3.2.2
6. Remind participants that they have to be cautious in making assumptions
7. While the presence of this type of behaviour may raise concern, it does not necessarily mean that a child has suffered this type of situation. Especially in conflict-affected settings, many children might show temporarily reactions to stress, which might be similar to the reactions we described. Therefore, a careful assessment of the child is necessary.
8. Conclude by explaining that specific behaviour of children should always be seen in the context of their current stage of development.
  - Some children will react with behaviour that shows a temporary regression to a previous developmental stage (e.g. a child which starts bedwetting again).
  - Other children will show delayed development after the abuse (e.g. learning problems at school) or give the impression to develop faster in certain areas of development (e.g. manifesting sexualised behaviour at an early age).
9. Distribute Handout 3.3.1.

***GBV reactions on children at a glance:***

- ***Emotional disturbance***
  - ***Behavioural disturbance***
  - ***Feelings of guilt and responsibility for the GBV***
  - ***Difficulty at school***
  - ***Difficulty relating to peers***
-

### **3.3.2. Lecture: Providing tools to support to children**

**Materials:** /

**Preparations:** /

**Handouts:** 3.3.2. Providing tools to support to children

**Group sizes:** Whole group

**Time:** 1.5 hours

1. First explain that it is important to know how to recognise and respond to reactions and consequences in children, in order to:
  - protect children against further harm
  - provide support to children
2. Now we will look more at how children cope, ways to support children or ways to encourage parents or other caregivers to support their children after such events.
3. Give a few examples of how children cope and ways to support children (see Handout 3.3.2).
4. Ask participants to give more examples of how we could respond to reactions and consequences of GBV on children or of how we could help parents to support their children. Generate answers. Probe for examples of culturally accepted means of addressing consequences of violence (e.g. ritual remedies).
5. Ask participants to think of things we should not do or not advise parents to do to support children. Generate responses. Ask why these would be bad strategies. Explain important points (see Handout 3.3.2).
6. Distribute Handout 3.3.2.

### **Session 3.4: MHPSS as part of a Multi-sectoral approach to GBV**

#### **Objectives<sup>5</sup>**

- This session reinforces and builds on the previous session about consequences of GBV and teaches participants about the minimum recommended response services that may be needed to reduce the harmful consequences and prevent further injury, trauma, and harm.
- The session introduces the four primary sectors/disciplines/specialties necessary for response and concludes with a mapping exercise so that participants can identify services that already exist in their community.
- Describe the relationship between consequences/after-effects of GBV, survivor needs, and response services.
- Identify the minimum recommended response services that must be available to reduce harmful consequences of sexual violence and prevent further injury, trauma, and harm.
- Identify both formal and informal support services that already exist in the community that can provide support and help to survivors.

#### **Activities:**

3.4.1 Discussion: Overview of minimum survivor services

3.4.2 Demonstration/Discussion: Reinforce Need for Multi-Sectoral Response Services

3.4.3 Exercise: Mapping of services in the community

**Total time:** 2 hours

#### **Handouts: /**

#### **Materials:**

Flip chart, markers, tape

4-legged chair

A4 paper – 10 sheets

Three types of seeds (corn, rice, beans) or cut up pieces of paper at least 3 different colours

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<sup>5</sup>The session lays the groundwork for further discussions about multi-sectoral and interagency coordination in other training sessions.

### 3.4.1 Discussion: Overview of Minimum Survivor Services (Response)

**Materials:** flip chart and markers

**Preparations:** Post the lists of Consequences/After-effects from previous sessions nearby

Prepare a flip chart and post it in the front of the room where it can be seen throughout this session:

RESPONSE = PROVIDING SERVICES AND SUPPORT

TO REDUCE THE HARMFUL CONSEQUENCES AND PREVENT FURTHER INJURY, SUFFERING, AND HARM

**Handouts:** /

**Group sizes:** Whole group

**Time:** 30 minutes

1. Point to the Consequences/After-Effects list and remind participants of the previous discussions about survivor needs. You will be reinforcing these previous sessions/previous learning throughout this session.
2. Point to the flip chart you prepared (Response =) and read it aloud.
3. Ask the group what kinds of help a survivor might need to reduce psychosocial harmful consequences. As they offer response actions, write them on a blank flip chart. The flip chart should begin to look something like this:

Response, then, can include action – AT LEAST, AT MINIMUM - in the following sectors/functional areas:

- Health care
- Psychosocial needs
  - Psychological and emotional support
  - Social acceptance and reintegration
- Security and safety
- Legal justice—formal and traditional

All must work in collaboration with one another

4. Emphasize that not all survivors need—or want—all of this help. Our job is to ensure that services are **available, accessible, and of good quality**. Discuss the meaning of these words, reinforcing previous learning about compassionate care, confidentiality, respecting survivor's wishes and choices, the principle of 'do no harm' and using a rights-based approach.
5. It is also important to note that we must educate the people who carry out these response services before advertising to the community that services are available. If these service providers are not properly trained and survivors go to them for help, the survivor may face more problems and probably further trauma and harm.

Response must also include:

- Training for all actors, all sectors, all levels—whether community volunteers or staff—to respond compassionately, confidentially, and appropriately.

- Reporting and referral systems (i.e., working with the community – especially women - to establish accessible methods for reporting cases and seeking help.)
- Documentation of reported incidents, data analysis, monitoring and evaluation
- Coordination and information sharing systems among the various actors and organizations to avoid duplicating efforts and confusing survivors.

**Do not harm at a glance:**

- **Never force someone to discuss a traumatic event if they do not want to.**
  - **If someone becomes very upset when talking about an event, give them the option to stop.**
  - **Never ‘interrogate’ the survivor.**
  - **Do not make promises you cannot keep.**
- 

**3.4.2 Demonstration/Discussion: Reinforce Need for Multi-Sectoral Response Services**

**Materials:** a chair

**Preparations:** /

**Handouts:** /

**Group sizes:** Whole group

**Time:** 30 minutes

1. Explain that response to GBV is like a four-legged chair. Bring a chair to the middle of the room and loudly place it on the floor. Discuss the qualities of a four-legged chair:
 

*All four legs to do their job properly and consistently if the chair is to function as a chair. If one leg is broken or missing, the chair falls down.*

*During this discussion, pick the chair up, set it down loudly, push it over so it falls down, move it around—make a memorable visual show of the functioning and non-functioning of the chair.*
2. Ask the participants and discuss: Why do all four sectors health, MHPSS, Security and Legal justice need each other?

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**▽ Good to know!**

- Leave the chair in the middle of the room if you can. As you continue this session, refer to the chair/four sectors working together when it fits with the discussion.
  - This session focuses only on the four primary/essential/minimum kinds of services that should be in place anywhere.
-

### **3.4.3 Exercise: Mapping Services in the community– 10 sheets**

Three types of seeds (corn, rice, beans) or cut up pieces of paper at least 3 different colours

**Preparations: /**

**Handouts: /**

**Group sizes: groups of 5 maximum**

**Time: 1 hour**

1. Introduce the activity by telling participants that discussions so far in this session have been about specific tasks, jobs, actors, sectors with specific responsibilities for responding to survivor needs. Explain that in this activity, we will focus on community level response – to think about and identify the various ways that many different people in the community can help survivors by providing information, support, and compassion.
2. Split participants up into groups of 5 or have one large group activity - depending on whether participants are from several different regions or from the same town.
3. Give each group a piece of flip chart paper, 3 coloured markers, seeds (3 types), or cut up pieces of coloured paper (3 colours).
4. Ask participants to map out their community, drawing roads, significant buildings, areas where people gather, market places, health care centers, mosques, sports areas, educational facilities, youth hang-outs, restaurants, etc. Give them 15 minutes for this.
5. Then ask participants to use the seeds or cut up pieces of coloured paper to mark out the places where a survivor of GBV such as sexual violence and exploitation can get help. They should use different coloured seeds or paper for medical, psychosocial, legal/justice support (e.g. beans-medical, rice-social, corn-legal). Participants should put up to 10 seeds where they think a survivor can receive comprehensive and good quality support and a fewer number of seeds where they can receive only a small amount of support. Give them 30 minutes to discuss and mark their maps.
6. Be sure to walk around to the different groups to listen to the discussions. Ask participants why they think certain places can provide more help than others, and who is in those places that provide the help. Encourage participants to think broadly about different groups in the community including:
  - Children – can provide information about where to go for help
  - Religious scholars – can provide information about where to go for help; can provide emotional/spiritual support
  - Women can talk and support each other when they are collecting water, washing, doing other activities
  - Teachers and others who work in schools – may be able to reach out to a child who seems to be troubled, can provide information about where to go for help, can provide emotional support.

7. At the end of the 30 minutes, have a large group discussion (15-20 min) to identify how the various needs of survivors of GBV can be met by different members of the community that they have identified.
  - During this discussion, participants will probably identify people/places in the community that can be harmful to survivors or not survivor-centred. If there is time, it is useful to have a brief discussion about why this occurs, identifying community attitudes; and discuss ideas for how to influence change in those attitudes and behaviours.
8. Close this session by reinforcing learning from previous sessions that emphasized the need for a supportive environment – to help a survivor to feel safer and less isolated and to access legal, medical and psychosocial services.

In Afghanistan the GBV sub-cluster has developed the 4 Ws (Who is Doing What, When and Where) within the cluster system<sup>6</sup>. It is important to make sure that all sectors are aware of the GBV MHPSS capacity, in order to integrate MHPSS at the early stages of planning and implementation.

Victims in more need of help are often less likely to demand for services, health professionals should be able to identify the regular places where community members interact and have access to information and support.

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<sup>6</sup> Afghanistan GBV Protection Sub-cluster  
<https://www.humanitarianresponse.info/en/operations/afghanistan/gender-based-violence>

# Participantguide

## SESSION 3.1 – HANDOUT 3.1.2 Stress, distress and disorder

### ***Definition of stress:***

- **Stress** is an immediate, biological, physiological, social and psychological response to a change in the situation around us. It is an 'alarm-reaction' when we are confronted with something that might be a threat. This threat might be a change in our internal or external environment to which we have to adapt, with which we have to cope. Every person reacts differently to stress: people have different thresholds. Not everyone feels stress in the same situation.
- Stress is a normal and natural response designed to protect, maintain and enhance life. If our ways of managing stress are adaptive and healthy, we may find stress to be a positive thing, a "challenge." Stress that we cannot manage well is experienced more negatively. This is sometimes known as distress.

### ***Definition of distress and extreme distress:***

- **Distress** is a temporary disruption of coping and problem-solving skills as a reaction to a very stressful situation.
- Distress covers a wide range of feelings, from powerlessness, sadness, and fear to anxiety and panic. In addition to feelings, distress may also affect such areas of your life as your thoughts and behaviours.
- **Extreme distress** or traumatic stress can occur following an extremely stressful event (also called traumatic event) in which there was a threat of injury or death to the person or someone close to the person. Reactions can be physical, emotional, cognitive, behavioural and/or social and include extreme fear, re-living the event, hyper arousal (such as being very jumpy), depression, severe relationship difficulties and substance abuse.

People experiencing extreme distress may experience a confused mental state as a result of intense stress (also known as shock). An extremely stressful event, like GBV, including sexual violence, is often so "shocking" and painful that it can overwhelm the person going through it. When this occurs, the person is, at that moment, unable to cope as s/he would in other situations.

*Every person reacts differently to extreme stressors:*



- The capacities and coping mechanisms of a person can determine how s/he reacts after stressful events.
- Also the social context (the reactions of people close to the survivor, the level of social support provided, etc.) has an important impact on the physical, emotional, cognitive, social and behavioural reactions.
- Culture also determines the way survivors respond. In some cultures, failure to act in specific ways, consonant with being “crazy,” may lead to the belief that the survivor was complicit in the crime and therefore increase victim blaming by the family and community as well as the survivor him or herself! Also, the social need for “obvious” signs of distress, may mask the severe and chronic, but less “obvious” internal distress (sense of emptiness or hopelessness, lack of trust, fear for children, future, etc.) experienced by the survivor.
- For most survivors’ reactions of distress or extreme distress are normal reactions to extremely stressful events. Especially with social and emotional support, many survivors learn to cope and the distress decreases over time.<sup>7</sup>

The difference between distress and extreme distress lies in the gradation of the severity of the events/stressors and of the reactions to these events/stressors.

***Definition of a mental disorder:***

That can develop after extremely stressful or potentially traumatic events:

- In most cases reactions to extreme stressors will decrease naturally, without outside intervention, after the stressor has disappeared. However, sometimes, potentially traumatic events can lead to internal psychological dysfunctions, also called mental disorder.
- Such dysfunctions are reactions that continue long after the events and/or the conditions have changed.
- A mental disorder is a group of symptoms or reactions, called a syndrome, that form a ‘dysfunction in the individual’. It also leads to impairment in the survivor’s ability to continue to perform daily tasks such as work, caring for others, schooling etc.

It is important to make the distinction distress – disorder because survivors with a disorder will most likely not be able to cope on their own. They will need specialised professional help (mental health evaluation and treatment). Survivors suffering from distress or extreme distress will also benefit from emotional and social support, although they can mostly also rely on their own coping mechanisms and capacities.

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<sup>7</sup>IASC. 2005. Guidelines for Gender-based violence interventions in humanitarian settings. p.69.

## SESSION 3.1 - HANDOUT 3.1.3: The After Effects<sup>8</sup>

### *The after-effects and outcomes:*

#### **HEALTH:**

With all types of gender-based violence, there are serious and potentially life-threatening health outcomes.

<b>Fatal Outcomes:</b>
Homicide
Suicide
Maternal Mortality
Infant Mortality
AIDS-related

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<sup>8</sup> Adapted from: Heise L, Ellsberg M, Gottemoeller M. (2002) *Reproductive Health and Rights: Reaching the Hardly Reached Article 10: Victims of Gender-based Violence*. In: PATH Series: Reproductive Health and Rights: Reaching the Hardly Reached, Article 10. Available at: <http://www.path.org/publications/pub.php?id=513>

**EMOTIONAL  
-  
PSYCHOLOGICAL - SOCIAL**

<b>Non-fatal Outcomes:</b>			
Acute Physical	Chronic Physical	Reproductive	Mental Health
Injury	Disability	Miscarriage	Post-Traumatic Stress
Shock	Somatic Complaints	Unwanted Pregnancy	Depression
Disease	Chronic Infections	Unsafe Abortion	Anxiety
Infection	Chronic Pain	STIs including HIV	Substance abuse
	Gastrointestinal	Menstrual disorders	Self-harm etc.
	Eating Disorders	Pregnancy complications	
	Sleep Disorders	Gynaecological disorders	
	Alcohol/Drug Abuse	Sexual disorders	

With all types of gender-based violence, there are serious and potentially life threatening emotional, psychological and social outcomes.

<b>Emotional and Psychological Consequences</b>	<b>Social Consequences</b>
Anxiety, fear	Blaming the victim
Anger	Loss of role functions in society
Shame, self-hate, self-blame	(e.g. earn income, care for children)
Suicidal thoughts, behaviour	Social stigma
Withdrawal and hopelessness	Social rejection and isolation
<i>Mental disorders like:</i>	Relationship and family problems
Post-Traumatic Stress Disorder	
Depression	

**SESSION 3.2: HANDOUT 3.2.1 - The guiding principles**

Every lesson taught in this training is guided by the four guiding principles.<sup>9</sup> In this training, we will learn to put these guiding principles into practice, by using survivor-centred skills.

***The guiding principles:***

**1) Ensure the physical safety of the victim(s) / survivor(s)**

Ensure the safety of the survivor and survivor's family at all times. Remember that the survivor may be frightened and need assurance of safety. You must be sure not to ask questions or perform services that could threaten a survivor's safety, or the safety of people helping the survivor (family, friends, and community service or health workers).

**2) Guarantee confidentiality**

All information gathered by participants must be stored securely to protect survivor's confidentiality. Moreover, if you need to share information about a survivor with an outside

<sup>9</sup> \*United Nations High Commission for Refugees. *Sexual violence against refugees: guidelines on prevention and response*. Geneva: The Commission; 1995, chapter 2.

\*IASC Guidelines for Humanitarian Gender-based Violence Interventions in humanitarian settings.

organization (a court judiciary or a counselling centre for example), ***you must first obtain the survivor's written consent, or that of a parent or guardian if the survivor is a child***<sup>10</sup>. In all cases, information about survivors should never be shared if it includes the individual's identifying details. Efforts should also be made to avoid stigmatization in programming, such as identifying survivors because they come to one place or you distribute something specific to them.

**3) Respect the wishes, the rights, and the dignity of the victim(s)/ survivor(s) and consider the best interests of the child, when making any decision on the most appropriate course of action to prevent or respond to an incident of GBV**

Guide all decisions and actions based on the wishes, the rights and the dignity of the survivor. This means conducting conversations, assessments or interviews in private settings with interviewers/translators of either the same sex or the sex chosen by the survivor. This also means that you must maintain a non-judgmental perspective and be patient with the survivor. You must not display disrespect for the survivor or the survivor's culture, family or situation. The survivor should only be asked relevant questions: the status of the survivor's virginity is not an issue and should not be discussed. The survivor should never be forced to participate in any part of an assessment, exam or interview that he or she does not want to participate in. Moreover, if the survivor is a child, the best interests of the child should guide all decisions. Caregivers must consider the age, sex, cultural background, general environment and the child's history when making decisions. Caregivers must also take into account objective standards, subjective opinions, and the child's own views when making decisions about providing the best care possible to a child survivor of sexual violence.

**4) Ensure non-discrimination**

Every adult or child should be given equal care and support regardless of race, religion, nationality, ethnicity, sex or sexual orientation.

**SESSION 3.2 - HANDOUT 3.2.2(1): Coping with Consequences**

***(Tool for exercise)***

*Connect the statement with the corresponding consequences.*

<b>Statement</b>	<b>Reaction</b>
1. "I'm constantly scared. A sudden noise, an angry voice, moving bushes and I am afraid. I am also afraid that husband will divorce me if he finds out, and my family will take my children."	<b>A. FLASHBACKS AND NIGHTMARES</b>
2. "I feel so tense and jumpy".	<b>B. ANGER / HOSTILITY</b>
3. "I want to kill him; I hate him, everything, everyone."	<b>C. GUILT / BLAME</b>
4. "I feel like I don't have anyone to talk to who understands and supports me. I can't tell anyone around me about this."	<b>D. LOSS OF SELF CONFIDENCE</b>
5. "I feel so helpless. Will I ever be in control again?"	<b>E. FEAR</b>

<sup>10</sup> See Handout 7.2 for exceptions to confidentiality

6. I feel I am going crazy – one minute I feel nothing then suddenly I feel really angry”.	<b>F. EMBARRASSMENT / SHAME</b>
7. “I’m okay. I’ll be alright. I don’t need any help.”	<b>G. POWERLESSNESS / LOSS OF CONTROL</b>
8. “I feel as if I did something to make this happen. If only I hadn’t...”	<b>H. DENIAL</b>
9. “I feel so dirty, like there is something wrong with me now. Can you tell that I’ve been raped? What will people think?”	<b>I. DEPRESSION</b>
10. “I feel I can’t do anything anymore...I’m disgusted by myself. I’m just worthless.”	<b>J. ALIENATION/ ISOLATION</b>
11. “Suddenly people in my community won’t talk to me – my neighbours stopped helping me, and the kids at the school tease my children.”	<b>K. MOOD CHANGES</b>
12. “Since the rape, things have been tense in my family.”	<b>L. RELATIONSHIP DIFFICULTIES</b>
13. “How am I going to go on? I feel so tired and hopeless, and nothing seems to interest me anymore.”	<b>M. ANXIETY</b>
14. “I can’t stop thinking about the attack. I have nightmares when I sleep.”	<b>N. STIMGA AND DISCRIMINATION</b>

## Session 3.2 – HANDOUT 3.2.2(2): Factors that promote coping, resilience and recovery

### Definitions:

- **Resilience** is a person's ability to 'bounce back', to overcome difficulties and adapt to change and difficulties. It is determined by the characteristics of the survivor and a number of outside factors.
- **Coping** refers to the specific efforts, behavioural, psychological and social, that people employ to master, tolerate, reduce or minimise stressful events.
  - There are different types of coping strategies. The main important types are problem-solving strategies – efforts to do something active to ease stressful circumstances – and emotion-focused coping strategies, which involve efforts to regulate the emotional consequences of stressful or potentially stressful events.
  - The type of coping style used depends on the characteristics of the person as well as on the type of stressful event and the social environment.<sup>11</sup>

Both individual factors and factors in the environment have an impact on coping, resilience and recovery.

### ➤ **Individual capacity of the survivor:**

- The skills, knowledge and personality of the survivor:
  - Characteristics like high self-esteem, self-control, positive coping skills, sense of optimism, ability to seek help and assistance will have a positive impact on coping, resilience and recovery.
- The personal history: did the survivor grow up in a safe environment? Has s/he experienced earlier incidents of abuse or GBV?
  - If a survivor has experienced GBV, (sexual) violence and/or abuse and neglect earlier in life, especially during childhood, his or her coping skills may be affected.

### ➤ **Environmental factors:**

- Social network and support: Can the survivor rely on support from immediate/extended family and community? What is the place of the survivor in his/her community? What is the socio-economic situation of the survivor and his/her family? Does s/he have a source of income?
  - The presence of a social network (family, friends) will make it easier for the survivor to deal with reactions and seek help. Strong social support can facilitate coping, resilience and recovery.
- Societal factors, culture and religion: Is there peace and security? How is GBV perceived by the society of the survivor? What are the traditional ways of dealing with violence in the society? Is the survivor religious?
  - Often traditional ways of self-expression and rituals, both religious and secular, play a part in culturally accepted ways of coping with difficult situations. Also rules for expressing emotions such as anger and sorrow, which vary greatly

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<sup>11</sup> Definition adapted from: John D. and Catherine T. MacArthur@Research Network on Socioeconomic Status and Health

from culture to culture, influence coping and recovery.<sup>12</sup> Religion can offer a sense of purpose that can facilitate coping.

### ***Coping Mechanisms***

<b>Encourage positive coping strategies</b>	<b>Discourage negative coping strategies</b>
<ul style="list-style-type: none"> <li>- Talk and spend time with family and friends</li> <li>- Discuss problems with someone you trust</li> <li>- Do activities that help you relax (pray, sing, play with children, ...)</li> <li>- Do physical exercise</li> <li>- Practice relaxation exercise</li> <li>- Use calming self-talk</li> <li>- Help others</li> <li>- Get enough sleep</li> <li>- Eat as regularly as possible and drink water</li> </ul>	<ul style="list-style-type: none"> <li>- Don't take drugs or narcotics or drink alcohol to cope</li> <li>- Don't isolate yourself from family and friends</li> <li>- Don't sleep all day</li> <li>- Don't over-eat or under-eat</li> <li>- Don't be violent</li> <li>- Don't neglect personal hygiene</li> <li>- Don't work all the time</li> </ul>

**Give information and help the person access other services (psychological, social, legal and protection services) that she/he might think helpful, but provide appropriate warnings about taking it home and keeping it in a safe place where others cannot find it as this may further compromise their safety.**

- Give plain and correct information about her/his rights, the importance of security and various available services (psychological, social, legal and protection)
- Provide contact details for the services with appropriate warnings about taking it home and keeping it in a place where others cannot find it.
- Refer the survivor directly
  - If possible and appropriate, accompany the person to the service
  - Call the service and make an appointment
- Provide follow-up for the referral, if needed

### **Help the survivor to connect with family/ family networks and other social supports**

GBV survivors who have good social support will cope better.

- Explain the importance of social support
- Help her identify people from within her social network with whom she can reach out to and that she trusts in case she wants to talk about her experience.
- If a survivor lets you know that prayer, religious practice or support from religious leaders might be helpful for them, try to connect them with their spiritual community.

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<sup>12</sup> UNICEF, psychosocial programming, a field guide

## Helping Women Cope with Negative Feelings

		Job aid
<b>Helping women cope with negative feelings</b>		
<b>The feeling</b>	<b>Some ways to respond</b>	
<b>Hopelessness</b>	"Many women do manage to improve their situation. Over time you will likely see that there is hope."	
<b>Despair</b> يأس	Focus on her strengths and how she has been able to handle a past dangerous or difficult situation.	
<b>Powerlessness, loss of control</b>	"You have some choices and options today in how to proceed."	
<b>Flashbacks</b>	Explain that these are common and often become less common or disappear over time.	
<b>Denial</b>	"I'm taking what you have told me seriously. I will be here if you need help in the future."	
<b>Guilt and self-blame</b>	"You are not to blame for what happened to you. You are not responsible for his behaviour."	
<b>Shame</b>	"There is no loss of honour in what happened. You are of value."	
<b>Unrealistic fear</b>	Emphasize, "You are in a safe place now. We can talk about how to keep you safe."	
<b>Numbness</b>	"This is a common reaction to difficult events. You will feel again—all in good time."	
<b>Mood swings</b>	Explain that these can be common and should ease with the healing process.	
<b>Anger with perpetrator</b>	Acknowledge that this is a valid feeling.	
<b>Anxiety</b>	"This is common, but we can discuss ways to help you feel less anxious."	
<b>Helplessness</b>	"We are here to help you."	

## Coping with Consequences Handout Answers

**1. Statement:** "I'm constantly scared. A sudden noise, an angry voice, moving bushes and I am afraid. I am also afraid that my husband will divorce me if he finds out, and my family will take my children."

### Consequence: FEAR

During an assault many victims fear for their lives. Often this fear is a direct result of the offender's threats. After the assault, a survivor may be fearful of the dark, being alone or going out by him/herself. They may experience fear generated by the possibility of pregnancy or sexually transmitted infections (STIs) or live in fear of running into their assailant again. They can also be fearful of the possible consequences of the sexual violence, whether on their relationships with others, their living conditions or their health. A survivor may also fear retaliation from the perpetrator or others if they report the incident.

### Coping mechanisms:

All of these fears are very real concerns and the caregiver should try to ensure that practical steps are taken to ensure that the survivor is as secure as possible. In all instances the caregiver should regard the survivor's fears as legitimate and support them to develop strategies that will contribute to a gradual rebuilding of their security and confidence in day-to-day living. A referral to a health service may help to take away fears about the medical consequences of sexual violence. Ensuring



confidentiality will minimise the risk of the potential negative consequences of others finding out what happened.

11. **Statement:** "I feel so tense and jumpy."

**Consequence: ANXIETY**

Survivors of GBV often experience severe anxiety that may manifest in physical reactions such as difficulties in breathing, muscle tension, nausea, stomach cramps or headaches. They are often easily startled.

**Coping mechanisms:**

These reactions can be eased as survivors gradually deal with the issues underlying the stress, and employ relevant stress management strategies. Offering relaxation exercises or rituals, and/or physical exercise may also help to deal with anxiety.

3. **Statement:** "I want to kill him; I hate him, everything, everyone."

**Consequence: ANGER / HOSTILITY**

Anger is a difficult emotion for most people. Culturally, women and children are often discouraged from expressing anger and it is most frequently displaced rather than directed at the appropriate target. The survivor's anger towards their offender is more than justified. They may also be angry at the response they receive from others to whom they share their experiences with.

**Coping mechanisms:**

It must be recognized that given their experiences, the survivor's reactions of anger are justified and these feelings of hostility are a natural emotion rather than a necessarily negative one. However, if you deal with a survivor, you need to be aware that you too could be a target of this anger and you must assist survivors to identify ways to safely express their anger. Anger can indicate that the survivor is not placing the entire blame for the assault on him/herself but is recognizing that their perpetrator was responsible. It is most important to work towards the moment when the survivor is able to see the role played by society in creating both the perpetrator and the conditions in which rape occurs. Again, you can help to help the survivor find positive and safe ways to vent anger and hostility and use their energy in a positive way, e.g. to participate in a justice process.

4. **Statement:** "I feel like I don't have anyone to talk to who understands and supports me. I can't tell anyone around me about this."

**Consequence: ALIENATION/ ISOLATION**

GBV survivors often experience feelings of alienation, isolation and despair if they are unable to share their experiences with others. They avoid talking about their experiences since remembering the violence is painful, they fear that others cannot understand them, and they fear being stigmatized or isolated by friends or family. But many survivors never forget their experiences and these are relived in nightmares and flashbacks. Not speaking about the violence, but reliving it in nightmares and flashbacks, results in a state of speechless fear that prevents survivors from healing.

**Coping mechanisms:**

As a caretaker, you serve as a "safe person" in whom survivors can confide in. Assure survivors their confidentiality, and refer them to support groups and other safe places where they can share their concerns and begin to recover. It is very important that survivors have the opportunity to be listened to in a compassionate, non-judgemental way. It is very important for survivors to understand that they are not alone, that they are not crazy, and that they can get help. Ensuring that survivors have the opportunity to share their concerns with people who are empathetic and respectful will help to restore the survivor's dignity and help him/her to heal. Survivors may or may not wish to talk about the GBV situation – you should respect this choice while assuring them that if they do wish to discuss it, you are available, will not judge them and would keep the information confidential. You should also help them to determine if there are others around them they could get emotional or practical support from (whether or not they wish to confide in them about their experience of violence).

As caretakers and community members it is important to sensitize the community about the causes and consequences of GBV with special considerations of towards sexual violence to minimize rejection of survivors by the community. It is important to stress that GBV, including sexual violence, not only has consequences for the individual survivor, but also affects the community as a whole.

**5. Statement:** "I feel so helpless. Will I ever be in control again?"

**Consequence: POWERLESSNESS/LOSS OF CONTROL**

Because all forms of GBV involve a survivor losing power over his or her body and mind, one of the caretaker's primary roles must be to help the survivor regain a sense of control.

**Coping mechanisms:**

By explaining procedures and options, by respecting and advocating for their choices, a caretaker can assist the survivor to regain a sense of control in their life. Supporting rather than advising the survivor is one of the most important, and difficult skills of caring for survivors. By helping them to find solutions to problems they face, such as how to make a living, you can help them regain a sense of control.

**6. Statement:** "I feel I am going crazy – one minute I feel nothing then suddenly I feel really angry".

**Consequence: MOOD CHANGES**

Survivors' emotions may swing from intense emotional pain to complete numbness. They may feel depressed, restless or deflated, confused or stridently angry. Feeling at the whim of emotions over which they have no control may make them believe they are psychologically unstable or crazy.

Among the most commonly misunderstood reactions is emotional numbness – a common response to terrifying events, especially in initial stages. Those around survivors often misunderstand this response. For example, it may be taken as an indication that they are in control of the situation, or that they are calm and relatively unharmed. A numb reaction may even make people think that the survivor was never raped. However, in reality it is a victim's way of coping with the overwhelming experience.

**Coping mechanisms:**

As caretakers, we can support survivors by explaining that intense mood changes are common and normal responses to extremely stressful events. The survivor should also be reassured

that as they better understand and cope with the effects of the situation these reactions will progressively subside. For emotional numbness, it is important to recognize that numbness is a normal reaction and not a sign that the person is in control or the situation is/was not real. Explaining such a reaction to a survivor may help them to recognise and acknowledge it. Severe and persistent numbness may be a sign of mental disorder and should be an indicator for referral to receive mental health services.

**7. Statement:** "I'm okay. I'll be alright. I don't need any help"

**Consequence: DENIAL**

Following the initial shock of the assault, or even months later, a survivor may deny to others or to themselves that they have been assaulted. They try to ignore the memory of what has happened in an attempt to regain stability.

**Coping mechanisms:**

As a caretaker it is important to help the survivor to acknowledge what happened, so that s/he can accept help if needed and start the recovery process. However, denial is also a strong defence mechanism. Therefore, a survivor should NEVER BE PRESSURED to explain what happened or to reveal details! By listening and showing you care you can create a safe environment in which the survivor can begin to re-establish trust and share as much as they feel is appropriate.

It must be remembered that GBV and sexual assault exists on a continuum and that all forms GBV, sexual harassment and violation are experienced as threatening and can have devastating consequences for the survivor.

**8. Statement:** "I feel as if I did something to make this happen. If only I hadn't..."

**Consequence: GUILT / BLAME**

Survivors of GBV, including sexual assault, may feel that they could have avoided it by acting differently. These sorts of reactions are often strongly linked to the myths about GBV that prevail in the community which frequently blame the survivor rather than the offender. The behaviour and reactions of friends, family, neighbours and police may reinforce the survivor's own feeling that s/he 'asked for it' or should have done something to avoid it. The survivor may also feel guilty that they have brought shame on their family and themselves by talking about it or reporting it to the police or others. Similarly, if they believe they could have resisted more forcefully they may also feel at fault. This is particularly true for adult survivors of childhood abuse who tend to see themselves as they are now, as adults, rather than as they were at the time of the abuse.

**Coping mechanisms:**

As caretakers and community members, our role is to provide information that demonstrates that men, women and children can and have been suffering GBV under many circumstances. The offender is always at fault, never the survivor. Nothing a survivor does is "asking for it." Under all circumstances, the caretaker must reinforce that the survivor is not to blame and that it is the offender who must take full responsibility for the crime they have committed. However, they need to realise that it may take time for the survivor to accept this and the survivor's feelings of guilt need to be acknowledged while being reassured that they were not responsible.

**9. Statement:** "I feel so dirty, like there is something wrong with me now. Can you tell that I've been raped? What will people think?"

**Consequence: EMBARRASSMENT / SHAME**

Many people who have suffered GBV feel intensely ashamed and embarrassed. They often feel dirty and in some way 'marked for life'. This reaction may prevent survivors from speaking out about the assault. Cultural background factors can intensify such feelings, such as societal issues surrounding the honour of women and the need for chastity. Underlying these reactions is that survivors often have to live with day-to-day discrimination and stigma – some also believe the myths pertaining to GBV, and in particular to sexual assault. This is also the case for women that has suffered other types of GBV and did not ask for help at the early stages.

**Coping mechanisms:**

Providing opportunities for survivors to express and question these beliefs will help them place the responsibility for the assault with the offender. Confidentiality and privacy are particularly important in order to help the survivor feel comfortable in a caregiving setting. Stressing that feelings of embarrassment are very normal reactions can help the survivor to accept these feelings and deal with them. Helping the survivor to recognise those situations in which they face stigma and discrimination that reinforce feelings of shame and embarrassment and how to deal with those situations can help. Providing opportunities for survivors to work with others to change social attitudes towards survivors can help reduce shame and become stronger at personal and social levels.

**10. Statement:** "I feel I can't do anything anymore...I'm disgusted by myself. I'm just worthless."

**Consequence: LOSS OF SELF CONFIDENCE**

The experience of violence exposes the survivor to the stark reality that they cannot always protect themselves no matter how hard they try. The assault is not only an invasion of the survivor's physical self but also affects emotions, thoughts and social interactions. The experience of assault brings up many vulnerability issues that can devastate self-confidence and destroy assumptions about the world. Violence humiliates and degrades survivors. Therefore, it is not surprising that survivors often experience low self-esteem.

**Coping mechanisms:**

To facilitate the healing process, caretakers must concentrate on helping survivors to build a newly defined sense of confidence. This confidence can begin with the realization that surviving the violence took incredible strength and determination. Every action the survivor takes (e.g. going to the police, seeking help, sharing his/her story...) should be encouraged and recognized as a step towards regaining confidence and recovery. It is essential that, as caretakers, we focus our attention on the positive aspects of the survivor's character, coping strategies, and personal achievements.

**11. Statement:** "Suddenly people in my community won't talk to me – my neighbours stopped helping me, and the kids at the school tease my children."

**Consequence: STIGMA AND DISCRIMINATION**

A common problem for survivors is the stigma and discrimination they experience. This can take many forms including neighbours and other community members ostracizing the survivor, blatant verbal and sometimes physical abuse of the survivor and/or their family and children, and discrimination in access to services such as health, social welfare and education. This serves both to exacerbate the survivor's emotional distress (shame, isolation, depression etc.) as well as add additional practical difficulties that further undermine their rights to support.

**Coping mechanisms:**

It is important to help the survivor develop his/her own coping mechanisms to deal with the stigma and discrimination, as well as to help access alternative sources of social support (e.g. identifying neighbours who are supportive or social support networks of other survivors). If possible, engage key community member or leaders to combat stigma and discrimination against survivors. It is also important to provide the survivor with information on services that are sensitive to survivors, and if these do not exist to provide her with accurate information about the existing services and the benefits and risks involved. Where possible, the survivor should have a support person with them when accessing services.

**12. Statement:** "Since the event, things have been tense in my family."

**Consequence: RELATIONSHIP DIFFICULTIES**

Many survivors experience difficulties in relationships as a result for GBV, especially in cases of sexual violence. This can stem from many factors, including stigma among family members, changes in the survivor's behaviour and emotions, difficulties of family members to understand and support the survivor, and secondary stressors resulting from the violence such as loss of employment or health problems. For instance, family members may disagree on how to respond to the sexual violence (e.g. a husband may be supportive of his wife but his extended family blames her).

**Coping mechanisms:**

It is important to try to understand the source of the problem in the family. Discuss with the survivor and try to help her/him find strategies to address the problems. If you are known and trusted by the other family members, and the survivor agrees, discuss with the other family members how the situation is affecting them and how they could better support the survivor in dealing with the consequences. If the family knows about the situation of violence, provide them with general information about its effects how to support survivors – do not ask family members about details of the violence but do listen if they bring it up.

**13. Statement:** "How am I going to go on? I feel so tired and hopeless and nothing seems to interest me anymore."

**Consequence:(POSSIBLE)DEPRESSION**

Many survivors of GBV suffer periods of depression and /or low energy. It may take the form of the loss of will-to-live or interest in daily activities, loss of self-worth, numbness, loss of appetite, disturbed sleep or include other physical indications of stress such as constant tiredness or lethargy.

**Coping mechanisms:**

As a caretaker, you should try to help to express personal grief, and repressed anger: anger at the perpetrator, anger at the injustice of the assault, and often anger at the injustice of the community's reaction. The release of grief and the appropriate re-focusing of anger will empower the survivor. Survivors expressing signs of severe depression (e.g. suicidal thoughts and behaviour) should be referred to specialized mental health services.

**14. Statement:** "I can't stop thinking about the attack. I have nightmares when I sleep and sometimes during the day I feel as if it is happening over again."

**Consequence: FLASHBACKS AND NIGHTMARES**

Memories of the assault often return without warning. Nightmares are common among survivors. Sometimes flashbacks during day-time will be so vivid that the survivor feels as if they have re-lived the experience of assault.

**Coping mechanisms:**

As a caretaker, you need to explain to a survivor that she is having a flashback – she may not realize what is going on. Reassure the survivor that flashbacks are not the result of irreversible psychological damage or an indicator of insanity. They represent a response to the situation that, like nightmares, will decrease as the recovery process progresses.

If a survivor experiences a flashback while talking to you, help them to calm down. Encourage her/him to take slow, gentle breaths. Tell the survivor that s/he is remembering but not experiencing the violence. Help the survivor to look around the room and realize where they are. Tell the survivor over and over again that s/he is in a safe place and give indicators on this that no one is going to hurt her that this reaction is very normal, that it does not mean she is going crazy. Do not continue with the technique if the person expresses severe reactions or states that is not able to continue. Always use this technique progressively and evaluate potential risks. Whenever possible, seek for supervision of a mental health professional to apply this technique

## Session 3.2 – HANDOUT 3.2.3: Obstacles on the path to help. The story of Malalai

### **Case study**

*Malalai, a 27-year-old mother, is regularly beaten up by her husband. Sometimes he also rapes her. The neighbours know what is happening. One day, the lady next door comes to talk to Malalai, trying to convince her to look for help or go to the police. The neighbour tells Malalai that she is worried about her and wants to help her; she wants her to be happy. Malalai refuses and even denies that her husband is mistreating her. She becomes very angry. The neighbours don't understand her reaction and people in the village start to talk about her. Why does she not stop this? She must have done something very bad! Maybe her husband gives her a lot of money? The neighbours start to avoid contact with Malalai and she and her child become more and more isolated. The abuse continues...*

### **Survival strategies**

**Avoidance:** The survivor does everything within her or his power to avoid further violence or abuse within the relation. The survivor may become docile and completely obedient to the perpetrator.

**Identification with the perpetrator:** The survivor feels that she might not survive the violence and that escape is not possible. She will try to gain approval of the perpetrator as a last chance to survive, she will even try to put herself in the position of the perpetrator, adopt his views, feel and think like he does.

**Numbing:** Eventually the identification has become so strong that the survivor becomes alienated from her emotions and thoughts and shows an extremely high level of apathy or indifference towards her own suffering.

What can everybody in the community do to help? Trying to get to know her better, not avoiding her

- Ensuring her physical safety if possible
- Not judging her
- Not telling stories about her to others in the village
- Showing care, helping her with small things
- Listening to her story
- Not telling her what she should do, but informing her about options to find help
- Eventually trying to express your worries and concerns
- Assisting her in finding solutions and assistance, if she wants to.

## Session 3.3 – Handout 3.3.1: Understanding the consequences and coping mechanisms

Consequences of GBV with focus on sexual abuse or violence on children<sup>13</sup>

- Many (especially small) children will not say anything about abuse that has happened. This often stems from the fear of the perpetrator. Often, the perpetrator has told them that the abuse is normal or that something bad will happen if they react or say anything. Also, children sometimes don't understand that the abuse is wrong.
- However, most children will show reactions after the abuse or violence. These behavioural reactions may be an indicator of abuse. But while the presence of these indicators may raise concern, it does not always mean that a child has been sexually abused. Especially in conflict-affected settings, many children might show temporarily reactions to stress, which might be similar to the reactions described below. Therefore, a careful assessment of the child and their circumstances is necessary.
- In a later stage of development, when they fully understand what happened and develop their own sexuality, many children develop reactions and psychosocial problems, as a backlash of the earlier abuse.

### **Common Behavioural Reactions**

The following are some of the most common consequences of sexual violence on children:

#### **Inappropriate Sexualized Behaviour**

When children are sexually assaulted their sense of what is right and wrong becomes distorted. What they had previously learnt about bodies and sexual activity becomes invalid. When a child is raped by someone in their family, he or she may believe that they will get attention by being sexual with another person. If children have experienced sexual feelings, which are common in children who have been sexually assaulted, they are likely to try and recreate those reactions. They may begin to sexually act out with other children to try and make sense of what has happened to them. In some circumstances, the trouble they may get into as a result of this behaviour might then confirm their view of themselves as dirty and bad.

Sexualised behaviour is, to a certain extent, part of normal child development. However, when it occurs at greater frequency or at an earlier age than would be developmentally appropriate, when it is accompanied by coercion (the child forcing another child to engage in sexual acts) or when it is associated with emotional distress it can be an indicator of sexual abuse.

#### **Wetting/Soiling**

Many young children lose bladder/bowel control following sexual violence. It can be frustrating for parents and humiliating and embarrassing for children.

All children wet from time to time when they are sick, stressed or anxious. Children who have been sexually assaulted will often bed wet every night and sometimes more than once a night. Bedwetting can be linked to feelings and may be a result of nightmares. Extreme fear can cause loss of bladder control and may serve the purpose of waking a child from a terrifying dream. Bedwetting can also result from feelings of helplessness when children feel a loss of ownership and power over their body when it has been used by someone more powerful than they are.

<sup>13</sup>WHO (2003). Guidelines for medico-legal care for victims of sexual violence. p.75-92; <http://whqlibdoc.who.int/publications/2004/924154628X.pdf>



## **Nightmares**

All children have bad dreams from time to time but children who have experienced sexual assault often have nightmares every night sometimes more than once. They may have recurring dreams that are all the more frightening because they know what is coming. Nightmares can make children terrified of the dark leading to difficult behaviours. Their dreams are likely to reflect their fears and their sense of lack of control. Asking them to tell their dreams can help them to talk about what has happened.

## **Persistent Pains**

Lots of children develop aches and pains that have no physical cause. These will often have a connection to an aspect of the assault. Sometimes if a child has experienced physical pain during the assaults their body can retain the memory of this pain, for example, one child who had been tied up continued to have tingling in his hands; another child had severe stomach pains after vaginal penetration. Another boy had blinding headaches because he felt he could not get the offender out of his head. Children may also think that something is broken inside of them. Repeated pain can also be a way for children to gain the extra love and attention they need at the time. Sometimes emotions manifest themselves physically for children because they do not have the ability to put it into words.

## **Clinginess**

Previously independent children often cling closely to their parents or caretakers after sexual assault. It is a communication of a real need to be reassured by the caregiver that they are lovable and secure. Children are attempting to rebuild a sense of safety and trust through their relationships with close adults. They are trying to restore a sense of good touch by demanding affection and cuddles. In essence, they are trying to heal their wounds. Constant physical and verbal demands can be difficult for parents but can be modified by identifying what the child needs and putting limits on when and how they are met. Talking about a child's fears can help reduce clinginess.

## **Aggression**

Aggression in children after sexual assault tends to be related to fear and anger. It can be a direct communication that states, "I am never going to be hurt again." Anger is a normal response and can be a part of the recovery process from any terrifying event. It needs to be expressed in a safe and constructive way with firm limits against hurting yourself or others. To do this, anger needs to be acknowledged and recognized by the child and the adult. A child needs to learn how to control and express their anger in acceptable ways. Adults can help children learn skills in controlling and managing their anger without aggression.

Aggression causes the child more problems as their aggression prevents other people from seeing or understanding the child's needs. It stems from fear and a need to protect themselves from further hurt. This can be evident in boys who may believe they were weak because they did not fight off the offender. Sometimes they can make themselves feel more powerful by hurting other children or animals.

Being aggressive can also cause children to punish themselves and confirm their low self-esteem because they have no friends and are always in trouble.

## ***Other consequences of GBV on children:***

Consequences of GBV on children can be wide-ranging and diverse. Other consequences include resuming behaviours from earlier stages of their development or stopping newly acquired behaviours (e.g. toilet trained children may regress to wetting) withdrawal from family and friends, difficulties to

concentrate at school, lack of interest in daily activities, severe fear of strangers, and risk-taking and changes in beliefs and values (especially among adolescents). Secondary effects such as social isolation and stigmatisation, dropping out of school, and lack of marriage and employment opportunities, can compound the initial harm done by GBV and undermine their long-term development. If the situation is not addressed and/or continues for a long time, it risks undermining children's emotional, social and cognitive development.

### ***Coping mechanisms of children: (See also handout 3.2.2 (2))***

Just like with adults, different factors have an impact on coping, resilience and recovery of children.

#### **Individual capacity of the child:**

Generally, children have a large set of resources to adapt to change after difficult or stressful experiences. In fact, children generally demonstrate a huge resilience and have the capacity 'to bounce back'.

Three aspects of well-being have an impact on a child's ability to cope<sup>14</sup>:

- Skills and knowledge: include life and vocational skills, use of appropriate coping mechanisms, and the ability to process information in order to access resources.
- Emotional well-being: refers to one's sense of security, trust, self-confidence and hope for the future. Spiritual well-being will influence many of these factors; it may be one way of constructing a sense of order in the world, and providing meaning to experiences.
- Social well-being: is the ability to form and maintain positive relationships with care givers, peers and adult role models who promote healthy functioning. This ability also refers to one's having a socially appropriate role and identity within a community.

#### **Family and social support:**

More than adults, children need the support of parents, siblings, extended family and friends to feel protected and deal with the impact of sexual violence. Attachment to stable and supportive caregivers is a fundamental building block for a healthy development, including the development of coping mechanisms. A safe environment of a family – which implies that no one of the family is complicit in the abuse - will help the child-survivor to play, deal with their emotions and thoughts, and recover from the violence.

#### **The community, culture and religion:**

Factors related to the community, culture and religion will also have an impact on the coping, resilience, and recovery of children. Norms and values, attitudes may help to protect children against further harm and help them in their recovery. Religious and traditional rituals, such as cleansing or healing rituals, can as well promote recovery.

It is important to understand local beliefs regarding the physical and moral consequences of violence against children, including culturally 'appropriate reactions, in order to help children. For example: are child-victims believed to become predators, paedophiles or homosexuals in later life? How are children

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<sup>14</sup> UNICEF, Psychosocial support of children in emergencies, field version 2007. p. 9

expected to react to violence? What if they react differently? What are local remedies that are believed by the population to reverse the effects of violence on children?

**A few examples:**

- Children may use individual or group play, drawing etc. to deal with the effects of sexual violence. (individual capacity)
- Interaction with parents or other caregivers may offer children reassurance and safety, which may help children to deal with the effects of sexual violence. (family and social support)
- Community activities (school, sport, play) can offer a forum to children to express emotions, to find safety and regain self-esteem after sexual violence. (community, culture and religion)
- Traditional cleansing rituals may help children and their families to start the recovery process and/or to find closure after violence. (community, culture and religion)

See also Handout 3.3.2



## Session 3.3 – Handout 3.3.2: Providing support to children

### **Possible methods to support children<sup>15</sup>:**

#### **Offer safety:**

- Protect the child. Limit situations that are dangerous for the child. Work with the children's caregivers to reduce the risk that the child would be exposed to further violence. Provide the child with accurate and reassuring information about their safety in an age appropriate way.
- Make a safety plan with the child if there is a risk or s/he is scared that the abuse will happen again. Identify with the child's family members, friends or neighbours where the child can go if s/he feels unsafe. Give, if the child wants this, the number of the local police station. Repeat that the child can say no if s/he doesn't like the way someone is touching him or her.
- Protect the child from further distress. Do not hesitate to cut short or stop activities that are upsetting the child or give them a chance to sit out some activities. If the child is upset, make sure someone they know well talks to them individually to understand the reason. Do not ask the child private or sensitive information unless necessary, and then only by someone trusted by the child and in private.
- Provide a consistent, predictable pattern for the day and make sure the child knows the pattern: in this way you show children that their caretakers are 'in control'.
- Give the child 'choices' and some sense of control in daily activities appropriate to their age and level of development. Just like adults, children who are survivors of violence have experienced a situation where they were totally not in control. Giving back control that is appropriate to their age and level of development can make children feel confident and safe again.
- Reassure a child that is clinging to his/her caretaker. Prepare the child in advance if you have to leave. Try to always leave the child with someone s/he knows very well.

#### **Offer possibilities to express concerns, feelings and thoughts:**

- Give the child opportunities to express feelings and thoughts in a safe environment. Talk with the child in a quiet place; build trust; allow the child to talk about what is on their mind; to express feelings through play or drawings. Give the child the chance to talk about nightmares and flashbacks. For younger children, puppets and dolls can help children to talk about their concerns in a safe way. Do not put pressure on the child to talk about what happened to them. However, if you are in a trusting, ongoing relationship with the child, do let them know that you will not judge them, it is ok to tell you anything that happened to them, and that you will keep it a secret unless they agree to tell someone else.
- Help children to try to learn skills to deal with their problems. Support them to identify key concerns and explore positive ways to deal with these issues.
- Help the child to reengage in daily activities and social interactions that build their confidence, help restore their relations with others, build their sense of security and especially for older children help them restore a sense of purpose and hope in the life.

#### **Offer support:**

- Help the child feel positive about him/herself. Give reassuring, accurate messages to the child: *'it was not your fault', 'it is ok to feel scared', 'you are very brave', 'it is good that you talked about it, now we can make sure/put all our efforts to avoid the abuse*

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<sup>15</sup> Partly drawn from: Macksoud M. (1993) Helping children cope with the stresses of war. UNICEF, New York. V. Patel (2003). Where there is no psychiatrist. Gaskell, London. p. 170 – 175.

*to happen again'. If the abuse was directly suffered by a family member, we will offer support to this person always careful with the feelings of the child about disclosing the situation, if this is the case.*

- If a child demonstrates inappropriate behaviour, calmly try to explain to the child why this might be happening and what we can do to stop it. Use language that is adapted to the level of development of the child.  
Example: (after bedwetting) *'This can happen to everyone, let's get you dry and back to bed. Was there something that was upsetting you?'*
- Show warmth and affection to the child but make sure you do this in a way the child feels comfortable with.

### **Some don'ts**

- DON'T pressure a child to talk about the violent event or situation, to talk about nightmares, flashbacks or feelings.
- DON'T touch or hug a child if s/he doesn't want to. Physical contact and intimacy for child survivors is often associated with confusion, pain, fear or abandonment.
- DON'T scold or punish the child for 'bad behaviour' like bed-wetting, sexualised behaviour, aggression, etc.
- DON'T embarrass a child by talking about the events to family members, siblings, etc.
- DON'T tell children things that are not true. Child survivors need to be able to trust those around them and telling them things that are not true, even if it makes them feel better in the short-term, will further undermine their ability to trust others.



**Ministry of Public Health**  
**Directorate of policy and plan**  
**Directorate of Gender**

**Module 4: Communication and Survivor-centred Skills**

## Module 4: Communication and Survivor-centred Skills

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## Module 4: Communication and Survivor-centred Skills

# Facilitator guide

### Purpose:

The purpose of this module is to help participants understand and practice the key-principles of communication to be applied when receiving a disclosure of GBV or when dealing with survivors in different professional contexts. Health care providers are also given the opportunity to further develop their skills.

### Specific Objectives:

*At the end of this Module participants should be able to:*

- Understand the importance of survivor-centred skills:
  - Understand the importance of confidentiality, obtaining informed consent and the survivors' right to choose; know how to put these principles in practice when communicating with a survivor.
  - Understand the importance of a non-blaming attitude when dealing with survivors.
  - Understand the difference between informing vs. advising.
- Apply basic communication and engagement skills like active listening skills and techniques for asking questions in their own professional contacts.

**Estimated Time:** 8 hours

### Module 4 at a glance

Sessions	Time	Handouts <sup>1</sup>
<b>Part 1: Skills Development and practice</b>		
Session 4.1: Introduction to Survivor-centred Skills  4.1.1 Exercise: Dealing with survivors and receiving disclosures  4.1.2 Discussion: What are survivor-centred skills	75 min	Handout 4.1.2: Survivor-centred skills
Session 4.2: Confidentiality, the right to choose and consent  4.2.1 Lecture: Confidentiality, the right to choose and consent  4.2.2 Exercise: Right or Wrong?	1.5 hours	Handout 4.2.1: Confidentiality, the Right to Choose and Consent  Handout 4.2.2: Right or Wrong?

<sup>1</sup>Partially adapted from: IASC Caring for Survivors of Sexual Violence in Emergencies. Training Guide.

<p>Session 4.3: Engagement and Communication skills: how to listen and to ask Questions?</p> <p>4.3.1 Exercise: Introduction to Active Listening</p> <p>4.3.2 Exercise: With or without hat?</p> <p>4.3.3 Lecture: Techniques for active listening and asking questions</p> <p>4.3.4 Exercise: Practice engagement skills!</p> <p>4.3.5 Exercise: Communication do and don'ts</p>	<p>3 hours 15 min</p>	<p>Handout 4.3.3: Active listening techniques and 'listening roadblocks'</p> <p>Handout 4.3.5: Communication Do and Don'ts.</p>
<p><b>Part 2: Health care professionals practice</b></p>		
<p>Session 4.4. Survivor centred communication practice. Health care.</p>	<p>2 hours</p>	<p>Handout 4.4. <sup>2</sup>Healthcare scenarios</p>

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<sup>2</sup>Partially adapted from: Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan. Participant Handbook Ministry of Public Health and WHO. Afghanistan 2015

## Part 1: Skills Development and practice

### Session 4.1: Introduction to Survivor-centred Skills

**Objective:**

To understand the importance of using survivor-centred skills when dealing with survivors of GBV, in particular when receiving disclosures.

**Activities:**

4.1.1. Exercise: Dealing with survivors and receiving disclosures

4.1.2. Discussion: What are survivor-centred skills?

**Preparations: /****Handouts:**

Handout 4.1.2: Survivor-centred skills

**Materials: /**

#### 4.1.1. Exercise: Dealing with survivors and receiving disclosures

**Materials:** flip chart and markers

**Preparations: /**

**Handouts: /**

**Group sizes:** whole group

**Time:** 45 minutes

1. Ask participants to think for a few minutes about their own experiences with dealing with survivors of GBV.
  - Did you ever receive a disclosure from a survivor? How did you respond? What did you do?
  - Think about an experience you had with talking to/dealing with survivors which was particularly difficult. What made it difficult or challenging?
2. Ask participants to write down some of their responses and reactions as well as things they found challenging,
  - For example: "I tried to listen", "I didn't know what to say, I felt uncomfortable", "I told the person what to do", "I wanted to help but didn't know how" ...
3. Ask participants to walk around in the room. After 30 seconds, ask them to stand still in front of someone and share with this person some of the responses they wrote down. The 'partner' can ask questions to clarify the answers or to find out what was difficult or challenging. They can take 10 to 15 minutes for this exercise.
4. Discuss the activity: invite participants to share some of the experiences, reactions and responses they discussed with their partner in the exercise. Elicit discussion, make a list of responses on a flip chart, group them under 'survivor-centred responses' and 'challenges'. In the second column (challenges) you can also include reactions and responses that participants may have labelled as helpful or positive but which do not reflect a survivor-centred attitude (e.g.: giving advice).

5. Optional: You can also ask participants what made it difficult or easy to share these experiences with a partner in this exercise. Highlight responses that show a parallel with survivor-centred skills.
- Example: “my partner showed that he/she was listening”, “he/she asked the right questions (which questions?)” or: “it was difficult to share this with someone I don’t really know”, “I didn’t feel comfortable (why?)” ...

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**▽ Good to know!**

- Remind participants of the guiding principles/ground rules:
  - They should never reveal the identity of a survivor to other participants.
  - They should only speak about what they feel comfortable with and never feel forced to share experiences they do not want to talk about.
- Participants who have no experience in dealing with survivors or who have never received a disclosure can focus on their experiences with dealing with victims of other extremely stressful events in conflict-affected and complex settings. It is however important that the plenary discussion focuses on dealing with survivors of GBV.
- Step 5 is optional.

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**4.1.2. Discussion: What are survivor-centred skills?**

**Materials:** flip chart and markers

**Preparations:** /

**Handouts:** 4.1.2: Survivor-centred skills

**Group sizes:** Whole group

**Time:** 30 minutes

1. Start the discussion by referring to the flip chart of the previous exercise. Go through the first list of responses and explain that these are ‘survivor-centred responses’ which reflect survivor-centred skills.
  - Ask participants why they think the skills are called ‘survivor-centred’.
  - Why is the use of survivor-centred skills important for survivors?Write down key-words on a flip chart.
2. Distribute Handout 4.1.2, explain the skills and ask participants to give examples. Make the link between the survivor-centred skills and guiding principles, as addressed in Module 3 (see Handout 4.1.2).
3. Explain the difference between informing and advising (see Handout 4.1.2).
4. Explain that in the next sessions, we will learn more about survivor-centred skills and practice how to use them.

---

**▽ Good to know!**

- For more background information about skills for providing support to people in complex emergencies, check the **IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings**, e.g. p 119 (Providing psychological first-aid. Available at: <http://www.humanitarianinfo.org/iasc/content/products/default.asp>)

## **Session 4.2: Confidentiality, the right to choose and consent**

### **Objective:**

To understand the importance of confidentiality, obtaining informed consent and the survivors' right to choose as central elements of a survivor-centred attitude;

Know how to put these principles in practice when communicating with a survivor.

### **Activities:**

4.2.1. Lecture: Confidentiality, the right to choose and consent

4.2.2. Exercise: Right or Wrong?

### **Preparations: /**

### **Handouts:**

Handout 4.2.1 Confidentiality, the Right to Choose and Consent

Handout 4.2.2: Right or Wrong?

### **Materials: /**

### **4.2.1. Lecture: Confidentiality, the Right to Choose and Consent**

**Materials:** flip chart and markers

**Preparations: /**

**Handouts:** 4.2.1 Confidentiality, the Right to Choose and Consent

**Group sizes:** whole group

**Time:** 1 hour

1. Explain that you would like to talk more about 'Confidentiality', 'the right to choose' and 'Consent'. They are three very important elements of survivor-centred skills, which are also closely related to each other.
2. Recap with participants the concept of confidentiality. Ask participants why they think this is so important when you deal with survivors? Generate answers. (See Handout 4.2.1)
3. Make sure you highlight:
  - Safety of the survivor (and of family members accompanying the survivor)
  - Respect for the survivor
4. Ask participants what confidentiality means in the context of a survivor-centred attitude. Generate answers. See Handout 4.2.1. Explain.
5. Highlight the exceptions to confidentiality (see Handout 4.2.1).
6. Ask what consent could mean. Generate answers. Explain the concept of informed consent (see Handout 4.2.1).
7. Link consent with the right to choose. Explain the right to choose. (See Handout 4.2.1).

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**▽ Good to know!**

- Highlight that where children are concerned, extra precautions should be taken to ask for consent.
  - Make sure you clearly highlight the relevance of confidentiality; consent and the right to choose as part of survivor-centred skills (see also Handout 4.2.1).
- 

**4.2.2. Exercise: Right or Wrong?**

**Materials:** /

**Preparations:** /

**Handouts:** 4.2.2 Right or Wrong?

**Group sizes:** whole group

**Time:** 30 minutes

1. Explain that you will do a short exercise to illustrate the concepts of confidentiality, consent and the right to choose as part of survivor-centred skills.
2. Read out the statements on Handout 4.2.2. After each statement participants should indicate whether they think the statement is right or wrong.
  - Participants who think it is right should *clap their hands*.
  - Participants who think it is wrong, should shout '*nonononono...*'
3. Listen to the sound that dominates, explain and discuss the right answer. Refer back to Handout 4.2.1.
4. Distribute Handout 4.2.2

---

**▽ Good to know!**

- Some statements can be right and wrong! Make sure you explain well the nuances.
-

## **Session 4.3: Survivor-centred Engagement and Communication Skills: How to Listen and to Ask Questions?**

### **Objective:**

To learn to apply communication and engagement skills like active listening skills and techniques for asking questions, as part of developing survivor-centred skills.

### **Activities:**

- 4.3.1. Exercise: Introduction to Active Listening
- 4.3.2. Exercise: With or without hat? Open-ended and Closed questions
- 4.3.3. Lecture: Techniques for active listening and asking questions
- 4.3.4. Exercise: Practice communication skills!
- 4.3.5. Exercise: Communication do and don'ts

### **Preparations:**

#### *Exercise 4.3.5:*

Prepare 12 index cards: write on each card one of the 'interview do or don'ts' so that all cards have a different statement written on it.

### **Handouts:**

Handout 4.3.3: Active listening techniques and 'listening roadblocks'

Handout 4.3.5: Communication Do and Don'ts.

### **Materials:**

*Exercise 4.3.2:* A hat

*Exercise 4.3.5:* A ball

12 index cards

### **4.3.1 Exercise: Introduction to Active Listening<sup>3</sup>**

**Materials:** /

**Preparations:** /

**Handouts:** /

**Group sizes:** whole group

**Time:**20 minutes

1. Ask participants to visualise a time when they felt really listened to.  
Guiding questions:

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<sup>3</sup> RHRC Consortium, Communication Skills Training Manual – Facilitator's Guide, p.19  
[http://www.rhrc.org/resources/gbv/comm\\_manual/comm\\_manual\\_toc.html](http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html)



- What was going on for you at the time that made you decide to talk to someone? It may have been a problem, difficulty, concern or something you wanted to share with someone else.
  - How did you feel about talking to this person? What were your fears, anxieties and thoughts about how it might be received?
  - What qualities did the person you talked to have that made you decide that it would be safe to talk to them?
  - What were some of the things that s/he said to you?
  - How did you know that the person really listened?
  - How would you describe the experience of feeling really listened to?
2. Ask a few participants to share their experiences. Remind them that they should only share what they feel comfortable sharing!
  3. Explain participants that these are examples of active listening. These are the kind of feelings that you want to elicit from a survivor when s/he shares his/her experiences with you.
  4. Ask participants why they think active listening is an important aspect of survivor-centred skills.

#### **4.3.2. Exercise: *With or Without Hat?* – Open-ended and Closed Questions**

**Materials:** a hat, flip chart and marker

**Preparations:** / You can use a hat or something else you find available and relevant in the local context

**Handouts:** /

**Group sizes:** whole group

**Time:** 25 minutes

1. Hold a hat in your hand. Start asking participants simple questions while wearing the hat (open-ended questions) or while taking off the hat (closed questions).
  - Example:  
*Tell me what you did after you went home last night?* (an open-ended question: put on the hat).
  - Did you eat lunch during your break?* (a closed question: take off the hat).
2. Ask participants what is different about responses to questions 'with a hat' and 'without a hat'. Write down key-words in two columns (open-ended / closed or leading questions).
3. Explain the difference between open-ended and closed or leading questions.
  - Answers to open-ended questions are usually longer, they are not "yes" or "no" questions, open-ended questions do not guide respondents in their answers.
  - Leading questions are not helpful because they suggest that there is a specific answer, they often put words into the respondent's mouth. For example, '*did you fight back?*' suggests that a fight would have been appropriate. Instead, asking 'what did you do?' does not suggest that there was a specific action the

survivor should have taken, but rather elicits information about what took place.

4. Ask participants:
  - Which style of questioning is better for eliciting truthful and complete answers?
  - What would happen if they posed the following questions to survivors: *'did you fight back?'*, *'Did you look at him in a certain way?'*, *'Are you upset or angry?'*

Highlight that:

- Because open-ended questions do not guide respondents in their answers, they are better to elicit truthful and complete answers.
  - Leading or closed-ended questions can easily be perceived as victim-blaming.
- 

#### **4.3.3. Lecture: Techniques for active listening and asking questions**

**Materials:** 2 chairs for role –play, flip chart and markers

**Preparations:** /

**Handouts:** 4.3.3. Active listening techniques and roadblocks

**Group sizes:** whole group

**Time:** 45 min

1. Explain that active listening is more than just listening. It requires an active attitude and the use of specific skills. Aside from using open-ended questions, there are a number of other techniques that can help to listen and to ask questions in a survivor-centred way.
2. Invite a volunteer to participate in a short role-play. Sit in front of the volunteer and ask him/her to tell a personal story. Make sure the volunteer chooses a story which s/he feels comfortable sharing with others. If necessary, you briefly discuss this beforehand.
3. Demonstrate ways to ask questions about the story and to offer support to the volunteer. You can also demonstrate 'listening roadblocks' (see Handout 4.3.3 for examples).
4. After a few minutes you stop and ask the volunteer how s/he feels, which interventions were helpful or not to tell the story.
5. Write down, together with participants, a list of skills for active listening and asking questions. Specify how these techniques can be helpful for survivors. (see Handout 4.3.3)
6. Make another list of 'listening roadblocks': elements that might stop the person from telling his story in a good way and that prevent you from listening. (see handout)
7. Distribute Handout 4.3.3.
8. Conclude by stressing that:

- Active listening requires knowledge, skills but also the right attitude. You need a willingness to listen and to take distance from any assumptions you might have about the person you listen to develop survivor-centred skills and to engage with survivors in a helpful way.
- You don't master communication skills overnight; a lot of practise is required. This training can only offer you basic skills; it does not turn you overnight into a counsellor!

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**▽ Good to know!<sup>4</sup>**

**REMEMER CORE ACTIVE LISTENING CONSIDERATIONS:**

- Use non-verbal communication techniques
  - Use summarising and paraphrasing statements and clarifying questions
  - Avoiding giving opinions or arguing
  - Trying not to be distracted
  - Focusing on what the person is saying, rather than guessing, or preparing what you yourself will say next
  - Being awake, focus and attentive
  - Allowing time for silence and thoughts
- 

**4.3.4. Exercise: Practice engagement skills!**

**Materials:** /

**Preparations:** /

**Handouts:** /

**Group sizes:** groups of 3

**Time:** 1 hour

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**▽ Good to know!<sup>5</sup>**

This exercise should be adapted to the level and experience of the group. Option 1 can be used for a group with little experience in communicating with survivors. Option 2 can be used for a group with some or extensive experience in engaging with survivors. In case you teach a group with a very mixed level of experience you may want to offer option 1 and 2 together and leave the choice of the topic to the participants

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**OPTION 1:**

1. Divide the group into groups of three.
2. Assign each person a different role: listener, respondent and observer.

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<sup>5</sup>Adapted from UNFPA Myanmar PSS and GBV training.

3. Ask the groups to discuss a neutral subject during 5 to 10 minutes. (For instance: food - what food do they eat now? how does it differ from the food they ate when they were kids? ...)
4. Assign tasks:
  - The respondent should tell a personal story about the subject;
  - The 'listener' should help the respondent to tell his/her story in the best way possible.
  - The observer takes note about the techniques the listener used and about the body-language of the respondent and the listener. He/she should also note any 'listening roadblocks' s/he observed.
5. Watch the time and make sure every group stops their conversation after 5 to 10 min (shout 'stop' when the time is over).
6. When the conversation is over, observers should share their observations in a constructive manner with the listeners.  
The respondent can also give feedback on how s/he experienced the conversation (What helped him/her to tell the story? What was difficult or not helpful?)
 

*For example: "you were moving a lot on your chair, which gave me the feeling that I had to tell my story really fast."*
7. Participants should switch roles within the same group, so that they can each experience the role of listener, respondent and observer.
8. Conclude by reconvening the group for a short debriefing. You can discuss:
  - What listeners found most difficult,
  - What observers saw as common 'mistakes',
  - How respondents felt/reacted when they were asked leading vs. open questions, when the listener made assumptions, ...
 Refer back to the list of active listening skills and listening roadblocks.

## OPTION 2

The procedure of this exercise is identical to option 1.

However, instead of discussing a neutral subject, participants set up a role-play in which:

- The respondent plays a survivor,
- The listener plays the role he or she would have in his/her professional situation (nurse, midwife, medical doctor, psychosocial counsellor, community worker, ...)
- The observer has the same role as in option 1. In addition, s/he should have attention for the impact of the questions of the listener on the interviewee/survivor.

Example:        - *"The listener said that the survivor is not to blame – the survivor looked more relaxed."*

- *"As soon as there was silence, the listener hurried to ask a question – the survivor skipped important parts of his/her story."*

- The observer should also observe how well survivor-centred skills are applied.

- Example:
- *"The listener did not give advice but was listening and gave information."*
  - *"The listener gave the survivor the chance to choose between options".*
  - *"The listener asked for consent of the survivor".*

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**▽ Good to know!**

- If you choose for option 2:
  - Make sure participants respect confidentiality if they choose to use one of their cases in the role-play. Encourage participants who play the survivor not to use their own name in the role-play, to create more distance to the role.
  - Make sure you do a proper group-debriefing to give participants the chance to give feedback about the experience of playing a survivor or engaging with a survivor.

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**4.3.5. Exercise: Communication do and don'ts**

**Materials:** Index cards, a ball

**Preparations:** Prepare 12 index cards, write on each card one do or don't (see handout)

**Handouts:** 4.3.5 Communication do and don'ts

**Group sizes:** 3 groups

**Time:** 45 min

1. Divide participants in three groups. Distribute the 12 index cards you prepared, each of them has a different 'Interview do or don't' written on it. Give each group 4 cards (see Handout 4.3.5).
2. Ask each group to go to a corner of the room; put a ball in the middle of the room.
3. After a few minutes' preparation, ask each group to present a card in 30 sec. role-play or in another creative way (for instance a drawing...). They should just present the statement and not say whether it is a DO or a DON'T.
4. Each time a DO/DON'T is presented, the other groups should guess what is meant. When they know the answer one person has to run to the middle of the room, pick up the ball and shout the answer. The person who answered should also explain why this is DO or a DON'T.
5. Present all cards, the group who has the most correct answers at the end, wins the 'do or don't game'.
6. Distribute Handout 4.3.5. Summarise all 'do and don'ts' and ask whether participants have other examples that are not mentioned on the cards.

## Part 2: Health care professionals practice

### 4.4. Exercise: Survivor centered communication practice. Health care.

**Materials:** Index cards, paper

**Preparations:** You may want to use any of the given scenarios to present the situation.

**Handouts:** Survivor centred communication practice. Health care.

**Group sizes:** whole group, groups of 3

**Time:** 2 hours

## Module 4: Communication and survivor-centred skills

# Participant guide

### SESSION 4.1 – HANDOUT 4.1.2: Survivor-centred skills

By using survivor-centred skills, the guiding principles for helping survivors are put into practice.

Below is an overview of the guiding principles and the corresponding survivor-centred skills:

Guiding Principles	Survivor-centred Skills
<b>1. Ensure the physical safety of the victim(s) / survivor(s).</b>	<ul style="list-style-type: none"><li>✦ <i>Consider the safety of the survivor:</i><ul style="list-style-type: none"><li>○ Always be aware of the security risks a survivor might be exposed to after an incident of GBV or in an ongoing situation of GBV. Hold all conversations, assessments and interviews in a safe setting.</li><li>○ Try, as much as the context and your position allow you, to assess the safety of the survivor (Does the survivor have a safe place to go to? Will the survivor be confronted with the perpetrator?).</li><li>○ Conduct a participatory safety assessment with the survivor.</li><li>○ Inform yourself about all options for referral available to the survivor.</li><li>○ If possible, take action to ensure the safety of the survivor (including engaging other sectors).</li></ul></li></ul>
<b>2. Guarantee confidentiality.</b>	<ul style="list-style-type: none"><li>✦ <i>Ensure Confidentiality:</i><ul style="list-style-type: none"><li>○ Do not share the story of the survivor with others. If you need to share information with professionals, for instance to organise a referral, you can only do so if the survivor understands what this implies and has given his/her <u>consent</u> beforehand.</li></ul></li></ul>

**3. Respect the wishes, the rights, and the dignity of the victim(s)/ survivor(s) and consider the best interests of the child, when making any decision on the most appropriate course of action to prevent or respond to an incident of gender-based violence.**

✦ *Respect the wishes, needs and capacities of the survivor:*

- Every action you take should be guided by the wishes, needs and capacities of the survivor.
- Ensure the survivor has access to information of the survivor: medical and psychosocial needs as well as material needs and the need for justice.
- Respect the strength and capacities of the survivor to cope with what happened to her/him.
- After the survivor is informed about all options for support and referral, s/he has the right to make the choices s/he wants.
- For children, the best interests of the child should be a primary consideration and children should be able to participate in decisions relating to their lives. However, adults must take into account the child's age and capacities when determining the weight that should be given to their wishes.

✦ *Treat the survivor with dignity:*

- Show that you believe the survivor, that you don't question the story or blame the survivor, and that you respect her/his privacy.

✦ *Assure a supportive attitude:*

- Provide emotional support to the survivor. Show sensitivity, understanding and willingness to listen to the concerns and story of the survivor.
- Retain a caring attitude, regardless of the type of intervention you make.

✦ *Provide information and manage expectations*

- Provide the survivor with information about available services and their quality to enable them to make a choice about the care and support s/he wants.
- Check whether the survivor fully understands all the information, and if necessary adapt the presentation of the information to the capacity of the survivor at that time.
- Be aware of the fact that when a survivor discloses her/his story to you, s/he trusts you and might have high expectations about what you can do to help.
- Always be clear about your role and about the type of support and assistance you can offer to a survivor.
- Never make promises that you can't keep.
- Always refer the survivor to the appropriate services.
- Respect also the limitations of what you can do.

	<ul style="list-style-type: none"> <li>✦ <i>Ensure referral and accompaniment:</i> <ul style="list-style-type: none"> <li>○ Make sure you are well informed about the options for referral (medical, psychosocial, economic, judicial) and available services, along with their quality and safety.</li> <li>○ Inform the survivor about these options.</li> <li>○ Ensure that the survivor has access to the appropriate services.</li> <li>○ Consider the possibility of accompaniment of the survivor throughout the process – that is, having a supportive, trusted person who is informed about the process accompany the survivor to different services</li> </ul> </li> </ul>
<p><b>4. Ensure non-discrimination.</b></p>	<ul style="list-style-type: none"> <li>✦ <i>Treat every survivor in a dignified way, independent of her/his sex, background, race, ethnicity or the circumstances of the incident(s).</i> <ul style="list-style-type: none"> <li>○ Treat all survivors equally.</li> <li>○ Do not make assumptions about the history or background of the survivor.</li> <li>○ Be aware of your own prejudices and opinions about gender, GBV and sexual violence and do not let them influence the way you treat a survivor.</li> </ul> </li> </ul>

- Survivor-centred skills are important:
  - To protect survivors from further harm.
  - To provide survivors with the opportunity to talk about their concerns (including if they wish what has happened to her/him) without pressure.
  - To assist survivors in making choices and in seeking help, if they want to.
  - To cope with the fear that survivors may have of negative reactions (from the community or their family), or of being blamed for the violence.
  - To provide basic psychosocial support to the survivor
  - To give back the control to the survivor, which he/she lost due to the situation of violence.
- Survivor-centred skills should be applied by everyone who is in contact with survivors - regardless of their role in the community or professional position - who is in contact with survivors.

The difference between informing and advising:

**Advising** means telling someone what you think s/he should do and how s/he should do it. It also means giving your personal opinion. Giving advice is not survivor-centred because you cannot know if you are giving the right advice for that person. Applying a survivor-centred attitude is about empowering survivors to make their own decisions about their own lives. Telling someone what to do does not help a person to follow and understand his/her own choices. A survivor might feel you are not listening if you tell him/her what to do.

**Giving information** means telling someone facts so s/he can make an informed decision about what to do. **Informing** is survivor-centred because it empowers a survivor to have control of her or his choices. It also shows that you respect a survivor's opinion and judgment. The information should be adapted to the age and capacity of the person.



## SESSION 4.2 – HANDOUT 4.2.1: Confidentiality, the Right to Choose and Consent

Confidentiality, the Right to Choose and Consent are crucial elements of survivor-centred skills.

### **Confidentiality**

- For everyone who is dealing with survivors of GBV, maintaining confidentiality means that *you cannot share* any information about survivors (history, identity...) with anyone without the permission of the survivor.
- Maintaining confidentiality also means that no one except authorized health care providers will have access to medical data (written reports, etc.) about survivors without their permission. This means that information about survivors *cannot be shared* with reporters from newspapers, with government authorities, or even with other family members or caretakers without the permission of the survivor.
- Maintaining confidentiality ensures that a survivor does not experience further threats and/or violence as a result of seeking assistance.
- Confidentiality is one of the essential elements that lead to an increased sense of security for survivors; when programmes maintain confidentiality, more survivors feel comfortable reporting what happened to them, and therefore they are able to pursue help.<sup>6</sup>
- When a programme serving survivors of GBV breaks confidentiality, or when a health center is unable to keep their records safe and secure, information about survivors can easily get into the wrong hands. If the information gets into the hands of perpetrators, or other adversaries in the community, the consequences can be devastating. When confidentiality is broken, both survivors and caretakers are at further risk of harm.

### **Possible Exceptions<sup>7</sup>:**

- **Suspicion of child abuse or neglect**
  - You may have the duty to report any suspicion about child abuse or neglect. The safety of the child is in this situation more important than the confidentiality.
- **Emergency or life threatening situations**
  - In situations where the life of the survivor or of others is endangered, you have to release information and undertake action (e.g. if the person is suicidal or expresses a serious threat to harm others).
- Health care workers and psychosocial counsellors can share information about a case with colleagues, to ask for technical advice or in the context of supervision. It is not considered to be a breach in confidentiality. This must be explained to the survivor at the start of the consultation!

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<sup>6</sup> UNHCR (2001), How To Guide: Sexual and Gender-based Violence Programme in Liberia. [www.rhrc.org/pdf/h2g008.pdf](http://www.rhrc.org/pdf/h2g008.pdf).

<sup>7</sup>RHRC Consortium, Communication Skills Training Manual – Facilitator’s Guide, p.50. [http://www.rhrc.org/resources/gbv/comm\\_manual/comm\\_manual\\_toc.html](http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html)

## **Consent – Release of information**

- Asking for Consent means asking the permission of the survivor to share information about him/her with others (for instance, with referral services and/or monitoring organisations) - = *consent*;
- and/or to undertake any action (for instance, organising referral and/or starting a medical exam)<sup>8</sup> = *release of information*.
- Under no circumstances should the survivor be pressured to consent to any examination, conversation, assessment, interview or other intervention with which s/he does not feel comfortable. A survivor can also at any time decide to stop an intervention (e.g. during a medical examination).
- Healthcare providers, but also sometimes human rights workers, investigators and others will use a Consent Form. By signing this form survivor can formally agree (or disagree) with a physical examination, receiving medication, sharing information with other organisations etc. The form will clearly state how information will be used, stored and disseminated.
- If a survivor does not consent to sharing information, then only non-identifying information can be released to other organisations<sup>9</sup> (e.g. general information about the number of cases).
- We talk about Informed Consent, since the survivor should fully understand what s/he is consenting to. Before agreeing, s/he should be first informed about all the available options for support. The full range of choices should be presented to the survivor, regardless of the individual beliefs of the community worker, health care worker or others dealing with survivors.
- In the case of children, informed consent is normally requested from a parent or legal guardian and the children.

### **Elements of informed consent**

- Tell a survivor what is going to happen to him/her.
- Explain to him/her the benefits and risks of an intervention (medical treatment, interview...)
- Explain that s/he has the right to decline or refuse any part of an intervention.
- Explain that pressure will not be exerted in any form.
- Explain that if the survivor does not want to be interviewed about the events, this will NOT affect access to health and other services and does not preclude participation in future proceedings related to legal justice.
- Inform the survivor about any mandatory reporting in the setting.
- Inform the survivor that information about him/her will be discussed in the team.
- Ensure that the survivor understands what you have told him/her.

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<sup>8</sup> In case a person is under 18 or not able to understand or give informed consent (e.g. when the survivor is disabled), a parent, guardian or family member should be asked for consent.

<sup>9</sup>UNHCR. (2003). Sexual and Gender –Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response.

### ***Right to Choose***<sup>10</sup>

- The right to choose is particularly important because it gives back a feeling of control and power to the survivor, which s/he lost at the time of the incident or over the time in cases of multiple events/ongoing violence.
- Survivors should not be forced to or pressured to undergo any treatment, examination, or other intervention against their will. Decisions for health care, counselling, legal aid and other interventions are personal ones and can only be made by the survivor him/herself or in the case of children, the child and their parent or legal guardian<sup>11</sup>.
- In this context, it is essential that the survivor receives appropriate information to allow him/her to make informed choices.
- Survivors also have the right to decide whether, and by whom, they want to be accompanied when they receive information, are examined or receive other services. These choices must be respected.

### ***Ethical and safety considerations***

The following principles should inform all decisions and actions of healthcare provider, regardless of whether the GBV was established or only suspected.

- Never leave your patient without help. Withholding assistance from the person in need of cure goes against the teachings of Islam and the regulations of Islamic medical ethics.
- Physical safety of the survivor/victim and those who help her/him should be placed at the center of all efforts.
- Safety and well-being of children (possibly witnessing abuse) should constitute one of the primary concerns. Decisions and actions should be guided by the best interests of the child
- Confidentiality of patient's identity, medical records and GBV related experience should be protected by healthcare provider at all times.
- Healthcare provider should always respect the patient's wishes, rights, and dignity.
- Healthcare provider should respect and support the patients' choices at all times.
- Healthcare provider should treat all patients in non-judgemental, compassionate and understanding way.
- Healthcare provider should never discriminate against any patient based on ethnicity, gender, religion, wealth and other socio-cultural and economic factors.
- Leaving abusive relationship is one of the choices that GBV victim can make, however the choice should not be imposed by the healthcare provider.
- Healthcare provider should invest maximum effort into arranging privacy for the patient suffering (or possibly suffering from GBV).
- Healthcare provider should be familiar with safe exits and entrances into the healthcare facility venue and need to ensure that GBV victims have safe access to the healthcare facility.

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<sup>10</sup>WHO/UNHCR (2005). Clinical Management of Rape Survivors, p. 3

<sup>11</sup> Throughout the document, the term survivor will be used. In the case of children and consent, this refers both to the child themselves as well as their parent or legal guardian.

## **SESSION 4.2 – HANDOUT 4.2.2: Right or Wrong?**

1. A community worker can ask a close family member of a survivor to take care of her, without informing the survivor.

**WRONG (she cannot inform a family member without asking for permission)**

2. A teacher can tell a student of hers that it would be the best for her if she would go and talk to a counsellor about the situation she suffered from.

**WRONG (she can inform her about the option, but not tell her 'that it would be the best for her').**

3. A health worker can keep general statistics about the number of women that consulted in connection to GBV (including the different types of violence that may occur), without asking the survivors for their consent.

**RIGHT (as long as the information is anonymous)**

4. A survivor, who does not agree to give a detailed statement immediately after she was raped, loses her right to press charges and initiate legal action.

**WRONG (a survivor can change her mind and decide at any time to press charges. She then of course needs to agree to give a statement.)**

5. A survivor can decide to only get medical treatment from a nurse, without having to undergo a medical examination or having to tell her full story.

**RIGHT (A survivor can choose to only undergo treatment. It is however important to make sure that she fully understand all the options available).**

6. A counsellor needs to ask the permission of a survivor when she/he wants to talk about her case with her supervisor.

**RIGHT (if the counsellor never explained earlier to the survivor that she shares (anonymous) cases in supervision.)**

**WRONG (if the counsellor discussed with the survivor beforehand about supervisions and about which information will be shared).**

7. It is better not to tell a survivor about the possibility to give a statement to the police if she is too upset.

**RIGHT (if you make sure that the survivor gets this information at a later stage).**

**WRONG (if YOU decide that it would not be good for her to get this information, and therefore you don't give it to her.)**

8. A woman comes to you after having been beaten up by her husband, her wounds look severe and you fear for her life. But she does not want you to go to the police, so you can't do anything.

**WRONG (if the situation is life threatening for the survivor, you can go to the police.)**

## SESSION 4.3 – HANDOUT 4.3.3: Active listening techniques and ‘listening roadblocks’

### Active listening techniques<sup>12</sup>:

- ✦ Offering information (*‘I am ... and this is what I can do for you...’*)
- ✦ Asking broad questions (*‘What would you like to talk about?’*, *‘Would you like to tell me what happened?’*)
- ✦ Asking open-ended questions
- ✦ Encouraging the person to describe or clarify what happened without forcing him/her to talk (*‘what do you mean exactly?’*, *‘when did this happen?’*, *‘Can you explain that again?’*, *‘What do you mean by ...?’*)
- ✦ Attempting to place the story in sequence (*‘What seemed to lead up to this point?’* *“So this occurred”*)
- ✦ Allowing silence in the conversation
- ✦ Showing that you accept the story of the person (*‘yes’*, *‘Uh huh’*, *‘I hear what you are saying’...*)
- ✦ Attending acts<sup>13</sup> as a basis for listening to and observing the client. Attending well to the client places you in a good position to listen to them, to both their verbal and non-verbal messages!  
There are different ways in which you can show that you are attending to the client:
  - Posture
    - a. Your posture needs to be “open”, so that you signal that you are willing to engage with the client. Do not cross your arms in front of your chest.
    - b. Face the client directly, sit in a centred way, do not lean back in your chair
    - c. Do not sit in a higher chair as your client or even behind a desk
  - Eye contact
    - a. Maintain constant and direct eye contact, but do not fix the client with a stare! You should use the eye contact to demonstrate your availability.
    - b. Be natural and communicate your interest in your client in your own natural way.
  - Facial expression
    - a. The client will be watchful of you and your reaction to what he/she says, therefore you need to be aware of the information that your facial expression might convey!
    - b. How you look should be consistent with what you are saying.

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<sup>12</sup>Raising Voices.Rethinking Domestic Violence: A training Process for Community activists.Training Manual.

RHRC Consortium, Communication Skills Training Manual – Facilitator’s Guide.  
[http://www.rhrc.org/resources/gbv/comm\\_manual/comm\\_manual\\_toc.html](http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html)

<sup>13</sup>Professional Package for Psychosocial Counsellors Working in the BPHS in Afghanistan, Counselling skills and intervention technique, Basic counselling, Communication skills, p.17-26

- c. You can also mirror clients by matching your expression with theirs! Letting clients see, by the concern on your face, that you have some sense of the pain they have experienced may free them to begin to access those feelings

- ✦ Giving recognition (*"It takes courage to tell me your story"*)
- ✦ Giving feedback about what you see or hear, asking the person to validate those observations (*'I notice you are shifting in your chair...what is going on?', 'your muscles appear tight...what are you thinking about?', 'I can see that you are crying, how do you feel?'*...)
- ✦ Repeating or restating what the person says to check whether you fully understand what the person means (*'It sounds to me that you are feeling helpless right now', 'You mentioned that you feel very frustrated'*).
- ✦ Reflecting feelings (*"Sounds like you feel angry"*)
- ✦ Exploring (*"Could you tell me more about that?"*)
- ✦ Offering emotional support (*'I understand that you must feel very sad'...*)

**'Listening roadblocks':**

- ✦ Lack of privacy or inadequate seating (a noisy room, interruptions by other people)
- ✦ Asking leading questions (*Are you worried about being pregnant?*)
- ✦ Asking 'why' questions: they often put the respondent on the defensive and might sound accusatory (*Why didn't you tell anyone? Why did you go there?*)
- ✦ Guessing what the person is saying or jumping into conclusions after a few sentences
- ✦ Not letting the person finish his/her sentence
- ✦ Using inappropriate body language or not being aware of your body-language (*tone of voice, looking away from the person, crossing your arms, 'hanging' in your chair, being distracted...*)
- ✦ Making assumptions about the person: even if you don't express these explicitly, the person will pick it up (*thinking: 'it was her fault', thinking 'she must be a prostitute, what do you expect?'*...)
- ✦ Talking about oneself instead of listening or responding with your own feelings instead of focusing on what the speaker is saying (*'this once happened to me as well', 'I feel very angry when you tell me this'...*)
- ✦ Touching the person inappropriately
- ✦ Others.....

**SESSION 4.3 – HANDOUT 4.3.5: Communication Do and Don'ts.**

<b>DO</b>	<b>DON'T</b>
<p><b>DO ensure and respect confidentiality:</b></p> <p>If a woman or child says she needs help, try to have the conversation in a place that makes her comfortable. This may be a private place, or she may prefer a public place to avoid stigmatization. Confidentiality is essential to building trust and ensuring the survivor's safety.</p>	<p><b>DON'T pressure the survivor to tell the details of what happened to him/her:</b></p> <p>Never insist on telling the story or revealing details about what happened when a survivor does not feel ready to talk about this.</p>
<p><b>DO believe and validate the survivor's experience:</b></p> <p>Listen to the survivor and believe her/him. Acknowledge the survivor's feelings and needs and let the survivor know that she is not alone and you will try to get her help.</p>	<p><b>DON'T trivialize or minimize the violence:</b></p> <p>Not taking a survivor's story seriously is a violation of her/his trust and can serve as a barrier for a survivor seeking help. Not taking a survivor seriously is re-victimizing.</p>
<p><b>DO make referrals and promote access to community services:</b></p> <p>Provide information to survivors about medical care and other services and the consequences of seeking help or not doing so; provide practical assistance if needed and available (e.g. transport, calling the service, identifying someone to accompany the survivor).</p>	<p><b>DON'T refer survivors to services that will not provide confidential, respectful care:</b></p> <p>Community groups should work together to ensure that they refer survivors to agencies that provide compassionate and confidential care.</p>
<p><b>DO help the survivor to plan for safety:</b></p> <p>Whenever possible, ensure the survivor is not in immediate danger of re-victimization; if the perpetrator of the violence is in the survivor's home, help find the survivor an alternative place to stay or a way to keep them safe in the home (e.g. having someone else stay). This may prove difficult in conflict situations, but efforts should be made to improve the survivor's safety.</p>	<p><b>DON'T ignore the survivor's need for safety:</b></p> <p>Do not instruct the survivor to return to a home or avillage that she knows to be unsafe, or where her perpetrator continues to threaten her.</p>
<p><b>DO acknowledge the injustice:</b></p> <p>GBV is NOT the survivor's fault; do your best to ensure the survivor understands this.</p>	<p><b>DON'T blame the survivor:</b></p> <p>Do not ask questions like "why didn't you run?" or "what did you do to make him hurt you?" GBV is NEVER the survivor's fault. Reinforce this fact to the survivor.</p>

**DO provide information to the survivor:**

Inform the survivor about who you are, what you can do for him/her, and what the options are to seek help.

**DON'T tell a survivor what to do:**

You may suggest options for assistance to the survivor, and help a survivor to make a choice, but you should never decide for a survivor what to do.

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**▽ Good to know!<sup>14</sup>**
**REMEMER CORE ACTIVE LISTENING CONSIDERATIONS:**

- Use non-verbal communication techniques
  - Use summarising and paraphrasing statements and clarifying questions
  - Avoiding giving opinions or arguing
  - Trying not to be distracted
  - Focusing on what the person is saying, rather than guessing, or preparing what you yourself will say next
  - Being awake, focus and attentive
  - Allowing time for silence and thoughts
- 

**PART 2: Health care professionals practice*****SESSION 4.4 – HANDOUT 4.4: Survivor-centered Communications Practice*****Group Instructions:<sup>15</sup>**

1. You have 30 minutes to role play 3 different scenarios. Please consider both traditional health facilities and other places in the community where victims/survivors of GBV could be identified.
2. All groups will do all three stories.
3. Each person will play a different role in each story. Everyone will get a turn to be a A.) Survivor, B.) Healthcare Provider (choose a different type each time, including nurse, midwife, medical doctor and psychosocial counsellor), and C.) Observer.
4. Person 1 is the Survivor. The Survivor should review their individual story. The Survivor should keep the story confidential and not show it to the others. Be creative and act in anyway that you want. Feel free to be dramatic or not. Some victims cry, some are silent, some are angry – you can choose how you want to be. They should act as realistically as they can as a GBV survivor who is seeking medical care.
5. Person 2 is the Healthcare Provider. The Healthcare provider will use the survivor-centred communication that we have just learned to find out what happened to the Survivor so they can provide medical care if needed. Remember the Guiding Principles! The Healthcare Providers should try to listen to the story and ask open-ended questions,

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<sup>14</sup>Adapted from UNFPA Myanmar PSS and GBV training.

<sup>15</sup>Partially adapted from: Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan. Participant Handbook Ministry of Public Health and WHO. Afghanistan 2015



practice active listening, and use the GBV Guiding Principles while trying to find out what has happened to the GBV survivor in order to provide accurate medical care.

6. Person 3 is the Observer. You will watch carefully and silently during the role play (you can take notes if you want). You can take notes about the techniques the healthcare provider used and about the body-language of the GBV Survivor and the healthcare provider. He/she should also note any 'listening roadblocks' s/he observed. In addition, s/he should have attention for the impact of the questions of the listener on the interviewee/survivor. For example:
  - "The healthcare worker said that the survivor is not to blame – the survivor looked more relaxed." "As soon as there was silence, the healthcare worker hurried to ask a question – the survivor skipped important parts of his/her story."
  - The Observer will lead the discussion when the role play finishes. Give positive comments on what Healthcare provider did well. Then give constructive feedback on what they could improve. The observer should also observe how well survivor-centred skills are applied. For example:
    - "The listener did not give advice but was listening and gave information."
    - "The listener gave the survivor the chance to choose between options".
    - "The listener asked for consent of the survivor".
7. Survivor should discuss with the other two about how they felt as they disclosed the story. What helped him/her to tell the story? What was difficult or not helpful? For example: "you were moving a lot on your chair, which gave me the feeling that I had to tell my story really fast."
8. Healthcare Provider should discuss how they felt while hearing the story. Were they nervous? Did they feel like they were upsetting the Survivor? Discuss amongst all three.
9. After you have finished discussion, change roles. Person 1 now becomes the healthcare provider, Person 2 is the Observer, Person 3 is the GBV survivor.
10. Repeat: Person 1 is now the Observer, Person 2 is the GBV survivor, Person 3 is the Healthcare Provider.
11. After all discussions are finished, please inform the facilitator and be prepared to share experiences in plenary.



**Ministry of Public Health**  
**Directorate of policy and plan**  
**Directorate of Gender**

**MODULE 5. The different types of intervention in MHPSS and GBV**

## MODULE 5. The different types of intervention in MHPSS and GBV

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## **MODULE 5. The different types of intervention in MHPSS and GBV**

# Facilitator Guide

### **Purpose:**

To help health care providers enhance their knowledge to provide adequate different levels of MHPSS: psychosocial first aid (PFA), psychosocial support, psychosocial counselling follow-up and referrals to survivors of GBV.

### **Specific Objectives:**

*At the end of this module, participants should be able to*

- Further understand the psychological and social impact of GBV.
- Provide different levels of MHPSS using survivor-centred skills.
- Understand the timelines and variations for follow-up of survivors.
- Understand when to refer a survivor.
- Understand how to best use existing capacities.
- Practice some PSS and counselling techniques

### **Estimated Time:**

11 hours

### **Resources**

Different resources are available; we have focused on the most action oriented ones, and developed further materials adapted to our context.

## **1. *Accompanying Steps in Clinical Management of GBV Survivors: Counselling the survivor***<sup>1</sup>

Survivors seen at a health facility immediately after a critical incident or in cases of ongoing violence are likely to be extremely distressed and may not remember advice given at this time. Survivors suffering long term GBV may feel unsafe and guilty when asking for help for the first time. It is therefore important to repeat information during follow-up visits. It is also useful to prepare standard advice and information in writing, and give the survivor a copy before she leaves the health facility (even if the survivor is illiterate, she can ask someone she trusts to read it to her later).

Give the survivor the opportunity to ask questions and to voice her concerns.

### ***Psychosocial and emotional consequences***

Medical care for survivors of GBV includes PFA, psychosocial support and treatment/ referral for psychological and social problems, such as common mental disorders, stigma and isolation, substance abuse, risk-taking behaviour, and family rejection. Even though trauma-related symptoms may not occur, or may disappear over time, all survivors should be offered a referral to the psychosocial counsellors who are working in area of gender-based violence.

The majority of rape survivors never tell anyone about the incident. If the survivor has told you what happened, it is a sign that she trusts you. Your compassionate response to her disclosure can have a positive impact on her recovery.

Provide basic, non-intrusive practical care. Listen but do not force her to talk about the event, and ensure that her basic needs are met. Because it may cause greater psychological problems, do not push survivors to share their personal experiences beyond what they would naturally share.

Ask the survivor if she has a **safe place** to go to, and if someone she trusts will accompany her when she leaves the health facility. If she has no safe place to go to immediately, efforts should be made to find one for her. Enlist the assistance of the multi-sectorial services. If the survivor has dependants to take care of, and is unable to carry out day-to-day activities as a result of her trauma, provisions must also be made for her dependants and their safety.

Survivors are at increased risk of a range of symptoms and consequences, including:

- ✦ feelings of guilt and shame;
- ✦ uncontrollable emotions, such as fear, anger, anxiety;
- ✦ nightmares;
- ✦ suicidal thoughts or attempts;
- ✦ numbness;
- ✦ substance abuse;
- ✦ sexual dysfunction;
- ✦ medically unexplained somatic complaints;
- ✦ social withdrawal.

Tell the survivor that she has experienced a serious physical and emotional event. Advise her about the psychological, emotional, social and physical problems that she may experience. Explain that it is common to these situations in cases of GBV.

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<sup>1</sup>Adapted from *Accompanying Steps in Clinical Management of Rape Survivors Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons – Revised ed.* © World Health Organization / United Nations High Commissioner for Refugees, 2004.

Advise the survivor that she may need emotional support. Encourage her – but **do not force** her - to confide in someone she trusts and to ask for this emotional support, perhaps from a trusted family member or friend. Encourage active participation in family and community activities.

In most cultures, there is a tendency to blame the survivor in cases of rape. If the survivor expresses guilt or shame, explain gently that rape is always the fault of the perpetrator and never the fault of the survivor. Assure her that she did **not** deserve to be raped, that the incident was not her fault, and that it was **not** caused by her behaviour or manner of dressing. Do not make moral judgements of the survivor.

### ***Special considerations for men***

Male survivors of rape are even less likely than women to report the incident, because of the extreme embarrassment that they typically experience. While the physical effects differ, the psychological trauma and emotional after-effects for men are similar to those experienced by women.

### ***Pregnancy***

Female survivors of rape are likely to be very concerned about the possibility of becoming pregnant as a result of the rape. Emotional support and clear information are needed to ensure that they understand the choices available to them if they become pregnant:

- ✦ There may be adoption or foster care services in your area. Find out what services are available and give this information to the survivor.
- ✦ In many countries the law allows termination of a pregnancy resulting from rape. Furthermore, local interpretation of abortion laws in relation to the mental and physical health of the woman may allow termination of the pregnancy if it is the result of rape. Find out whether this is the case in your setting. Determine where safe abortion services are available so that you can refer survivors to this service where legal if they so choose.
- ✦ Advise survivors to seek support from someone they trust - perhaps a religious scholar, family member, friend or community worker.

Women who are pregnant at the time of a rape are especially vulnerable physically and psychologically. In particular, they are susceptible to miscarriage, hypertension of pregnancy and premature delivery. Counsel pregnant women on these issues and advise them to attend antenatal care services regularly throughout the pregnancy. Their infants may be at higher risk for abandonment so follow-up care is also important.

### ***HIV/STIs***

There is a concern about the possibility of becoming infected with HIV as a result of rape. While the risk of acquiring HIV through a single sexual exposure is small, these concerns are well founded in settings where HIV and/or STIs prevalence are high. Compassionate and careful counselling around this issue is essential. The health care worker may also discuss the risk of transmission of HIV or STI to partners following a rape.

The survivor may be referred to an HIV/AIDS counselling service if available.

The survivor should be advised to use a condom with all partners for a period of 6 months (or until STI/HIV status has been determined).

Give advice on the signs and symptoms of possible STIs, and on when to return for further consultation. Please refer to the *Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan. Participant Handbook. Ministry of Public Health and WHO. Afghanistan 2015.*

## **2. Follow-up care of the survivor**

It is possible that the survivor will not or cannot return for follow-up. Provide maximum input during the first visit, as this may be the only visit. Follow the guidance in the above mentioned Handbook.

### **Care for child survivors**

Follow the guidance in the above mentioned Handbook and also remember that:

Health care providers should be knowledgeable about child development and growth as well as normal child anatomy. It is recommended that healthcare staff receive special training in examining children who may have been abused.

### **Create a safe environment**

- ✦ Take special care in determining who is present during the interview and physical examination if needed. Remember that it is possible that a family member is the perpetrator of the abuse or that the child is suffering due to the situation faced by the accompanying person. It may be preferable to have the parent or guardian wait outside during the interview and have an independent trusted person present. For the examination, either a parent or guardian or a trusted person should be present. Always ask the child who he or she would like to be present, and respect his or her wishes.
- ✦ Introduce yourself to the child.
- ✦ Sit at eye level and maintain eye contact.
- ✦ Assure the child that he or she is not in any trouble.
- ✦ Ask a few questions about neutral topics, e.g., school, friends, who the child lives with, favourite activities.

### **Take the history**

- ✦ Begin the interview by asking open-ended questions, such as "Why are you here today?" or "What were you told about coming here?"
- ✦ Avoid asking leading or suggestive questions.
- ✦ Assure the child it is okay to respond to any questions with "I don't know".
- ✦ Be patient; go at the child's pace; do not interrupt his or her train of thought.
- ✦ Ask open-ended questions to get information about the incident. Ask yes-no questions only for clarification of details.
- ✦ For girls, depending on age, ask about menstrual and obstetric history.

The pattern of sexual abuse of children is generally different from that of adults. For example, there is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:

- ✦ the home situation (has the child a secure place to go to?);
- ✦ how the abuse was discovered;
- ✦ who did it, and whether he or she is still a threat;
- ✦ if this has happened before, how many times and the date of the last incident;



- ✦ whether there have been any physical complaints (e.g. bleeding, dysuria, discharge, difficulty walking, etc.);
- ✦ whether any siblings are at risk.

It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.

### **3. Assessment, Counselling and Interview**

#### ***An assessment<sup>2</sup>:***

- Is used in a specific context.
- Is mainly used by service providers.
- Has a specific goal, namely: gathering information or data at a given moment of time and evaluating it for the purpose of making an appropriate decision about what course of action to take.
- Uses the process of inquiry, the decision to take action is based on the evaluation of data, less on the opinion of the person who conducts the assessment.
- In an assessment of the needs of a survivor, survivor-centred skills should always be applied.

#### *Examples of an assessment:*

- A counsellor or psychosocial worker who conducts an assessment of the psychosocial needs of a survivor.
- A health worker who conducts a medical assessment (also called examination or exam) of a survivor to find out which treatment s/he would need.

#### ***Counselling:***

- Is used in a specific context and practised by professionally trained service providers: counsellors, psychologists and in some cases other trained health professionals.
- Can exist under different forms, but is often a process in which a client addresses and resolves problems and works through feelings.<sup>3</sup>
- Providing support is among the main goals of counselling.
- In counselling after GBV more specifically sexual violence, the counsellor will assist the client to identify and respond to needs that arise as the result of the assault or abuse. In addition to providing emotional and psychological support, the counsellor can act as an enabler and an advocate for clients. S/he can provide access to information, resources and services, help maintain individual rights and access to the legal and judicial systems, assist with coping, help restore family relationships and attachments, and access community resources and support.<sup>4</sup>

#### *Examples of Counselling:*

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<sup>2</sup>RHRC Consortium, Communication Skills Training Manual – Facilitator’s Guide, p.23.

[http://www.rhrc.org/resources/gbv/comm\\_manual/comm\\_manual\\_toc.html](http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html)

<sup>3</sup> Adapted from: glossary of the Royal College of Psychiatrists -

<http://www.rcpsych.ac.uk/mentalhealthinformation/definitions>

<sup>4</sup> IRC Tanzania, SGBV Counselling Training, p.18

- An NGO counsellor who provides individual counselling to women.
- A health centre counsellor who gives psychosocial support to women who consult in cases of GBV, including after sexual violence, or when attending women at the health centre who ask for other needs; and who may refer them to other services.

**Interview:**

- Can be used in several contexts and can exist under various forms.
- Has a specific goal, namely: collecting information, establishing facts, history etc. related to the interviewee and/or the situation/assault.
- Does not necessarily aim at *assisting* the survivor (e.g. the aim of the interview can be to collect generic data on sexual violence)<sup>5</sup>
- Has often a fixed structure and consists of a set of specific questions. A survivor-centred interviewer should maintain a supportive attitude towards the interviewee throughout the interview. Survivor-centred skills should always be respected!

*Examples of Interviews in a multi-sectorial environment:*

- *A medico-legal or forensic interview in a case of sexual violence:* the health worker will ask specific questions to the survivor to collect the assault history with the goal of allowing this history to guide the medical exam.
- 

**Remember:**

- A conversation is a tool that can be used by everyone.
- Conducting an assessment, counselling or an interview requires particular training. These tools are therefore used by specific professional groups in a specific context.
- The main goal of a conversation and counselling is usually to provide emotional support. The main purpose of an assessment and an interview is to gather information.
- Survivor-centred skills are tools that should be used by everyone when dealing with a survivor, regardless of the type or goal of the interaction!

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<sup>5</sup> Although an interview not always aims at assisting the survivor (e.g. in case of data-collection), it is necessary to ensure that the interviewed survivors have access to minimum services.

## Module 5 at a glance:

Sessions	Objectives	Time	Handouts
5.1. Lecture: What kind of psychological support does a survivor need?	Understand the psychological and social impact of GBV	1 hour	Handout 5.1: Psychological first aid
5.2. Discussion: The role of treatment for psychological sequela of GBV	Provide appropriate psychological support/treatment for survivors	1.5 hours	Handout 5.2: Basic guidelines for a mental health evaluation, psychological support and medications
5.3. Lecture: What follow-up is necessary?	Provide appropriate follow-up and referrals for survivors	1.5 hours	
5.4. Support and treatment of more severe mental health problems		6 hours	5.4. Handouts
5.5. Sample techniques for main symptoms and consequences		1 hour	5.5. Handouts

### 5.1 Lecture: What kind of psychological support does a survivor need?

**Materials:** Flip chart & markers (or overhead/PowerPoint), watch/clock to keep time

**Handouts:** Handout 5.1: Psychological first aid

**Preparation:** /

**Group sizes:** Whole group

**Time:** 1 hour

1. During this discussion, the main points can be written on a flip chart, or PowerPoint or overhead slides with these points can be used instead. The material for this discussion is in Participant guide on this module.
2. Introduce this lecture as an overview of psychological support for survivors.

3. Refer participants to **Handout 5.1: Psychological first aid** in their Participant guide at the end of the lecture.

## 5.2 Discussion: The role of treatment for psychological sequel of rape

**Materials:** Flip chart and markers, watch/clock to keep time

**Handouts:** Handout 5.2: Basic guidelines for a mental health evaluation, psychological support and medications

**Background from general & psychosocial modules:** Lecture 4.3.3: Active listening techniques and 'listening roadblocks'; Handout 5.1: Assessment, Counselling and Interview

**Group sizes:** Whole group

**Time:** 1.5 hours

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### ▽ Good to know!

Psychological support can and should be used in any context, however consider further adapting further treatment strategies to local culture/religious context in the area where you operate.

- 
1. Introduce the discussion as a discussion on the role of treatment for psychological consequences of GBV, including sexual violence.
  2. Ask participants the following questions and write down the main themes brought up by participants on the flip chart.
    - a. *What does "mental health/illness" mean to you?*  
You may find the knowledge of mental health/illness is limited. In many resource limited settings, evaluation of mental health is restricted to severe mental illnesses, such as psychosis (due to the perceived need for prioritizing immediate life-threatening illnesses, time constraints, lack of treatment options, etc.). Illnesses such as anxiety disorder and mood disorder are often not recognized as true illnesses by most patients and some health care providers. Knowledge of diagnosis and treatment is often limited.
    - b. *How does your society react to issues regarding mental health, (e.g. psychosis, severe mood disorder or non-pathological anxious feelings)?*  
Address what is considered mental illness, how people are treated and supported, if care is available, etc.
    - c. *How does your health care system address issues of mental health?*  
Address what the health care providers are taught in school (evaluation, diagnosis and treatment), in potentially available refresher/short courses on mental health, what happens in their practices, and how they receive clinical supervision, if any.

- d. *Are essential psychotropic regularly available? Do all health care providers have the right to prescribe? Which kind of health care provider can prescribe? If not you, can you easily coordinate with them in case of need? Is there a tendency to avoid medication? Or to prescribe too much? Does the treatment load of health care providers allow for time to talk extensively with patients? In your health facility, MHPSS can be taken as a reason to provide enhanced support to a survivor, including additional time from your end? Are health services in the position to refer people with minor mental health problems to general & psychosocial, social supports in the community?*
3. Conclude this part of the discussion by asking participants to consider what the above issues' relevance may be to survivor's experiencing psychological sequelae; how a survivor may be viewed in society; and how she can be appropriately cared for by the health care community.
  4. The next part of the discussion will be a review of a case study. We will discuss the story of Fahima.

**Case study: Fahima, 25 years' old**

*Ms. Fahima came to your clinic two days after being raped. The perpetrators entered her home at night and raped her and threatened to kill her and her family. She has two living children.*

*She has come for her 6-week follow-up evaluation after receiving treatment. She completed all of her medications without any significant problems.*

*You ask her how she is doing and this is what she replies:*

*"I am okay, but I have not been able to sleep since that night. I have nightmares about those men coming to attack me and kill my father. I wake up sweating and my heart is racing. I stay in the house now and don't leave unless I have to – my sisters are doing my chores. So during the day, I am home alone and all I do is think about what happened to me and how dirty I am. My job now is only to cook for the family, I can manage that, but I don't go to the market. I don't have the energy and I don't want people to see me. But even though I cook, I don't eat, I don't want to. I have not been intimate with my husband because I am ashamed."*

*You note she lost 10kg since the incident.*

5. Ask participants the following questions (write the main points on the flip chart):
  - a. *What symptoms have you identified?*  
Symptoms include nightmares, social withdrawal, guilt and shame, fear, decreased appetite, unable to carry out her usual daily activities.
  - b. *How could you support her?*  
Possible answers include psychological first aid, psychosocial counselling and referrals for further support.
  - c. *Are there more questions you would have for her? If so, what?*  
Possible answers include "Does she have anyone she talks to at home?", "How does she try to deal with the feelings she is having?"
  - d. *Is there a role for medications in this case?*

Possibly, antidepressants. may be considered but you need to coordinate with an authorised professional in case you cannot prescribe medication, or in case you feel she needs some type of support you cannot provide.

- e. *When would you consider medications for treatment for survivors? And what would you use?*

Participants should give their own opinions based on what they do in their practices. You will review treatment recommendations at the end.

- f. *What types of support outside of your clinic could you offer or organize for Fahima? (Do not restrict the discussion to what is actually available in the participants' areas but the discussion should reflect the reality of the supports available in most settings).*

Possible answers include support groups, counsellors, mental health specialists, etc. In case some of the service are not available in your areas but exist somewhere else or there is a reference to them in the national documents, is there anything you could do about it?

- g. *How would you evaluate Fahima for suicidal thoughts? And what could you do if she does have suicidal thoughts?*

Again, participants should give their own opinions based on what they do in their practices. You will review treatment recommendations at the end.

6. Next refer participants to **Handout 5.2** in their Participant Guide and review the basic mental health evaluation, treatment options and referrals with the participants.
- 

### 5.3 Lecture: What follow-up is necessary?

**Materials:** Flip chart & markers (or overhead/PowerPoint), watch/clock to keep time

**Handouts:** None

**Background from general & psychosocial modules:** Module 3

**Group sizes:** Whole group

**Time:** 1.5 hours

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#### ▽ Good to know!

Since MHPSS for GBV cases is part of an integrated system, Afghanistan National protocols and technical documents also provide information about appropriate follow-up and referrals. Those documents should always guide our interventions. Please consider:

- Basic Package of Health Services 2010
- Psychological First Aid
- Professional Package for Psychosocial Counsellors Working in the BPHS in Afghanistan Mental Health Department of the MoPH, Kabul-group-08
- Standard Package for Midwife and Community Supervisor or Nurse, Delivering Basic Psychosocial Counselling Services in the BPHS in Afghanistan- from MHD of MoPH

And two core documents:

- Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan. Participant Handbook Ministry of Public Health and WHO. Afghanistan 2015.
  - Model of Healthcare Sector Response to GBV, UNFPA Afghanistan (Attachment 1)
- 

1. During this discussion, the main points can be written on a flip chart, or PowerPoint or overhead slides with these points can be used instead. The material for this discussion is in your Trainer Packet.

Introduce this lecture as an overview of the follow-up needed for survivors

## MODULE 5. The different types of intervention in MHPSS and GBV

# Participant Guide

### Handout 5.1: Psychological first aid<sup>6</sup>

Most individuals experiencing acute mental distress following exposure to extreme stressful events are best supported without medication. All aid workers, and especially health care providers, should be able to provide very basic psychological first aid (PFA). PFA is often mistakenly seen as a clinical or emergency psychiatric intervention. Rather, it is a description of a humane, supportive response to a fellow human being who is suffering and who may need support. PFA is very different from psychological debriefing in that it does not necessarily involve a discussion of the event that caused the distress. PFA reflects the principles of a survivor-centred approach. It encompasses:

1. Protecting from further harm (in rare situations, very distressed persons may take decisions that put them at further risk of harm);
2. Providing the opportunity for survivors to talk about the events, but without pressure. Respect the wish not to talk and avoid pushing for more information than the survivor may be ready to give;
3. Listening patiently in an accepting and non-judgmental manner;
4. Conveying genuine compassion;
5. Identifying basic practical needs and ensuring that these are met;
6. Asking for survivor's concerns and trying to address these;
7. Discouraging negative ways of coping (specifically discouraging coping through use of alcohol and other substances; explaining that people in severe distress are at much higher risk of developing substance abuse problems);
8. Encouraging participation in normal daily routines (if possible) and use of positive means of coping (e.g. culturally appropriate relaxation methods, accessing helpful cultural and spiritual support);
9. Encouraging, but not forcing, company from one or more family member or friends;

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<sup>6</sup>Adapted from *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, Action Sheet 6.2, pg. 119-120. © Inter-Agency Standing Committee 2007.  
<http://www.humanitarianinfo.org/iasc/content/products/default.asp>

10. As appropriate, offering the possibility to return for further support;
11. As appropriate, referring to locally available support mechanisms or to trained health care providers.

## **Handout 5.2: Guidelines for a mental health evaluation, psychological support and medications**

### ***Guidelines for a mental health evaluation***

Evaluation of a patient's psychological well-being should be done for every patient (survivor or not). It does not have to be a formal evaluation. Most of the time, you can assess this by simply observing someone's body language and how she responds to your questions and to her surroundings. With a survivor, it is important to not only observe but ask directly about psychological symptoms.

Survivors may or may not suffer from acute symptoms. However, it is the health care provider's responsibility to evaluate, educate and follow-up survivors to assist them in case of GBV, also informing them that some of the symptoms or reactions may appear weeks and even months after the incident, or when the violence is already over.

It may feel uncomfortable for you to ask these types of questions, but it is important for you to obtain this information in order to provide proper care. Once you have asked these kinds of questions a few times, it will get easier.

Survivors may also not feel comfortable answering these questions. Remember to use your survivor-centred skills and never force anyone to answer a question s/he is not willing to answer. For survivors who are suffering psychological sequelae, your role is to provide support (and treatment, when necessary), but not to force someone into receiving psychological support (severe suicidal ideation is the one exception. In that case the survivor at risk should not be left alone).

*What do you want to know? Here are some basics to evaluate:*

1. Are you eating okay? (And if not, why? Is it a problem with appetite/taste of the food/lack of availability/a physical problem like nausea, vomiting or diarrhoea?)
2. Are you sleeping okay? (And if not, why? Nightmares, feeling anxious, issues with safety, oversleeping because of no energy, etc.)
3. Are you able to do the things you want or need to do during the day? (And if not, why? Physical complaints, no energy, fear of leaving the house, difficulties in concentrating).
4. How is the relationship with the spouse/family? Do they know what happened? (If yes), how did they react? Is it affecting your relationship (if so, how)? How is the support from your spouse (and family)? How do you feel the assault has affected your relationships with your spouse and family?
5. How is the relationship with your friends and neighbours? Are there any difficulties?



6. Do you have any thoughts of hurting yourself? (If yes), can you describe what thoughts you have been having? Possible follow-up questions include: Have you thought of how you would hurt yourself? What is your plan? Do you think you would actually do it?

The reasons to ask these follow-up questions are to establish how far the thoughts of suicide have progressed. Many people (survivors and others) have had thoughts of hurting themselves, but have not actually made a plan. Making a plan for suicide establishes an increased level of commitment to the act and should be taken more seriously. If you conclude that someone is at acute risk for suicide, immediate intervention is necessary (do not leave the person alone) (see below).

### ***Psychological support***

Psychosocial support should be offered to all survivors. Remember to use the principles of psychological first aid. You do not need to be a trained counsellor to provide basic psychosocial support. If there are no adequate psychosocial support services (or mental health services) available, YOU can use basic active listening skills to provide support.

Often having someone the survivor can trust and who will listen to them without judgment is an effective treatment. You, as her/his health care provider can be that person- do not underestimate the help you can provide by just offering your time to listen. You can also suggest confiding in someone else (spouse, friend, etc.).

#### ***What should I say?***

As long as you remember your survivor-centred skills, you will be able to help. Use open-ended questions and allow the survivor to speak freely without interruptions. Do not force the survivor to talk, share emotions, etc. Inform her/him that it is common for people to have strong, negative emotions or feel numb after such a serious physical and emotional event. Also, inform the survivor that s/he may suffer from difficulties in sleeping, eating, and continuing daily activities. While these will often decrease with time, s/he can come to the clinic to discuss these problems with you at any time.

#### ***What to do if psychological support services are available:***

Know the psychological and social support available in your community and how the survivor can access the services (where, when, cost, confidentiality, quality etc.).

Not all survivors will need referrals. Referrals are appropriate in cases where you feel you cannot properly treat the survivor's psychological and social problems – either on the initial evaluation or on follow-up visits or if there is someone else appointed to do so. In most cases, a referral on the initial visit is not appropriate, but information that a referral is possible, it is inappropriate to give to the survivor at the initial visit. This will help the survivor have better understanding about possible recovery paths and empower her across a difficult process. Referrals are NOT a substitute for the basic care you offer a survivor.

#### ***What to do if you think a survivor is at acute risk for suicide:<sup>7</sup>***

Ensure the survivor is out of immediate danger – i.e. have she taken any medications or suffered serious injury needing immediate medical treatment? She should not be left alone;

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<sup>7</sup> Adapted from ***Where There is No Psychiatrist: A mental health care manual***. Vikram Patel © The Royal College of Psychiatrists, 2003. Pages 63-69

ask a family member or friend to spend time with her – especially if she has attempted suicide and you think she is at risk for harming herself again.

If the family is not interested in the survivor's well-being, try to contact more distant family members or friends for support. If this fails, consider any women's groups, etc. that could provide support. If one of these groups can offer accommodation, it may be appropriate for the survivor to seek temporary shelter.

Once the immediate risk is gone, involve the survivor in regular psychological support until she feels more in control of her problems. If she is depressed, try to make a referral to a specialist. If no specialist is accessible/available, consider antidepressant medications (see below). However, be aware that treatment takes 3-4 weeks to show effects and support during this time is essential.

The survivor should also be referred to the nearest hospital if the suicide attempt was serious and life-threatening; thoughts of suicide persist despite support; there is a serious mental illness (like psychosis); and/or there is a repeated suicide attempt.

### **Medications<sup>8</sup> - only for use for severe psychological reactions!**

*Only treat psychological symptoms with medications if absolutely necessary – in MOST cases, survivors will NOT require medication!*

#### **When should you consider medication? And which medications?**

If a survivor exhibits severe acute psychological symptoms – i.e. SYMPTOMS ARE LIMITING BASIC FUNCTIONING (such as not being able to talk to people, for at least 24 hours):

1. Make sure the survivor is physically stable.
2. Diazepam 5-10mg tablets – 1 tablet at night time up to 3 days' maximum.
3. Refer the survivor to a mental health professional, if possible.
4. If no referrals available, re-evaluate the survivor daily – adjusting the regimen appropriately.
5. Do not use diazepam with the aim to reduce anxiety, although it may be indicated for sleeping problems for a few days. **Be very cautious: benzodiazepine use may quickly lead to dependence, especially among very distressed survivors.**

If a survivor complains of severe, sustained distress lasting at least 2 weeks AND the incident occurred within the last 2-3 months AND the survivor is asking for more intense treatment **AND you cannot refer her:**

1. Consider trial of imipramine, amitriptyline or similar antidepressant medicine. Dose 75-150mg at bedtime (starting with 25mg dosing and adjust if necessary).
2. Watch out for side-effects, such as a dry mouth, blurred vision, irregular heartbeat, and light-headedness or dizziness, especially when the survivor gets out of bed in the morning.
3. Duration of treatment will vary with response.

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<sup>8</sup> Adapted from *Steps 6 & 7 from Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons – Revised ed.* © World Health Organization / United Nations High Commissioner for Refugees, 2004.

If the incident occurred more than 2-3 months ago AND psychological support is not reducing highly distressing or disabling trauma-induced symptoms, such as depression, nightmares, or constant fear AND no referrals are possible:

1. Consider a trial of an antidepressant (see medications listed above – imipramine, etc.).

***If a patient is suffering from psychological symptoms/illness - regardless of the type of symptoms, diagnosis or treatment given - follow-up is critical. Even if you refer a survivor to a mental health professional, it is important to also follow-up on the survivor's symptoms yourself<sup>9</sup>.***

## **Hand out 5.4. Support and treatment of more severe mental health problems<sup>10</sup>**

### ***Helping with more severe mental health problems***

#### ***Assessment of mental status***

You assess mental status at the same time that you do the general health examination. Assessing mental status begins with observing and listening closely. Take note of the following:

<b>Appearance and behaviour</b>	Does she take care of her appearance? Are her clothing and hair cared for or in disarray? Is she distracted or agitated? Is she restless, or is she calm? Are there any signs of intoxication or misuse of drugs?
<b>Mood, both what you observe and what she reports</b>	Is she calm, crying, angry, anxious, very sad, without expression?
<b>Speech</b>	Is she silent? How does she speak (clearly or with difficulty)? Too fast/too slow? Is she confused?
<b>Thoughts</b>	Does she have thoughts about hurting herself? Are there bad thoughts or memories that keep coming back? Is she seeing the event over and over in her mind?

#### **You can also gather information by asking general questions:**

- "How do you feel?"
- "How have things changed for you?"
- "Are you having any problems?"
- "Are you having any difficulties coping with daily life?"

<sup>9</sup>Full text on medications updated from Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan. Participant Handbook. Ministry of Public Health and WHO. Afghanistan 2015.

- <sup>10</sup> This chapter has been adapted from Clinical Handbook on Health care for women subjected to intimate partner violence or sexual violence. WHO, UN Women, UNFPA 2014.

If your general assessment identifies problems with mood, thoughts or behaviour and she is unable to function in her daily life, she may have more severe mental health problems.

Details on the assessment and management of all the problems mentioned below and other common mental health problems can be found in the mhGAP intervention guide and its annex on conditions specifically related to stress.  
[http://www.who.int/mental\\_health/publications/mhGAP\\_intervention\\_guide/en/](http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/)

### **Imminent risk of suicide and self-harm**

Some health care workers fear that asking about suicide may provoke the woman to commit it. On the contrary, talking about suicide often reduces the woman's anxiety around suicidal thoughts and helps her feel understood.

If she has:

- current thoughts or plan to commit suicide or to harm herself,

OR

- a history of thoughts or plans for self-harm in the past month or acts of self-harm in the past year, and she is now extremely agitated, violent, distressed or uncommunicative,

then **there is immediate risk of self-harm or suicide, and she should not be left alone.**

**Refer her immediately to a specialist or emergency health facility.**

### ***Moderate-severe depressive disorder***

Women who have suffered intimate partner violence or sexual assault may feel extreme emotions of continuing fear, guilt, shame, grief for what they have lost, and hopelessness. These emotions, however overwhelming, are usually temporary and are normal reactions to recent difficulties.

When a woman is unable to find a way to cope and these symptoms persist, then she may be suffering from mental disorders such as depressive disorder.

People develop depressive disorder even when not facing extreme life events. Any community will have people with pre-existing depressive disorder. If a woman has suffered from such depressive disorder before experiencing violence, she will be much more vulnerable to having it again.

**Note:** The decision to treat for moderate-severe depressive disorder should be made only if the woman has persistent symptoms over at least 2 weeks and cannot carry out her normal activities.

### **Typical presenting complaints of depressive Disorder**

- Low energy, fatigue, sleep problems
- Multiple physical symptoms with no clear cause (for example, aches and pains)
- Persistent sadness or depressed mood; anxiety
- Little interest in or pleasure from activities

### **Assessment of moderate-severe depressive disorder**

1. Does the woman have moderate-severe depressive disorder? Assess for the following:
  - A. *The woman has had at least 2 of the following core depression symptoms for at least 2 weeks.*
    - Depressed mood (most of the day, almost every day), (for children and adolescents: either irritability or depressed mood)
    - Loss of interest or pleasure in activities that are normally pleasurable
    - Decreased energy or easily fatigued
  - B. *The woman has had at least 3 other features of depression during the last 2 weeks:*
    - Reduced concentration and attention
    - Reduced self-esteem and self-confidence
    - Ideas of guilt and unworthiness
    - Bleak and pessimistic view of the future
    - Ideas or acts of self-harm or suicide
    - Disturbed sleep
    - Diminished appetite
  - C. *The woman has considerable difficulty functioning in personal, family, social, occupational, or other important areas of life.*

Ask about different aspects of daily life, such as work, school, domestic or social activities.

***If A, Band C – all 3 – are present for at least 2 weeks, then moderate-severe depressive disorder is likely.***

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2. Are there other possible explanations for the symptoms (other than moderate severe depressive disorder)?
  - A. Rule out any physical conditions that can resemble depressive disorder.
  - B. Rule out or treat anaemia, malnutrition, hypothyroidism, stroke and medication side-effects (for example, mood changes from steroids).
  - C. Rule out a history of manic episode(s). Assess if she has had a period in the past when several of the following symptoms occurred at the same time:
    - Decreased need for sleep
    - Euphoric (intensely happy), expansive, or irritable mood
    - Racing thoughts; being easily distracted
    - Increased activity, feeling of increased energy, or rapid speech
    - Impulsive or reckless behaviours such as excessive gambling or spending, making important decisions without adequate planning
    - Unrealistically inflated self-esteem.

The woman is likely to have had a manic episode if several of the above five symptoms were present for longer than 1 week and the symptoms significantly interfered with daily functioning or were a danger to herself or others. If so, then the depression is likely part of another disorder called **bipolar disorder** and she requires different management. Consult a specialist.

- D. Rule out **normal reactions** to the violence. The reaction is more likely a normal reaction if:
- There is marked improvement over time without clinical intervention
  - There is no previous history of moderate-severe depressive disorder or manic episode, and
  - Symptoms do not impair daily functioning significantly.

### ***Management of moderate-severe depressive disorder***

#### **1. Offer psychoeducation**

Key messages for the woman (and caregiver if appropriate):

1. Depression is a very common condition that can happen to anybody.
2. The occurrence of depression does not mean that she is weak or lazy.
3. The negative attitudes of others (e.g. "you should be stronger", "pull yourself together") may relate to the fact that depression is not a visible condition (unlike a fracture or a scar) and the false idea that people can easily control their depression by sheer force of will.
4. People with depression tend to have negative opinions about themselves, their lives and their future. Their current situation may be very difficult, but depression can cause unjustified thoughts of hopelessness and worthlessness. These views are likely to improve once the depression is managed.
5. It usually takes a few weeks before the treatment starts working.
6. Even if it is difficult, she should try to do as many of the following as possible. They will all help to improve her low mood:
  - Try to continue activities that were previously pleasurable.
  - Try to maintain regular sleeping and waking times.
  - Try to be as physically active as possible.
  - Try to eat regularly despite changes in appetite.
  - Try to spend time with trusted friends and trusted family.
  - Try to participate in community and other social activities, as much as possible.
7. Be aware of thoughts of self-harm or suicide. If you notice these thoughts, do not act on them. Tell a trusted person and come back for help immediately.

#### **2. Strengthen social support and teach stress management**

#### **3. If trained and supervised therapists are available, consider referral for brief psychological treatments for depression *whenever these are available*:**

- Problem-solving counselling
- Interpersonal therapy
- Cognitive behavioural therapy
- Behavioural activation

#### **4. Consider antidepressants**

Prescribe antidepressants only if you have been trained in their use.

Details on the assessment and management of moderate severe depressive disorder, including prescription of antidepressants can be found in the mhGAP intervention guide: [http://www.who.int/mental\\_health/publications/mhGAP\\_intervention\\_guide/en/](http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/)

**5. Consult a specialist when:**

- She is not able to receive either interpersonal therapy, cognitive behavioural therapy or antidepressants.
- OR
- She is at imminent risk of suicide/self-harm.

**6. Follow-up**

- **Offer regular follow-up.** Schedule the second appointment within one week and subsequent appointments depending on the course of the disorder.
- **Monitor her symptoms.** Consider referral if there is no improvement.

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**Post-traumatic stress disorder**

Immediately after a potentially traumatic experience such as sexual assault, most women experience psychological distress. For many women these are passing reactions that do not require clinical management. However, when a specific, characteristic set of symptoms (re-experiencing, avoidance and heightened sense of current threat) persists for more than a month after the event, she may have developed post-traumatic stress disorder (PTSD).

It should be noted that despite its name, PTSD is not necessarily the only or even the main condition that occurs after violence. As mentioned above, such events can also trigger development of many other mental health conditions, such as depressive disorder and alcohol

**Typical presenting complaints of PTSD**

Women with PTSD may be hard to distinguish from women suffering from other problems because they may initially present with non-specific symptoms such as:

- Sleep problems (e.g. lack of sleep)
- Irritability, persistent anxious or depressed mood
- Multiple persistent physical symptoms with no clear physical cause (e.g. headaches, pounding heart).

However, on further questioning they may reveal that they are suffering from characteristic PTSD symptoms.

use disorder.

**Assessment for PTSD**

If the violence occurred more than 1 month ago, assess the woman for post-traumatic stress disorder (PTSD).

**Assess for:**

- A. **Re-experiencing symptoms** – repeated and unwanted recollections of the violence, as though it is occurring in the here-and-now (for example, frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror).
- B. **Avoidance symptoms** – deliberate avoidance of thoughts, memories, activities or situations that remind the woman of the violence. For example, avoiding talking about issues that are reminders of the event, or avoiding going back to places where the event happened.
- C. **Symptoms related to a heightened sense of current threat**, such as excessive concern and alertness to danger or reacting strongly to unexpected sudden movements (e.g. being “jumpy” or “on edge”).
- D. **Difficulties in day-to-day functioning. If all of the above are present approximately 1 month after the violence, then PTSD is likely.** Check also if she has any other medical conditions, moderate-severe depressive disorder, suicidal thinking or alcohol and drug use problems.

***Management of PTSD***

***1. Educate her about PTSD***

Explain that:

- a. Many people recover from PTSD over time without treatment. However, treatment will speed up recovery.
- b. People with PTSD often feel that they are still in danger, and they may feel very tense. They are easily startled (“jumpy”) or constantly on the watch for danger.
- c. People with PTSD repeatedly experience unwanted recollections of the traumatic event. When this happens, they may experience emotions such as fear and horror similar to the feelings they had when the event was actually happening. They may also have frightening dreams.
- d. People with PTSD try to avoid any reminders of the event. Such avoidance can cause problems in their lives.
- e. (If applicable) people with PTSD may have other physical and mental problems, such as aches and pains in the body, low energy, fatigue, irritability and depressed mood.

Advise her to:

- a. Continue normal daily routines as much as possible.
- b. Talk to people she trusts about what happened and how she feels, but only when she is ready to do so.
- c. Engage in relaxing activities to reduce anxiety and tension.
- d. Avoid using alcohol or drugs to cope with PTSD symptoms.

***2. Strengthen social support and teach stress management***

***3. If trained and supervised therapists are available, consider referring for:***

- Individual or group cognitive behavioural therapy with a trauma focus (CBT-T)
- Eye movement desensitization and reprocessing (EMDR)



#### **4. Consult a specialist (if available)**

- If she is not able to receive either cognitive behavioural therapy or EMDR
- OR
- she is at imminent risk of suicide/self-harm.

#### **5. Follow-up**

Schedule a second appointment within 2 to 4 weeks and later appointments depending on the course of the disorder.

### **Handout 5.5. Sample techniques for main symptoms and consequences**

#### **Relaxation and Grounding Exercise**

##### **1. Simple relaxation exercise**

###### **Introduction:**

"Tension and anxiety are common when experiencing violence. Unfortunately, they can make it more difficult to cope with what you went through. There is no easy solution to cope with what you went through, but taking time during the day to calm yourself through relaxation exercises may make it easier to sleep, concentrate, and have more energy. Here is a basic breathing exercise that may help":

###### **For Adults:**

- Inhale slowly (one-thousand one; one-thousand two; one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.
- Silently and gently say to yourself, "My body is filled with calmness." Exhale slowly (one-thousand one; one-thousand two; one-thousand three) through your mouth and comfortably empty your lungs all the way down to your stomach.
- Silently and gently say to yourself, "My body is releasing the tension."
- Repeat five times slowly and comfortably.
- Do this as many times a day as needed.

###### **For Children:**

- "Let's practice a different way of breathing that can help calm our bodies down.
- Put one hand on your stomach, like this [demonstrate].
- Okay, we are going to breathe in through our noses. When we breathe in, we are going to fill up with a lot of air and our stomachs are going to stick out like this [demonstrate].
- Then, we will breathe out through our mouths. When we breathe out, our stomachs are going to suck in and up like this [demonstrate].
- We are going to breathe in really slowly while I count to three. I'm also going to count to three while we breathe out really slowly.
- Let's try it together. Great job!"

##### **2. Grounding**

###### **Introduction:**

"After an experiencing violence, you can sometimes find yourself overwhelmed with emotions or unable to stop thinking about or imagining what happened. You can use a method called 'grounding' to feel less overwhelmed. Grounding works by turning your attention from your thoughts back to the outside world. Here's what you do...."

### ***For adults:***

- Sit in a comfortable position with your legs and arms uncrossed.
- Breathe in and out slowly and deeply.
- Look around you and name five non-distressing objects that you can see. For example, you could say, "I see the floor, I see a shoe, I see a table, I see a chair, I see a person."
- Breathe in and out slowly and deeply.
- Next, name five non-distressing sounds you can hear. For example: "I hear a woman talking, I hear myself breathing, I hear a door close, I hear someone typing, I hear a cell phone ringing."
- Breathe in and out slowly and deeply.
- Next, name five non-distressing things you can feel. For example: "I can feel this wooden armrest with my hands, I can feel my toes inside my shoes, I can feel my back pressing against my chair, I can feel the blanket in my hands, I can feel my lips pressed together."
- Breathe in and out slowly and deeply.

### ***For children:***

You might have children name colours that they see around them. For example, say to the child, "Can you name five colours that you can see from where you are sitting. Can you see something blue? Something yellow? Something green?" If none of these interventions aids in emotional stabilization, consult with medical or mental health professionals, as medication may be needed. Modify these interventions for a person who has difficulty with vision, hearing, or expressive language.

## ***Stress Reduction Exercises***

### ***1. Slow breathing technique***

- Sit with your feet flat on the floor. Put your hands in your lap. After you learn how to do the exercises, do them with your eyes closed. These exercises will help you to feel calm and relaxed. You can do them whenever you are stressed or anxious or cannot sleep.
- First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.

### ***2. Progressive muscle relaxation technique***

- In this exercise you tighten and then relax muscles in your body. Begin with your toes.
- Curl your toes and hold the muscles tightly. This may hurt a little. Breathe deeply and count to 3 while holding your toe muscles tight. Then, relax your toes and let out your breath. Breathe normally and feel the relaxation in your toes.
- Do the same for each of these parts of your body in turn. Each time, breathe deeply in as you tighten the muscles, count to 3, and then relax and breathe out slowly.
  - Hold your leg and thigh muscles tight...
  - Hold your belly tight...
  - Make fists with your hands...

- Bend your arms at the elbows and hold your arms tight...
  - Squeeze your shoulder blades together...
  - Shrug your shoulders as high as you can...
  - Tighten all the muscles in your face....
- Now, drop your chin slowly toward your chest. As you breathe in, slowly and carefully move your head in a circle to the right, and then breathe out as you bring your head around to the left and back toward your chest. Do this 3 times. Now, go the other way...inhale to the left and back, exhale to the right and down. Do this 3 times.
- Now bring your head up to the centre. Notice how calm you feel.

**Annex:**

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**Risk Assessment and Safety Planning**

INCIDENT  
CODE

REGISTER  
NUMBER

PERSONNEL  
CODE

**CONFIDENTIAL**

***Family Violence***

***a) Risk assessment with survivors of family violence:***

***Note to the health care provider:***

Consider only the steps/questions that respond to the survivor’s individual situation.

When a woman answers “yes” to at least three of the following questions, she may be at especially high immediate risk of violence:

1. Are you in immediate danger?  yes  no
2. Has the physical violence happened more often or gotten worse over the past six months?  yes  no
3. Has he ever used a weapon or threatened you with a weapon?  yes  no
4. Do you believe he could kill you?  yes  no
5. Has he ever beaten you while you were pregnant?  yes  no
6. Is he violently and constantly jealous of you?  yes  no

If the survivor feels at risk, give her/him information about her/his rights and referral options.

- For safety: Provide concrete information about legal, protection and mediation services.
- For emotional safety: Provide information and motivate for mental health referral.
- Provide referral to secondary level of care. Sometimes a hospitalization can be proposed to ensure the survivors safety in order to find appropriate solution to guarantee her/his safety.

When the survivor, accepts the referral, ensure direct referral.

When the survivor does not accept the referral at the moment:

- Help her/him to make a safety plan
- Make an appointment for a follow-up consultation

***b) Safety plan for survivors of family violence***

***Note to the health care provider:***

Explain to the survivor that a she/he does not have control over the violent behaviour of her/his aggressor(s), but that she/he does have a choice about how she/he responds to the aggressor(s) and how to best get her/himself (and the children) to safety.

1. If you need to leave your home in a hurry, where could you go?

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2. Would you go alone or take your children with you?

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3. How will you get there?

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4. Do you need to take any documents, keys, money, clothes or other things with you when you leave? What is essential?

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5. Can you put together items in a safe place or leave them with someone, just in case?

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6. Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?

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7. Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

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INCIDENT  
CODE

REGISTER  
NUMBER

PERSONEL  
CODE

**CONFIDENTIAL**

***Non-family violence***

***a) Risk assessment with survivors of non-family violence:***

***Note to the health care provider:***

Consider only the steps/questions that respond to the survivor's individual situation.

1. Is there a possibility to meet the aggressor(s) again?  yes  no  
If yes, explain: \_\_\_\_\_

2. What information, if any, does the aggressor have about where you live, work, go to school or about places you go to on a regular basis?  
\_\_\_\_\_

3. Do you believe the aggressor could kill you?  yes  no  
4. Has the aggressor contacted you since the incident?  yes  no  
If yes, explain: \_\_\_\_\_

5. Does the aggressor have access to your housing?  yes  no  
If yes, explain: \_\_\_\_\_

6. There anybody (own family, in-law family, neighbours, friends, community) who you that could talk to for advice or that could play a protective role?  yes  no  
If yes, explain: \_\_\_\_\_

If the survivor feels at risk, give her/him information about her/his rights and referral options.

- For safety: Provide concrete information about legal, protection and mediation services.
- For emotional safety: Provide information and motivate for mental health referral.

- Provide referral to secondary level of care. Sometimes a hospitalization can be proposed to ensure the survivors safety in order to find appropriate solution to guarantee her/his safety.

When the survivor accepts the referral, ensure direct referral.

When the survivor does not accept the referral at the moment:

- Help her/him to make a safety plan
- Make an appointment for a follow-up consultation

### ***b) Safety plan for survivors of non-family violence***

#### **Note to the health care provider:**

Explain to the survivor that she/he does not have control over the violent behaviour of her/his aggressor(s), but that she/he does have a choice about how she/he responds to the aggressor(s) and how to best get her/himself to safety.

1. What places does the perpetrator frequent?

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Explain the survivor to be conscious about those places

2. Who can help and protect you (even without informing them)?

3. What strategies can you use to improve the safety at home?

4. Who can accompany you when you leave the house, when you go to school or to work?

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⇒ The experience of violence is usually exhausting and emotionally draining. Explain to the survivor that is important that she/he tries to conserve her/his emotional energy and resources and tries to avoid emotional difficult situations.

- a. What are things that you might do if you came into contact with the aggressor?

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- b. What can say to yourself to give you strength whenever the aggressor is trying to put you down, control or abuse you?

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- c. Who can you contact for support?

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### **Safety Planning Elements**

<b>Safety Planning Elements</b>	
<b>Safe place to go</b>	If you need to leave your home in a hurry, where could you go?
<b>Planning for children</b>	Would you go alone or take your children with you?
<b>Transport</b>	How will you get there?
<b>Items to take with you</b>	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?
	Can you put together items in a safe place or leave them with someone, just in case?
<b>Financial</b>	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
<b>Support of someone close by</b>	Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

### **Referral Chart<sup>11</sup>**

			<b>Job aid</b>
<b>Referral chart</b>			
<b>What to refer for</b>	<b>Where / who to refer to</b>	<b>Contact info</b>	<b>Responsibility for follow-up</b>
Shelter/housing			
Crisis centre			

<sup>11</sup>Please use the Model of Healthcare Sector Response to GBV developed by UNFPA Afghanistan as a reference.

Financial aid			
Legal aid			
Support groups			
Counselling			
Mental health care			
Primary care			
Child care			
Other			