



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

PARTICIPANT'S MANUAL



পরিবার পরিকল্পনা অধিদপ্তর

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

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Shukhi Jibon

PATHFINDER

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# Preface

## Message from the Director General, Directorate General of Family Planning



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

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

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

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

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

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

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

<sup>2</sup> NIPORT and ICF, BDHS 2022.

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

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



**Shahan Ara Banu, ndc**

*Director General (Grade 1)*

*Directorate General of Family Planning*

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

The family planning program in Bangladesh is a milestone activity. In the last fifty years, the TFR in Bangladesh has decreased from 5.21 in 1982 to 2.04 in 2019,<sup>4</sup> the CPR has increased from 8 percent in 1975 to 63 percent in 2017, and the unmet need has decreased from 17 percent in 2007 to 12 percent in 2017.<sup>5</sup>

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

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

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

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

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

**Md. Sohel Parves**

*Director (Finance) and Line Director (Family Planning - Field Services Delivery)  
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<sup>4</sup> Bangladesh Bureau of Statistics, *Report on Bangladesh Sample Vital Statistics (SVRS) 2020*, (Dhaka, Bangladesh) 2021.

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

# Acknowledgements

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



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

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

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

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

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

**Md. Mahbub Ul Alam**

*Project Director, USAID Shukhi Jibon, and  
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## Acronyms and Abbreviations

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

# Overview of Training

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

## Day 2

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

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

# Module 0: Introduction to Training

## What You Can Expect to Learn

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

## Schedule

	Duration
<b>MODULE 0: Introduction to Training</b>	
Session 0-A: Introductions, Group Norms, and Pre-test	30 min.
<b>Total Module Time</b>	<b>30 min.</b>

## Introduction

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

GBV remains a global issue that is frequently and consistently exacerbated in times of stress and crisis. Global estimates by the World Health Organization (WHO) and other UN agencies indicate that one in three women<sup>6</sup> will experience sexual violence in their lifetime. As many as two in three women will experience intimate partner violence (IPV), and as many as 30 percent of girls have a non-consensual sexual debut.<sup>7</sup> Bangladesh is no exception. Thirty-one percent of women ages 20–49 reported that they were married by age 15.<sup>8</sup> An estimated fifty percent of ever-married/partnered women ages 15–39 have experienced IPV in their lifetime.<sup>9</sup> These forms of GBV frequently intersect with reproductive coercion and contraceptive sabotage.<sup>10</sup> While Bangladesh-specific data is unavailable, global evidence suggests that as many as one in four women will experience a form of contraceptive sabotage in her lifetime.<sup>11</sup>

Since 2016, WHO has outlined clear evidence, strategies, and entry points for the health-sector response to violence against women and girls. Notably, the Global Plan of Action for Health System Response to Violence Against Women and Girls<sup>12</sup> highlights the unique role that health providers—particularly sexual and reproductive health (SRH) care providers—play as an extra-familial, professional point of contact. Furthermore, the report highlights that, globally, those most affected by violence are more likely to need and use health services. Yet, SRH providers and service managers are often ill-supported and undertrained to recognize violence, build confidence and competence in discussing violence, and provide first-line response to clients in need of help.

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

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

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

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

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

<sup>10</sup> Contraceptive sabotage is the deliberate interference with agreed use of contraception.

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

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

## Goals and Learning Outcomes

### Overall Goal

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

### Learning Outcomes

1. Gain a greater understanding and knowledge of gender norms, dynamics, equity, and their role in GBV.
2. Gain a greater understanding of how GBV manifests in FP and SRH service provision and uptake.
3. Increase knowledge of how GBV is relevant to FP services, including GBV risk identification and analysis.
4. Gain skills to mitigate and respond to GBV threats within the context of FP and sexual and reproductive health and rights (SRHR) activities.
5. Master skills required to deliver the first three steps of the LIVES mnemonic<sup>13</sup> for disclosure response.
6. Gain knowledge on how to refer GBV survivors to appropriate service providers/facilities in a safe and ethical way.
7. Develop skill sets to manage GBV case recording and reporting during FP and SRH service provision.

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

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

# Module 1: Understanding Gender and GBV

## What You Can Expect to Learn

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

## Schedule

	Duration
<b>MODULE 1: Understanding Gender and GBV</b>	
Session 1-A: Understanding Gender in FP Services	1 h. 30 min.
Session 1-B: Gender Relevance in FP Success and Failure	1 h.
<b>Total Module Time</b>	<b>2 h. 30 min.</b>

Women are half the world's population. Yet, women live with a 3x greater lifetime experience of gender-based violence. In low- and middle-income countries, gender discrimination results in an estimated 3.9 million excess deaths among women and girls by the age of 60.<sup>14,15</sup>

## Gender Quiz

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

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

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

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<sup>14</sup> World Bank. World Bank Group Gender Strategy (FY16-23): Gender Equality, Poverty Reduction and Inclusive Growth (Washington, DC: 2015).

<sup>15</sup> World Bank. World Development Report 2012: Gender Equality and Development (Washington, DC: 2011).



## Differences Between Gender and Sex

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

*From WHO:*

**Gender** refers to socially constructed characteristics of women and men—such as norms, roles, and relations of and between groups of women and men.<sup>16</sup>

**Sex** refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females.<sup>17</sup>

*From USAID, Interagency Gender Working Group (IGWG):<sup>18</sup>*

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

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<sup>16</sup> WHO. *Gender mainstreaming for health managers: a practical approach* (Geneva: 2011).

<sup>17</sup> "Sexual health: definitions," WHO, accessed January 20, 2023, [https://www.who.int/health-topics/sexual-health#tab=tab\\_2](https://www.who.int/health-topics/sexual-health#tab=tab_2).

<sup>18</sup> "Handout: Gender-related Terms and Definitions," IGWG, accessed January 23, 2023, <https://www.igwg.org/wp-content/uploads/2017/05/HandoutGenderTerms.pdf>.

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

*Definitions from Pathfinder International:<sup>19</sup>*

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

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

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

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<sup>19</sup> For more information, visit <https://www.pathfinder.org/focus-areas/gender/>

## Key GBV-Related Terms and Concepts

### **Gender Norms**

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

### **Gender Awareness**

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

### **Gender Equity**

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

### **Gender Discrimination**

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

### **Gender-Related Barriers**

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

### **Gender-Based Violence (GBV)**

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

## Understanding Gender and Power

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

### Power Over

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

### Power To

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

### Power Within

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

### Power With

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

## Power and GBV



## Case Study 1: Rahima

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

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

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

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



### For Group Discussion

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

## Questions to Assess How Gender Affects FP and SRH Outcomes

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

## Some Areas of Gender Discrimination

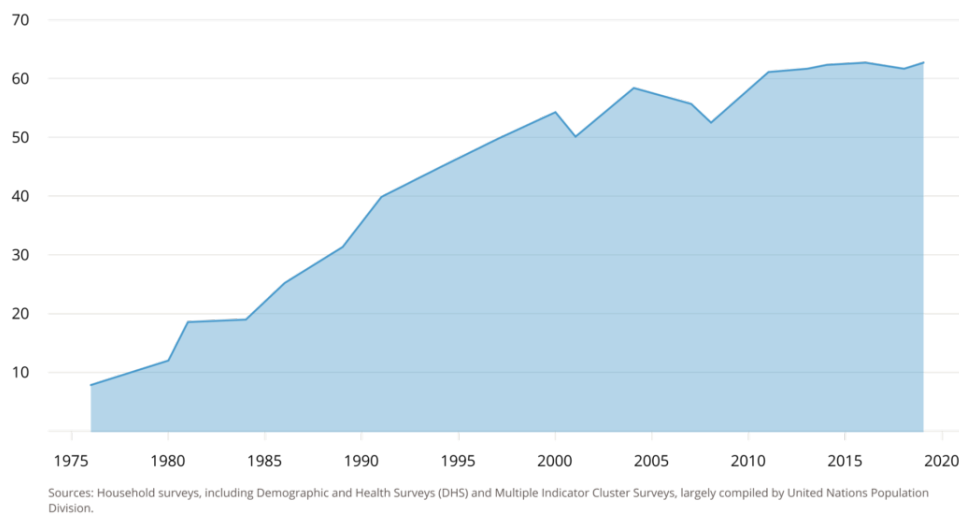
- Abortion of female fetus through sex determination
- Denial of sufficient and/or nutritious food
- Denial of education/proper opportunity for education
- Denial or delay in accessing healthcare when necessary
- Early marriage
- Dowry
- Divorce and destitution for trivial reasons
- Poor school enrollment

## Family Planning History in Bangladesh

Bangladesh has one of the oldest family planning programs in the world, initiated informally in 1953. Bangladesh has achieved historic progress in expanding access to voluntary contraception for nearly half a century. The percentage of married women of reproductive age who are using family planning increased sevenfold in less than 50 years.

### Increase in Contraceptive Use

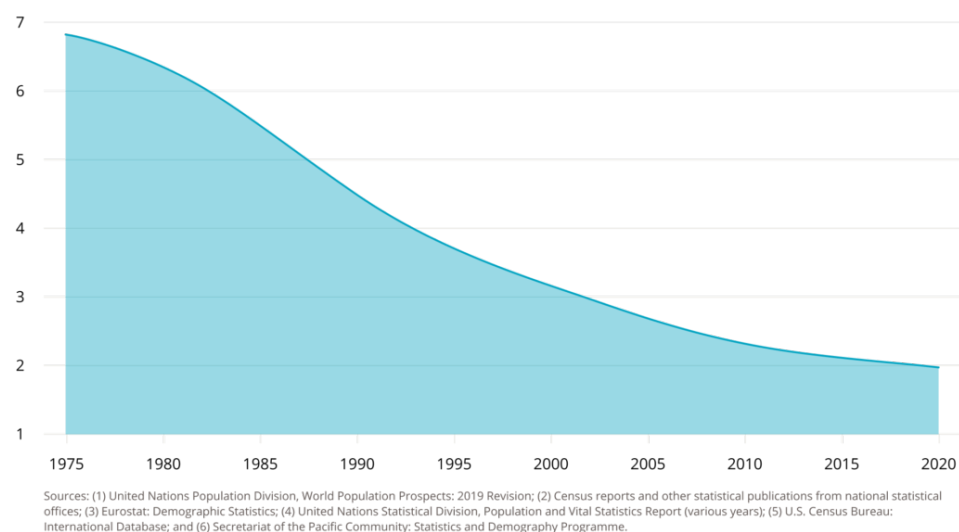
The percentage of married women ages 15–49 who are using any method of contraception



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

### Decrease in Total Fertility Rate

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





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

A cornerstone of Bangladesh's strategy to bring contraceptive options to people's doorsteps was the deployment of a massive cadre of female frontline health workers (called "family welfare assistants") who provided contraceptive counseling and services to women where they live.<sup>20</sup> Between 1976 and 1980, when it was uncommon for women in Bangladesh to work outside of the home, the government recruited 22,500 women from local communities as family welfare assistants. These frontline health workers became a symbol of empowerment in communities and revolutionized family planning service delivery for hard-to-reach women and families.

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

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

But today, Bangladesh's family planning agenda remains unfinished. Progress is stalling. The percentage of women currently using modern contraceptives decreased from 54 percent in 2014 to 52 percent in 2017–18.<sup>21</sup>

The **current contraceptive prevalence rate (CPR)** is **62 percent** among currently married women ages 15–49; **52 percent** of women use modern contraceptive methods, and **10 percent** use traditional methods.<sup>22</sup>

## Opportunities for Progress

*From BDHS 2017–2018:*

### Address High Rates of Discontinuation

It is currently estimated that 37 percent of contraceptive users stop their selected method within 12 months.

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<sup>20</sup> Sidney Ruth Schuler, Syed M. Hashemi, and Ann Hendrix Jenkins. "Bangladesh's Family Planning Success Story: A Gender Perspective." *International Family Planning Perspectives*, Volume 21, Number 4, December 1995.

<sup>21</sup> BDHS 2017–2018.

<sup>22</sup> BDHS 2017–2018.

### **Improve Service Quality and Balanced Method Mix**

Only 9 percent of currently married women are using a long-acting or permanent method (LAPM), such as female or male sterilization, implant, or Intrauterine device (IUD).

### **Address Unmet Need Among Adolescents**

An estimated 16 percent of adolescents ages 15–19 have an unmet need for family planning, in contrast to 5 percent among women at the end of their childbearing years (45-49).

### **Improve Services Offered to Women Who Were or Are Child Brides**

Nearly one-third (31%) of women ages 20–49 report that they had married by age 15.

### **Areas of Need**

While the national CPR is 62 percent, there are sizable variations across age geographies. For example, modern method use is highest in Rangpur (59%) and lowest in Chattogram and Sylhet (both have a CPR of 45%).

## Case Study 2: Hena

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

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

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



### For Group Discussion

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

### Case Study 3: Nazma

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

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



#### *For Group Discussion*

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

## Case Study 4: Rani

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

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



### *For Group Discussion*

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

## Case Study 5: Hossain

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



### *For Group Discussion*

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

# Module 2:

## Foundations in GBV

### What You Can Expect to Learn

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

### Schedule

	Duration
<b>MODULE 2: Foundations of GBV</b>	
Session 2-A: Understanding and Conceptualizing GBV	45 min.
Session 2-B: GBV Risk Analysis in FP and SRHR	45 min.
Session 2-C: Male Engagement in GBV Prevention Awareness	45 min.
Session 2-D: Understanding GBV in FP and SRH for Adolescents and Youth	1 h. 30 min.
Session 2-E: Day 1 Wrap Up	40 min.
<b>Total Module Time</b>	<b>3 h. 50 min.</b>

## GBV Key Messages

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

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

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

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

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

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

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

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



## Forms and Manifestations of GBV

### Physical

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

### Social

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

### Emotional/Psychological

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

### Sexual

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

## Reproductive Coercion

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

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

## Bangladesh's National Prevalence of GBV

### *VAW in Bangladesh Facts*

*2017 study | total 1,143 victims<sup>23</sup>*

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

### *Report on VAW Survey 2015<sup>24</sup>*

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

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<sup>23</sup> Nashid Tabassum Khan, et. al., “Violence against Women in Bangladesh.” *Delta Med Col J.* Jan 2017; 5 (1):25 – 29.

<sup>24</sup> Bangladesh Bureau of Statistics, Statistics and Informatics Division, Ministry of Planning. *Report on Violence Against Women Survey* (2015).

## United Nations Declaration on the Elimination of Violence against Women

*Declaration adopted December 1993:*

### **Article 1**

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

### **Article 4**

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

*For the full declaration, visit [ohchr.org](https://www.ohchr.org)*

## Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

*General Recommendation No. 19, January 1992:*

### **Article 1**

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

### **From Article 16 (and Article 5)**

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

*For the full General Recommendation, visit [ohchr.org](https://www.ohchr.org)*

## Bangladesh National Laws and Commitment

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

## GBV Risk Analysis in FP and SRH Service Context

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

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

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

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

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



**“Engaging men and boys as users, supportive partners, and agents of change improves health outcomes. More specifically, engaging men in FP/RH programs has been successful in decreasing unintended pregnancies, improving maternal health, reducing sexually transmitted infections (STIs) and HIV/AIDS, and better meeting the needs of youth.”<sup>25</sup>**

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

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<sup>25</sup> Breakthrough ACTION. *Advancing male engagement in family planning and reproductive health: An advocacy tool*. Johns Hopkins Center for Communication Programs (Baltimore: 2018).

## Benefits of Male Engagement in SRHR

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

### Risks

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



# Adolescents and Youth: Basic Concepts

## Background

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

The term “young people” includes girls and boys aged between 10 and 24 years, spanning the periods defined as adolescence (10–19 years) and youth (15–24 years). Young people make up a significant proportion of countries’ populations and comprise 16 percent of the global population.<sup>26</sup>

## Age Groups

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

## Essential Elements of Comprehensive SRH Services for Young People<sup>27</sup>

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

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

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<sup>26</sup> “Youth,” United Nations, accessed Feb 3, 2023, [www.un.org/en/global-issues/youth](http://www.un.org/en/global-issues/youth)

<sup>27</sup> WHO. *Core competencies in adolescent health and development for primary care providers: including a tool to assess the adolescent health and development component in pre-service education of health-care providers* (Geneva: 2015).

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

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

*From ICPD Program of Action paragraph 7.3:*

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

## Conceptuality of Child Marriage

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

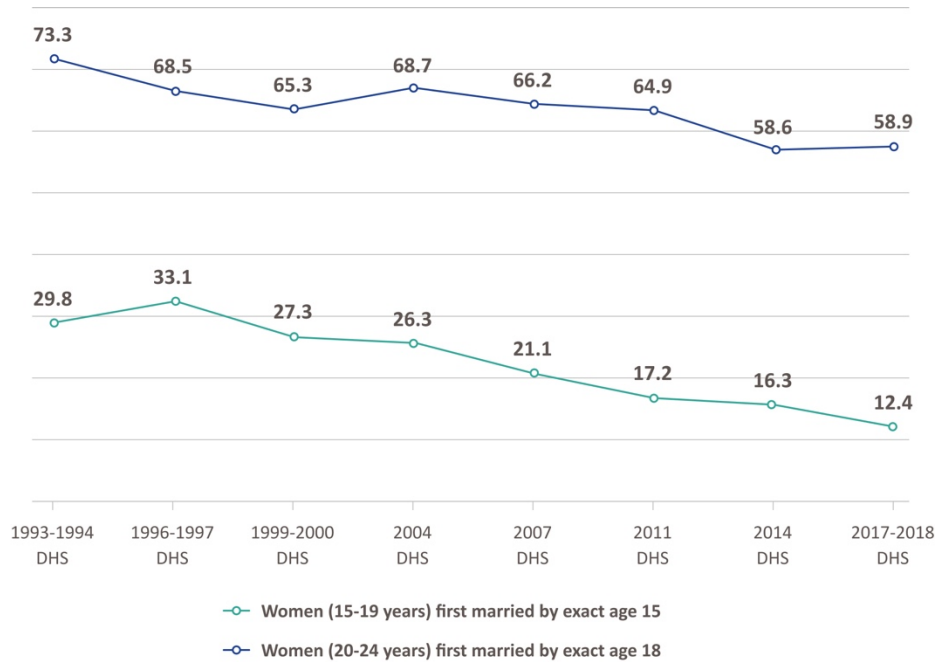
The current law in Bangladesh that addresses child marriage is the Child Marriage Restraint Act, 2017 (CMRA), which repealed the earlier British law of 1929. The Act sets the minimum age of marriage for a male as 21 years and for a female as 18 years. This refers to both formal marriages and informal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

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

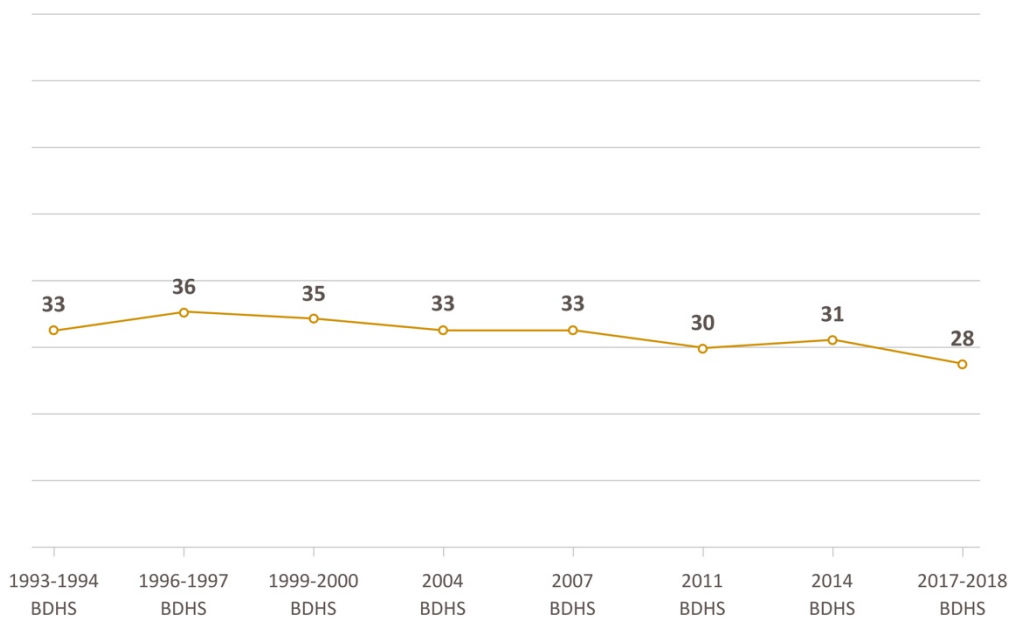
- Create a National Plan of Action by the end of 2014 (prepared in 2018).
- Revise the Child Marriage Restraint Act 1929 (revised in 2017).
- End the marriage of under 15-year-olds and reduce, by one third, child marriage under 18 years by 2021.
- Eradicate child marriage from the country by 2041.

## National Trends Related to Adolescent and Youth SRH

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



Teenage Childbearing in Bangladesh (Source: BDHS)



## Drivers of Adolescent Childbearing

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

## Existing Laws to Advance AYRH and Rights

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

INTEGRATING GBV-RESPONSE INTO FP AND RH SERVICE DELIVERY | PARTICIPANT'S MANUAL  
 MODULE 2: FOUNDATIONS IN GBV

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

## Case Study 6: Meena

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



*In your group, prepare to present the following:*

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

## Case Study 7: Parvin

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

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

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



*In your group, prepare to present the following:*

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

## Case Study 8: Khadija

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

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



*In your group, prepare to present the following:*

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



# Module 3:

## GBV-Responsive FP and SRH Service Provision

### What You Can Expect to Learn

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

### Schedule

	Duration
<b>MODULE 3: GBV-Responsive FP and SRH Service Provision</b>	
Session 3-A: GBV-Responsive Counseling in FP and SRHR	1 h. 30 min.
Session 3-B: Responding to Disclosures of GBV	1 h.
Session 3-C: Making GBV Referrals	1 h. 30 min.
<b>Total Module Time</b>	<b>4 h.</b>

## Background: GBV in the Context of SRH

### Reproductive Health

*As defined by WHO:<sup>28</sup>*

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

### Counseling

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

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<sup>28</sup> “Reproductive Health,” World Health Organization, accessed February 3, 2023, <https://www.who.int/southeastasia/health-topics/reproductive-health>.

## Principles of Client-Centered Counseling

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

## Summary of Tips for Counseling with Active Listening

### **It is important to:**

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

### **Do not:**

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

## Tips for Gender-Sensitive FP Counseling

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

## Specific Steps to Follow When Providing GBV Counseling in an FP Setting

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

## Checklist: Introduction and Engagement

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

## Ways to Make a Client Feel More at Ease

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

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

## Counseling Job Aid: GATHER Approach<sup>29</sup>

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

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<sup>29</sup> Pathfinder International, Comprehensive Reproductive Health and Family Planning Training Curriculum, Module 3: Counseling for Family Planning Services (Watertown, MA: 1998).

## IPV/Reproductive Coercion Considerations in FP Counseling

Adapted from WHO, *Caring for Women Subjected to Violence curriculum*.<sup>30</sup>

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

<sup>30</sup> WHO. *Caring for women subjected to violence: a WHO curriculum for training health-care providers*. Revised edition, 2021 (Geneva: 2021).



## Role Play 1: Partner IUD Concerns

### GATHER Counseling Skills Practice

#### Provider Info

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

#### Client Info

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

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



#### *Observers should provide feedback on:*

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

#### *Clients should give feedback on:*

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

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

### GATHER Counseling Skills Practice

#### Provider Info

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

#### Client Info

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



#### *Observers should provide feedback on:*

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

#### *Clients should give feedback on:*

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

## Role Play 3: Couple-Supported Permanent Method

### GATHER Counseling Skills Practice

#### Provider Info

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

#### Client Info

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



#### *Observers should provide feedback on:*

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

#### *Clients should give feedback on:*

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

## Job Aid: LIV(ES) Psychological First Aid

WHO developed the LIVES mnemonic<sup>31</sup> to ensure first-line support in primary and preventative health care settings that responds to the needs of survivors of sexual assault or intimate partner violence.

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

The first three steps make up **psychological first aid** and can be delivered by any level of health worker in any setting where privacy is available.

### Sample phrases to use:

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

<sup>31</sup> WHO. *Caring for women subjected to violence: a WHO curriculum for training health-care providers, revised edition* (Geneva: 2021).

## Role Play 4: IPV

### LIV(ES) Skills Practice

#### Provider Info

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

#### Client Info

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

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

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



#### *Reflection Questions:*

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

## Role Play 5: CEFM

### LIV(ES) Skills Practice

#### Provider Info

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

#### Client Info

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



#### *Reflection Questions:*

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

## Role Play 6: Sexual Violence

### LIV(ES) Skills Practice

#### Provider Info

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

#### Client Info

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



#### *Reflection Questions:*

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

## Risk Identification

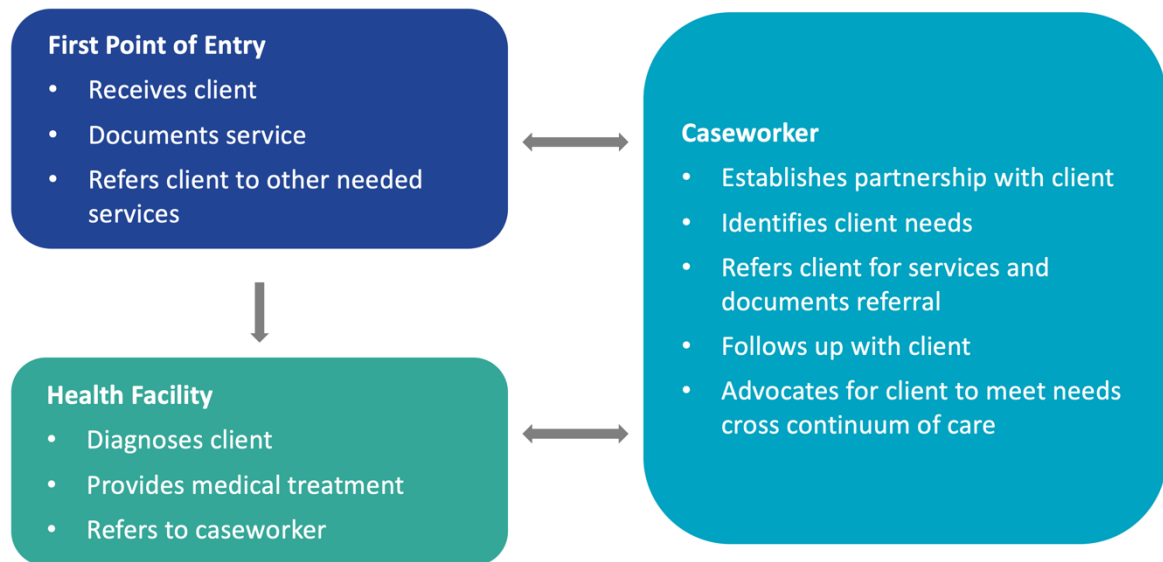
As FP providers, in most cases, you should not take on further response services. Many clients will not choose to act on referrals that you offer. However, the following may be signs that your client is in immediate danger. Should you see these signs or behaviors, you may wish to go fetch a GBV specialist colleague and have them join you in the appointment room:

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



## Effective Referral Pathway

### Case Management Referral System



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

## Case Study 9: Lovely

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

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

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



### *For Group Discussion*

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

## Making a Referral

### Intra-Facility

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

### Inter-Facility

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

### Reminders

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

## One-Stop Crisis Center and Cells

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

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

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

## Resource: One-Stop Crisis Center Contact Numbers

As of January 2023

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

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

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

## Resource: National Call Lines

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

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

## National Trauma Counseling Center

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

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

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



## Form: GBV Referral Slip

### REFERRAL SLIP

**Client number (as recorded):**

**Name of client (first name only/optional):**

**Age:**

**Gender:**

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

**Cause of referral:**

**Place of referral:**

**Date referral completed:**

*Source: Pathfinder International*

### Notes

While confidentiality must be protected, it is important to confirm referrals and be able to follow up on care as much as possible. Use a numeric coding system to assign a non-identifying code to each client referral. This enables tracking without having identifying information on the referral slip. Records linking numeric codes to client identifying information should be stored separately and in a locked location.

## Module 4:

# Foundational Knowledge on GBV Case Recording, Documentation, and Record Keeping

### What You Can Expect to Learn

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

### Schedule

	Duration
<b>MODULE 4: Foundational Knowledge on GBV Case Recording, Documentation, and Record Keeping</b>	
Session 4-A: Legality, Protecting Confidentiality, and Reporting GBV	45 min.
<b>Total Module Time</b>	<b>45 min.</b>

## Defining “Legality”

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

## Legal Considerations for FP and SRH Providers around GBV

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

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

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

### What to Include in Your Report

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

## Form: Sample GBV Disclosure Client Report

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

## Where to Report

There are a variety of places where you can report, including:

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

## Form: Sample Facility Register

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

Source: Pathfinder International

## Case Study 10: Aklima

### Referral and Report Skills Practice

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

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

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

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

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

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

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



#### ***For Reflection and Group Discussion***

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

## Form: Facility Report of Services for GBV

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

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

# Module 5:

## Closing

### What You Can Expect to Learn

- Be able to provide feedback on this training, share what you learned, and find additional resources.

### Schedule

	Duration
<b>Closing</b>	
Session 5-A: Closing Session and Post-Test	1 h. 30 min.
<b>Total Module Time</b>	<b>1 h. 30 min.</b>



## Individual Action Plan: Improving GBV-Sensitive FP Service Provision

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

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

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

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**PATHFINDER**



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

—Day 1—



পরিবার পরিকল্পনা অধিদপ্তর

# Module 0

## Introduction to Training

**MODULE 0 | SESSION A**

# **Introductions, Group Norms, and Pre-Test**

## Overall Goal of Training

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



# Learning Outcomes

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

# Module 1

## Understanding Gender and GBV

MODULE 1 | SESSION A

## Understanding Gender in FP Services

### What You Can Expect to Learn

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

## What Does Gender Mean to You?

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

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

## Definition of Gender

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

*Source: Pathfinder International*

## It's not fair or equal...

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

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

*Source: World Bank*

# Let's Try a Gender Quiz

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

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

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

# Understanding the Difference Between Sex and Gender

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



# Key Terms

## **Gender Norms**

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

## **Gender Awareness**

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

## **Gender Equity**

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

## Key Terms *continued*

### **Gender Discrimination**

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

### **Gender-Related Barriers**

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

### **Gender-Based Violence (GBV)**

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

# Understanding Gender and Power

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

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

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

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

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

# Power and GBV



# Case Study 1: Rahima



## *For Group Discussion*

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

## Gender Relevance in FP Success and Failure

### What You Can Expect to Learn

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

# Questions to Assess How Gender Affects FP and RH Outcomes

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

# The Power of FP for Women and Development



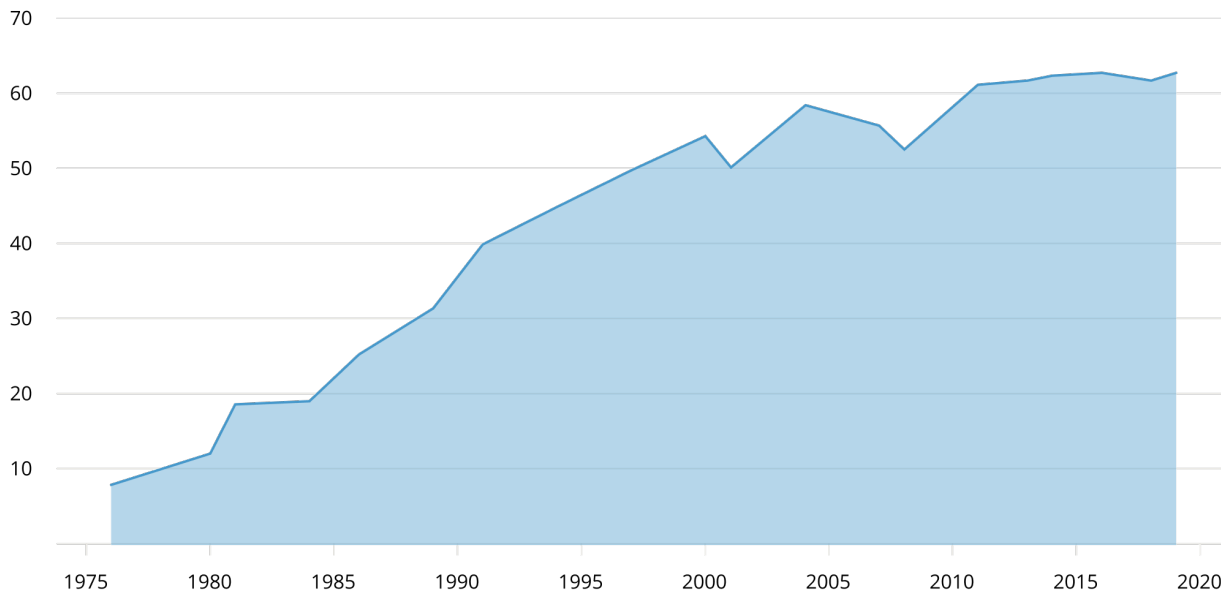
“Investing in family planning is a development ‘best buy’ that can accelerate achievement across the 5 Sustainable Development Goal themes of People, Planet, Prosperity, Peace, and Partnership.”

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



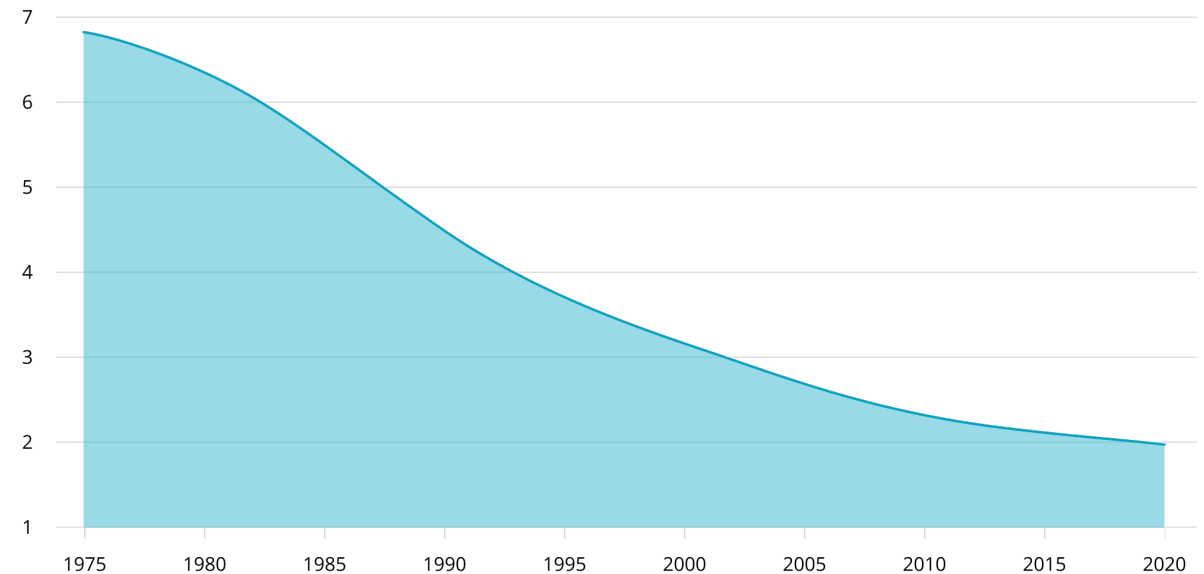
# Bangladesh has achieved historic progress in expanding access to voluntary contraception for nearly half a century.

## Increase in Contraceptive Use



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

## Decrease in Total Fertility Rate



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

# Bangladesh's Historic FP Progress

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

Source: BDHS 2017–2018

# Opportunities for Progress

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

Source: BDHS 2017–2018

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



## *For Group Discussion*

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

## Other Relevant Barriers

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

# Module 2

## Foundations in GBV

## MODULE 2 | SESSION A

# Understanding and Conceptualizing GBV

### What You Can Expect to Learn

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

# Unpacking GBV

## Gender-Based Violence (GBV)

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

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

## Violence Against Women & Girls (VAWG)

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

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



# Forms and Manifestations of GBV

## PHYSICAL

Hitting, beating, burning, cutting

Trafficking

Acid attacks, honor killings

## SOCIAL

Discrimination, and/or denial of opportunities

Denial of education

Denial of inheritance and/or property rights

## EMOTIONAL/PSYCHOLOGICAL

Abuse, Humiliation

Confinement/Isolation

Intimidation/Threats

Blame for uncontrollable outcomes

## SEXUAL

Forced Marriage

Sexual Exploitation/Forced Prostitution

Rape\*

Harassment

Female Genital Cutting

# Reproductive Coercion

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

## Examples:

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

# National GBV Prevalence

## VAW in Bangladesh Facts

### 2017 study | A total 1,143 victims

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

## Report on VAW Survey 2015

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

# UN Special Declaration

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

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

# National Laws and Commitments

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

## MODULE 2 | SESSION B

# GBV Risk Analysis in FP and SRHR

### What You Can Expect to Learn

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



0–2 years



4–10 years



Adolescent  
10–14 years



Adolescent  
15–19 years



Newly married  
couple



Couple who have  
completed family



Postpartum couple



Pregnant woman

## LIFE CYCLE APPROACH



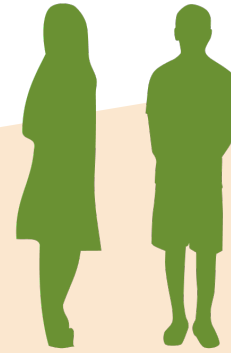
0–2 years



4–10 years



Adolescent  
10–14 years



Adolescent  
15–19 years



Newly married  
couple

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

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



Couple who have  
completed family

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



Postpartum couple



Pregnant woman

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

## GBV IN FP AND SRH ACROSS THE LIFE CYCLE



# GBV Impacts Across the Life Cycle

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

## Women living with intimate partner violence are:

**TWICE** as likely  
to experience depression

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

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

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

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

# What Can GBV Look Like in FP and SRH?

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

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

## MODULE 2 | SESSION C

# Male Engagement in GBV Prevention Awareness

### What You Can Expect to Learn

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

# Male Engagement in GBV Prevention

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

*Source: Breakthrough ACTION*

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



# Benefits of Male Engagement in SRHR

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

# Risks of Male Engagement in SRHR

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



# Key Things to Learn about Involving Men in FP

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

## **In Safe Motherhood and SRHR,**

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

- Pregnancy
- Delivery
- Postpartum period

# Men: Full Partners and Advocates for Good Reproductive Health

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

## MODULE 2 | SESSION D

# Understanding GBV in FP and SRH for Adolescents and Youth

### What You Can Expect to Learn

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

## Basic Concepts

# Adolescent and Youth SRHR and CEFMU

### Terms and Definitions

Adolescents: 10–19 years

Youth: 15–24 years

Young People: 10–24 years

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

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

# Comprehensive SRHR Services for Young People

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

# Concept of Child Marriage

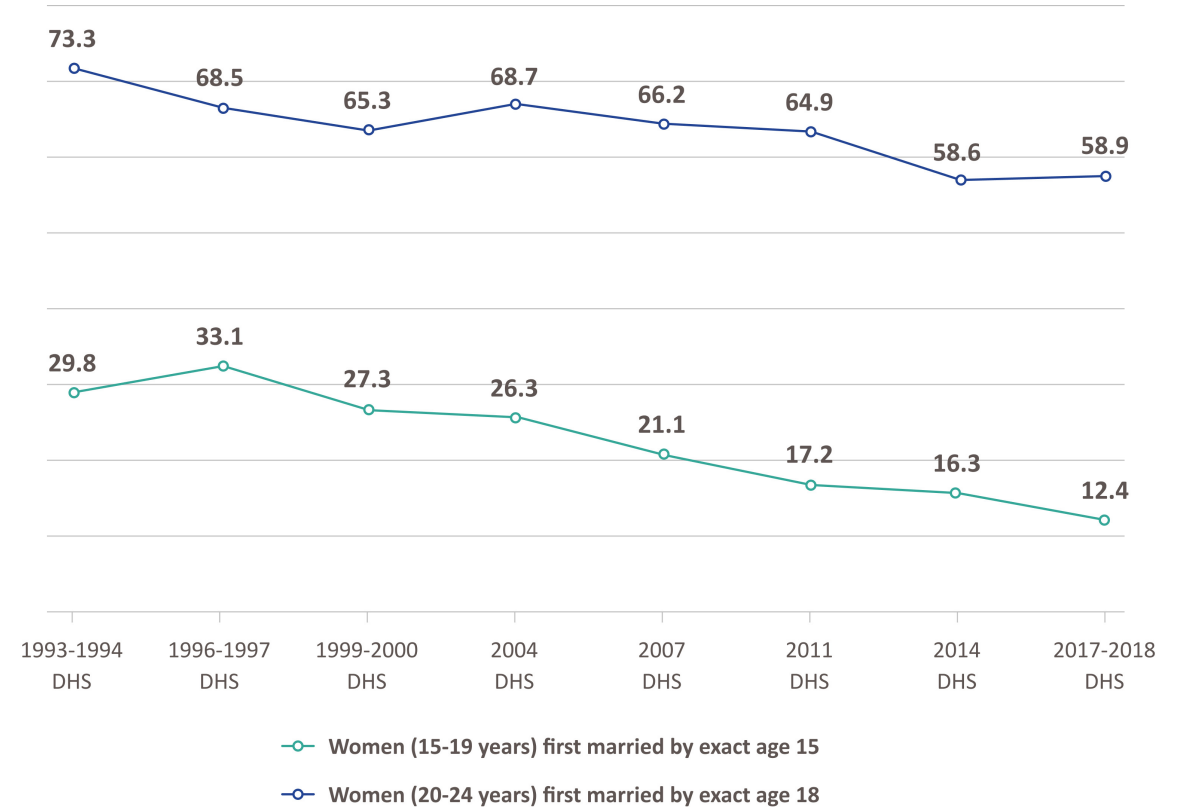
According to BDHS 2017–18, 71% of women ages 20–49 were married by age 18, and nearly one-third (31%) of women 20–49 reported that they had married by age 15.

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

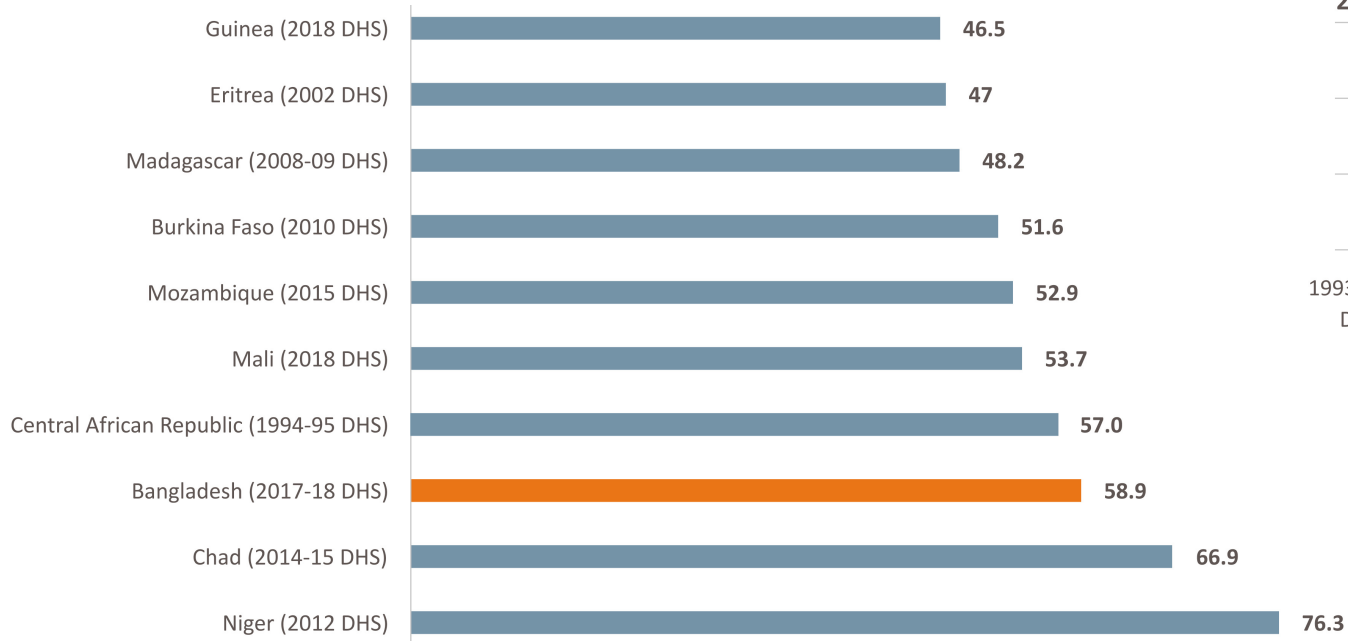
**To address the child marriage situation of the country, the Honorable Prime Minister of Bangladesh made the following commitments in July 2014:**

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

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

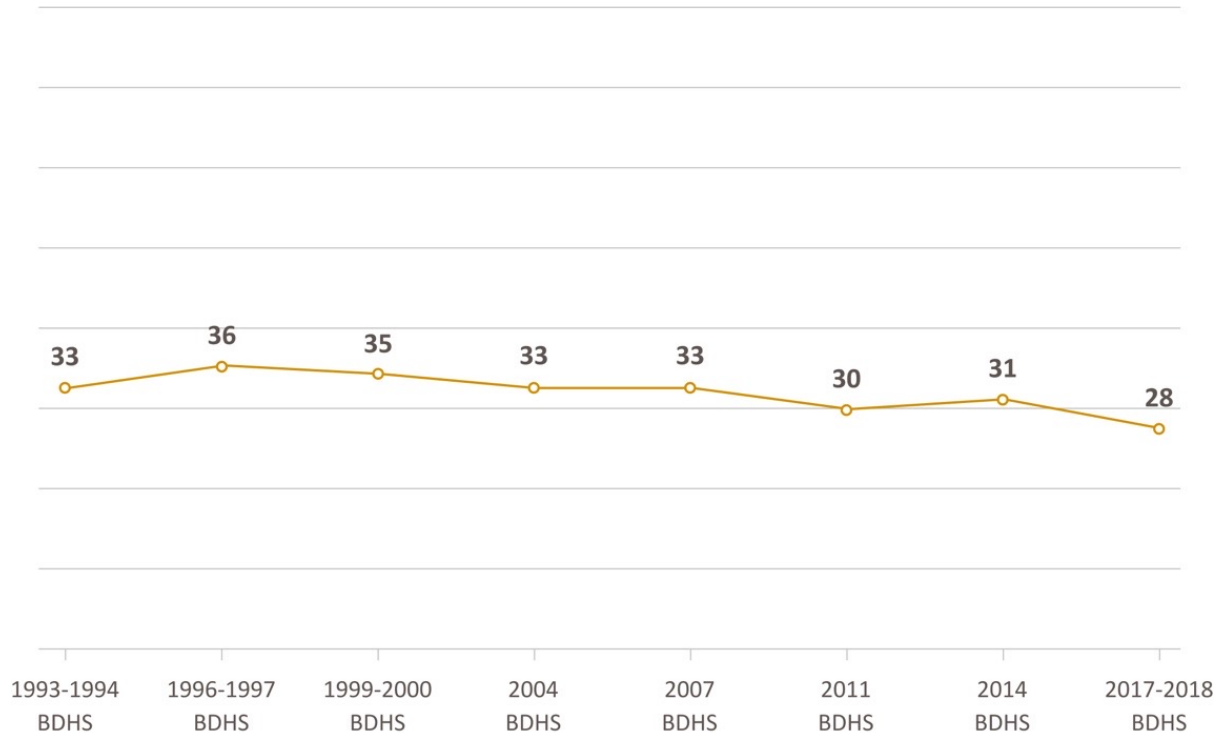


## % of Women (20–24 years) First Married by Exact Age 18: Top Ten Countries





## Teenage Childbearing in Bangladesh



## Drivers of Adolescent Childbearing

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

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

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

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



## *To Present in Plenary*

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



# Values Clarification

## Vote with Your Feet

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

# Key Takeaways

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



**Questions?**



Thank you!



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

—Day 2—



পরিবার পরিকল্পনা অধিদপ্তর



# Welcome Back

## TODAY'S OBJECTIVES

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

# Module 3

## GBV-Responsive FP and SRH Service Provision

## MODULE 3 | SESSION A

# GBV-Responsive Counseling in FP and SRH

### What You Can Expect to Learn

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

# Concept of Counseling

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

# Principles of Client-Centered Counseling

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

# Counseling with Active Listening

## IT IS IMPORTANT TO:

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



# Counseling with Active Listening



## DO NOT:

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

# GATHER Approach in FP Counseling

**G Greet**

**A Ask**

**T Tell**

**H Help**

**E Explain**

**R Return**

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



## IPV/ Reproductive Coercion Considerations in FP Counseling

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

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

# GATHER Skills Practice: Role Plays 1–3



## *Observers should provide feedback on:*

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

## *Clients should give feedback on:*

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

## MODULE 3 | SESSION B

# Responding to Disclosures of GBV

### What You Can Expect to Learn

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

# Responding to Disclosures

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

## Remember:

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

# LIV(ES)

## Listen, Inquire, Validate, Enhance safety, and Support

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

- **Listen** – Listen closely with empathy, no judgment.
- **Inquire** – Assess and respond to the client’s needs and concerns – emotional, physical, social, and practical.
- **Validate** – Show the client you believe and understand them.

### Psychological First Aid

- **Enhance Safety** – Discuss how to protect the client from further harm.
- **Support** – Help connect the client to appropriate resources and services, including social support.

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

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



## *Reflection Questions:*

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

# Risk Identification

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

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



## MODULE 3 | SESSION C

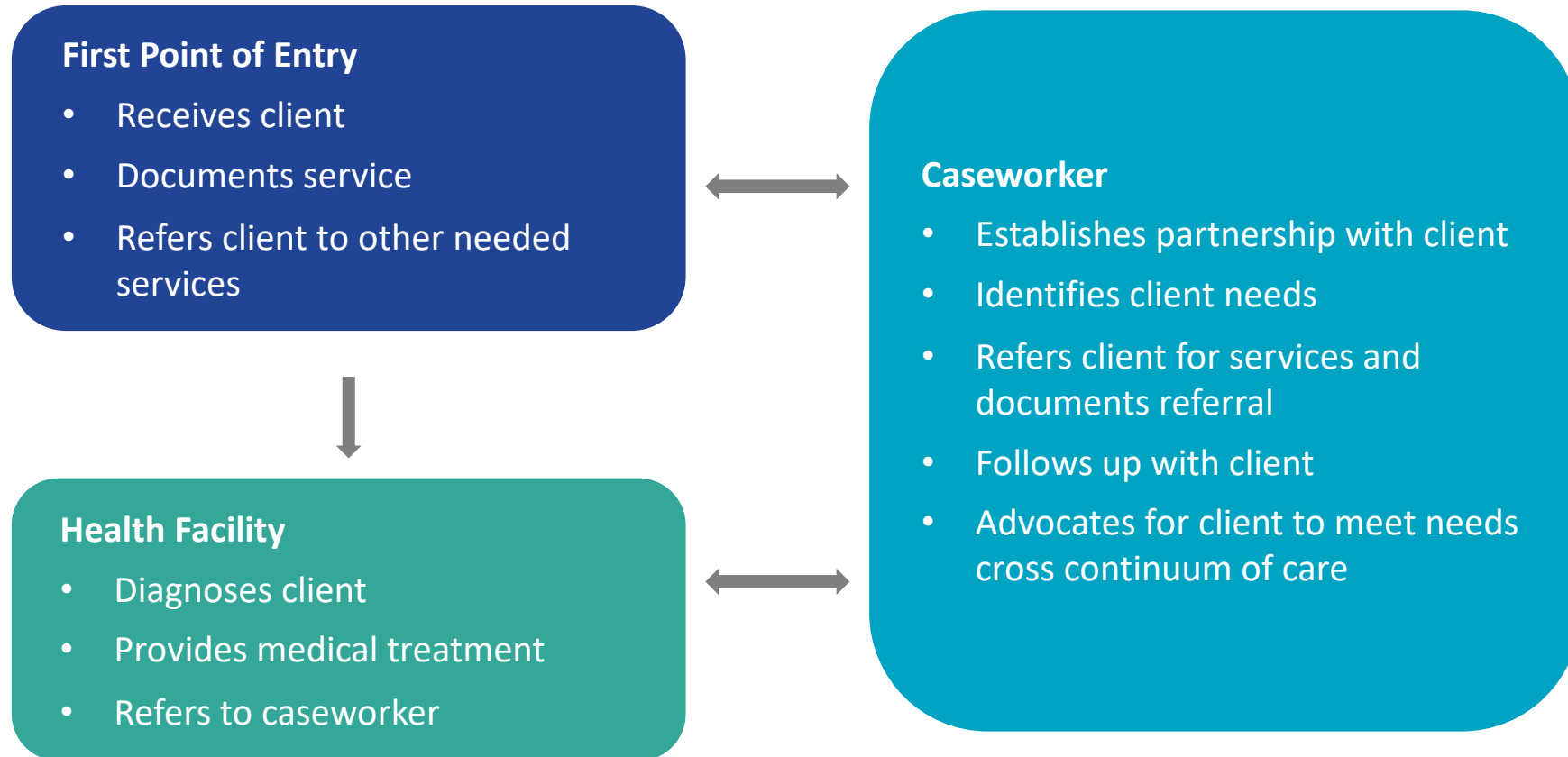
# Making GBV Referrals

### What You Can Expect to Learn

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

# Effective Referral Pathway

## Case Management Referral System



# Case Study 9: Lovely



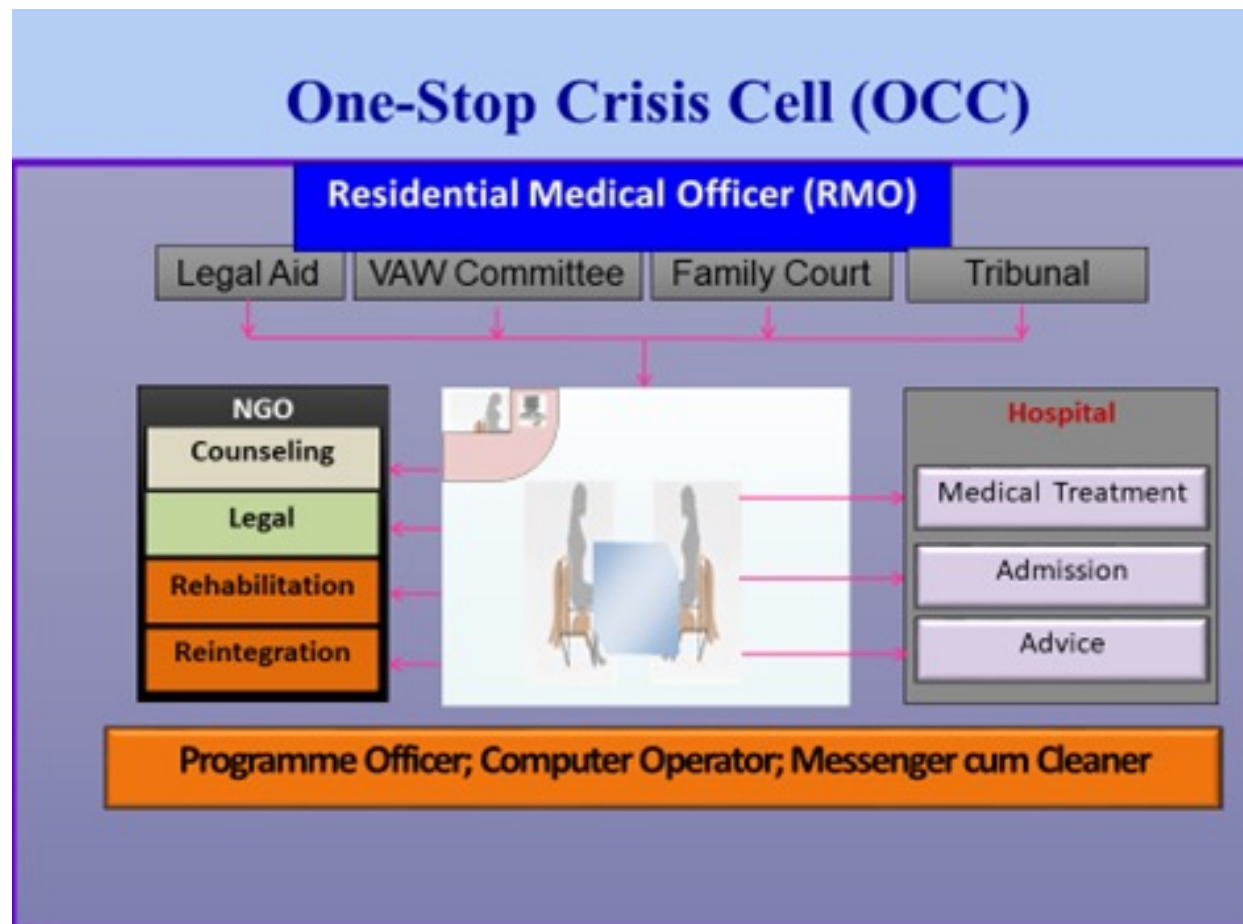
## *For Group Discussion*

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

# One-Stop Crisis Cell

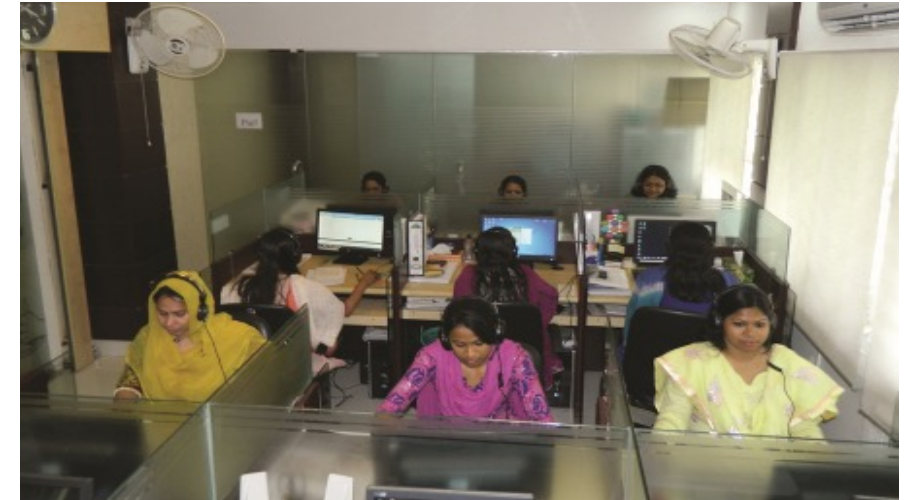
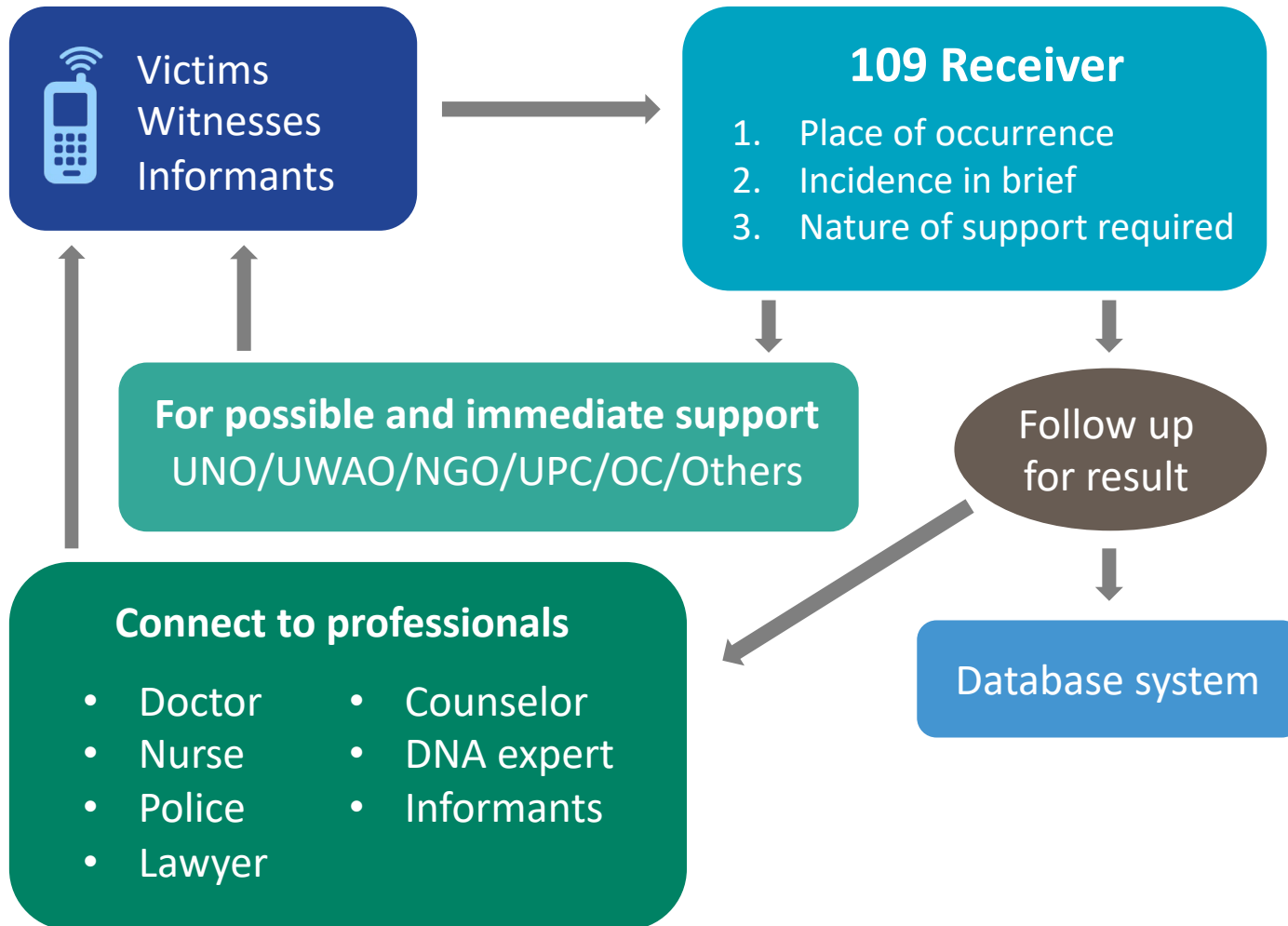
## Services of OCC at MCHs

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










# National Helpline Center as a Referral Way Out

## National Helpline Center for VAWC



# Important GBV Referral Centre Locations in Bangladesh



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

# Helplines for the Prevention GBV (VAW) and Child Marriage

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

# Where to Report

**There are several places where we can report:**

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



# National Trauma Counseling Center (NTCC)

## Objective of NTCC

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

## Psychosocial Counseling Services

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

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

# Intra-Facility versus Inter-Facility Referral

## Intra-Facility

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

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

## Inter-Facility

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

FP service facility does not house:

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

# Role Play 7: Web of Referrals

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

# Forms and Formats of GBV Recording and Reporting

## **REFERRAL SLIP**

**Client number (as recorded):**

**Name of client (first name only/optional):**

**Age:**

**Gender:**

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

**Cause of referral:**

**Place of referral:**

**Date referral completed:**

*Source: Pathfinder International*

# Case Study 9: Lovely

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

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

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

# Module 4

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

## MODULE 4 | SESSION A

# Legality, Protecting Confidentiality, and Reporting GBV

### What You Can Expect to Learn

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

# Defining “Legality”

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



# Legal Considerations for FP and SRH Providers Around GBV

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

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

## What to Include in Your Report

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

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

# Facility Registers for Recording Cases of GBV

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

Source: Pathfinder International

# Case Study 10: Aklima

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



## *For Reflection and Group Discussion*

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

# Module 5

## Closing

# Key Messages

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

# Wrap Up

You have three final steps in this training:

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



**Questions?**





Thank you!



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