وزارة شؤون المرأة

وزارة الشؤون الاجتماعية

VIOLENCE AGAINST WOMEN CURRICULUM

For
Healthcare Students

2011

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جذور للإنماء الصحي والاجتماعي
Juzoor for Health & Social Development

مركز المرأة للإرشاد القانوني والاجتماعي
Women's Centre for Legal Aid and Counselling

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TAKAMOL Project

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BY

Women's Centre for Legal Aid and Counselling

And

Juzoor for Health & Social Development

Preface

The present curriculum contains basic information and teaching material relating to the issue of violence against women (VAW). It is designed for use in teaching healthcare faculty students including medical, nursing, midwifery and community health program students. It has been developed as part of TAKAMOL project which is funded by EU. This project is carried out by the Women's Center for Legal Aid and Counseling (WCLAC) and Juzoor Foundation for Health and Social Development.

The purpose of VAW curriculum is to prepare a comprehensive syllabus that educators can use in facilitating students' learning. This is envisaged to help modify their attitudes and equip them with the needed knowledge and skills which can be used in assuming their responsibilities toward abused women. Special importance is attached to this curriculum as an effective means in helping and supporting VAW survivors and preventing further violence.

Acknowledgment

This curriculum was developed as part of the EU-funded Takamol Project: "promoting women's rights and combating violence against women; building a sustainable legal-health-social-services referral system in the Palestinian territory". We, Juzoor for Health and Social Development and the Women's Centre for Legal Aid and Counselling (WCLAC), believe that violence against women is a health issue in the Palestinian society, as in any society, as well as a social, legal and economic problem. The production and implementation of this curriculum represent a small part of the larger process necessary for combating the damaging phenomenon of violence against women (VAW).

The purpose of this curriculum is to empower and sensitize healthcare students in the medical, nursing and midwifery schools of Palestinian colleges and provide them with knowledge and skills to enable them to competently provide appropriate services to women victims of violence presenting at health care facilities. The curriculum is considered a base which health college instructors may build upon and adapt according to the educational needs of their students and institutions.

Development was a long, thorough process which began with a curricula needs assessment, conducted at the start of the project, through focus group discussions with the health colleges regarding the curriculum's form and content, and how it should be used. The curriculum was developed and revised by local experts from health colleges. This consultation process had a considerable and valuable impact on the final product and we would like to sincerely thank all those involved for their efforts, which are greatly appreciated. Revision was followed by training on implementation of the new curriculum, which aimed to empower instructors with knowledge and skills they can subsequently impart to their students.

We would like to thank all those who participated in the process of developing this curriculum, as well as the health college deans and directors for the support with which they provided us. We are seeking to include the issue of addressing violence against women in all courses and trainings, in order to promote women's rights and strengthen services through improving the knowledge, skills and attitudes of health care workers in relation to VAW.

Abbreviation

GBV	Gender based violence
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
ED	Emergency department
oPt	Occupied Palestiwnian Territory
PCBS	Palestinian Central Bureau of Statistics
SCR	Security Counsel Resolution
VAW	Violence against women
WHO	The World Health Organization
WCLAC	Women's Center for Legal Aid and Counseling
UN	United Nations

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Section One: Introduction to the curriculum

Health care providers are among the most frequently accessed by women who are being abused. Despite the evidence that large numbers of abused women are coming into contact with health professionals, the problem often fails to be identified by practitioners. There are many barriers that exist to prevent abused women from accessing the support they need, but practitioners too are often reluctant to encourage disclosure of abuse for a variety of reasons, including lack of awareness and knowledge about the issue, their own feelings of powerlessness and lack of legal mandate and referral resources for supporting abused women. Training can provide professionals with the confidence to intervene in a way that will be supportive of the woman and will not undermine her safety.

The curriculum's framework and basic outline are derived from the outcome of a two-day workshop with the main stakeholders. The technical group assisted by the consultant provided critical inputs to the curriculum by reviewing the draft and making recommendations and suggestions.

How to use this curriculum?

Although some nursing colleges might choose adding a specific course on violence against women into their curriculum, other nursing programs may place the content into a number of courses. It is important to integrate the content in a purposeful way throughout the curricula. In considering where and how to integrate VAW content, the following were suggested by representatives of the nursing colleges:

- Adding a 2-hour obligatory course to the curriculum
- Adding a 2-hour elective course to the curriculum
- Incorporating signs and symptoms of abuse into physical and psychosocial assessment courses
- Teaching dynamics of violent relationships and helpful nursing responses in mental health courses
- Emphasizing ways of phrasing VAW assessment questions when teaching communication skills
- Using role-plays in clinical conferences to teach screening skills; including screening questions for abuse in health history interviews
- Covering the health effects of abuse when discussing physical and psychological disorders (medical and mental health courses).

- Adding the risk of abuse during pregnancy; and the high rate of depression, suicide, eating disorders in patients who have a history of violence to the maternity or midwifery courses).

Competencies:

At the end of the course the students will be able to:

1. Differentiate between all concepts and definitions of GBV and VAW.
2. Recognize the prevalence of GBV and VAW in all its forms nationally and internationally.
3. Recognize the potential significant physical and mental health effects of violence.
4. Identify the common myths and facts related to abusers and survivors.
5. Demonstrate understanding of the cycle theory of violence and the dynamics of abusive relationships.
6. Understand the relation between human rights and GBV.
7. Be familiar with the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee and the UN security resolution 1325 and its applicability to the occupied Palestinian territory (oPt).
8. Demonstrate competence in screening, assessment and intervention.
9. Thoroughly document all findings related to abuse and patients who are suspected of being abused.
10. Identify the ethical principles that apply to abused women.
11. Be familiar with the multi-sectoral and interagency approach when dealing with GBV and VAW.
12. Allocate and utilize the available national violence referral resources in the country.
13. Recognize the legal mandates and professional responsibilities regarding VAW.
14. Recognize appropriate methods for collection and documentation of data so that both the patient and the provider are protected.
15. Promote activities to address prevention of violence.

Teaching and learning methods:

Presentation	Demonstration
Video watching and discussion	Debate
Group assignment	Individual assignment
Games	Guest speakers
Case studies	Exercises
Role-playing	Field visits
Brainstorming	Research project
Discussion	Simulation
Independent Readings	

Assessment of learning:

Knowledge assessments: **Written or oral tests** which include questions that require learners to recall, analyze, synthesize, organize or apply information to solve or deal with violence related health problems. This is in addition to research and report writing, case study analysis and individual and group assignments.

Section Two: Aim, Structure and Curriculum Framework

This professional curriculum is designed for use in teaching healthcare students. The aims of curriculum are to provide knowledge, modify attitudes and transmit valuable skills. The curriculum objectives are:

1. To promote students' understanding of the issue of VAW.
2. To enhance students' awareness and sensitization of the VAW issue.
3. To help students to identify their own attitudes and value judgments and to gain insight of the issue of VAW.
4. To promote students' abilities to perceive and respond to victims' needs.
5. To enhance students' abilities to work in a multidisciplinary team and to cooperate and collaborate with all bodies and institutions involved in addressing VAW.
6. To enable students to capture ways of primary and tertiary prevention of VAW.

Curriculum Framework:

The curriculum is made up of 7 modules that provide fundamental information and skills on the issue of violence against women. Theoretical and practical materials including handouts, case studies, exercises for practical work and checklists, are supplemented. The curriculum framework is as follows:

Module	Objectives	Contents
• An overview of VAW	1. Define terms related to GBV; power, use of force and informed consent 2. Understand and describe the difference between sex and gender, GBV and VAW, intimate partner violence and sexual violence 3. Identify contributing factors to VAW, including political, cultural and social issues 4. Understand the relation between human rights and GBV. 5. Understand the difference between a "survivor" and a "victim" and the importance of choosing which word to use and when. 6. Determine scope of the problem at international and national levels (statistics). 7. Recognize the potential significant physical and mental health effects of both ongoing and previous violence against women. 8. Understand cultural and societal attitudes / beliefs, and myths related to VAW. 9. Recognize own feelings and attitudes about VAW.	• Background and definitions of gender based violence (GBV), and violence against women (VAW) including intimate partner violence and sexual violence. • Contributing factors to VAW. • Human rights and GBV. • CEDAW and SCR 1325. • Causes and pattern of violence. • Scope of problem at international and national levels. • Consequences of violence.

• Theories and dynamics of violence	1. Understand theories and models of violence. 2. Analyze power and control cycle. 3. Demonstrate understanding of change process.	• Theories and models of violence. • Power and control cycle. • Change process.
• Screening, assessment and documentation	1. Diagnose battered women (screen, assess & interact). 2. Perform physical, psychological, and socioeconomic assessment and intervention. 3. Identify barriers to abuse assessment and intervention. 4. Thoroughly document all findings related to VAW.	• Diagnosis: Associated sign and symptoms. • Physical assessment. • Psychological and socioeconomic assessment. • Abused women behaviors (reasons why she is destructive, angry etc., shock reactions).
• Overview of healthcare team responsibilities	1. Identify health-related responsibilities. 2. Identify psychosocial responsibilities. 3. Apply both health and psychosocial responsibilities. 4. Understand and complement other healthcare team members' roles.	• Health: actively screen clients; respond to immediate health and psychosocial needs; collect forensic evidence; provide testimony; provide referrals; confidentially collect, document, and analyze health data and data on quality of services. • Psychosocial: provide supportive and ongoing psycho-logical assistance; confidentially collect, document, and analyze client data; refer clients to safe environment; provide hotlines; conduct community education.
• Legal, ethical and cultural issues of reporting and treatment of abused women	1. Be aware of related legislations and laws related to women's rights and violence prevention. 2. Know the ethical principles that apply to abused women. 3. Define breaches of privacy and confidentiality.	• Legislations and laws related to women's rights and violence prevention. • Data collection and documentation. • Ethical principles (privacy, confidentiality, beneficence).

• Violence prevention	1. Discuss public health approach to understanding and preventing violence. 2. Identify levels of VAW prevention. 3. Promote programs and activities that address prevention of VAW.	• The public health approach to understanding and preventing violence. • Levels of prevention (primary, secondary, and tertiary).
• Health care responses to perpetrators of domestic Violence	1. Determine when and how to respond when they encounter perpetrators of domestic violence in their future practice. 2. Identify strategies for maximizing the safety of the victim when interacting with a patient who is the perpetrator. 3. Identify the ways by which healthcare professionals learn about perpetrators. 4. Discuss the specific factors to consider in evaluating the lethality of domestic violence and the risk of future injury or death. 5. Determine crisis intervention strategies.	• Strategies for increasing the safety of victims when interacting with perpetrators of domestic violence. • Learning about perpetrators. • Assessment of lethality when the patient is the perpetrator. • Crisis intervention strategies.

Section Three: Modules' Description

Each module is designed to include:

- Objectives
- Teaching and learning methods
- Resources & references
- Estimated time
- Content

Resources & references used in preparing this curriculum

- Facts on Violence against Women in Palestine. Oct. 2005. The Palestinian Initiative for the Promotion of Global Dialogue and Democracy-MIFTAH.
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- Injuries and Violence: The Facts. Geneva, World Health Organization, 2010.
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Module 1
An overview of VAW

Objectives: At the end of the module participants will be able to:

1. Define terms related to gender based violence; power, use of force and informed consent.
2. Understand and describe the difference between sex and gender, GBV and VAW, intimate partner violence and sexual violence.
3. Identify contributing factors to VAW, including political, cultural and social issues.
4. Understand human rights and GBV.
5. Understand the difference between a "survivor" and a "victim" and the importance of choosing which word to use and when.
6. Understand the meaning of the term "perpetrator."
7. Determine scope of the problem at international and national levels (statistics).
8. Understand cultural/societal attitudes/beliefs and myths related to violence.
9. Recognize own feelings and attitudes about VAW.
10. Recognize the potential significant physical and mental health effects of both ongoing and previously experienced violence against women.

Teaching and learning activities

- Presentation and discussion
- *Violence Against Women Awareness Exercise*: Reflective questions to help students explore their attitudes towards victims and perpetrators of abuse (Appendix A).
- Games.
    - Definition word scramble: Take your definition and divide it into relevant phrases. Put each phrase on a separate card. Scramble them up. Add words and phrases that don't belong in the definition on other cards. Ask students to assemble a definition. This could be done in teams.
    - Definition development: Tell students that you will give them a standard definition for the types of violence against women, but you'd like them to create their own. Have students work together to create the most inclusive, yet concise definition possible. Have each group present their definition and see how it compares to the commonly accepted definition.
    - Video watching (Women violence).

Estimated time: 5 hours
Content

Background information:

Traditionally, women have not enjoyed equal access to basic human rights, protection, resources, and services. Unfortunately, gender inequality is still present in every society. Unequal situations for women vary significantly by region, country, culture, society, community, etc. The origin of discrimination lies sometimes in the religion, beliefs, cultural traditions or political interests. These excuses in some occasions encourage the unequal and discriminatory treatment of women, thus creating demoralized women and therefore oppressed communities.

There are also two terms which explain different types of discrimination. First, sexism is a form of discrimination and stereotyping that oppresses women. Second, patriarchy is a system where males are dominant. It is so common in many societies and also within families and consequently, some violence against women is seen mostly in these types of communities and families. The WHO World Report on Violence (2008) came to the same conclusion, arguing that: where women have a very low status, violence is not "needed" to enforce male authority... Partner violence is thus usually highest at the point where women begin to assume nontraditional roles or enter the workforce.

Violence against women violates fundamental human rights and is an

insult to women's dignity. Physical, psychological, and sexual violence against women and girls, in the public and private domains, creates tremendous obstacles to the achievement of healthy communities, equality, development and peace.

1.1 Definition and discussion of terms related to GBV

In this section definition of terms related to sex and gender, power, use of force and informed consent, as well as description of the differences between sex and gender, GBV and VAW, and intimate partner violence and sexual violence will be presented sequentially

Gender: Refers to widely shared ideas and expectations (norms) concerning men and women. These ideas are about "typical" feminine/female and masculine/male characteristics, abilities and commonly shared expectations about how women and men should behave in various situations.

These ideas and expectations are learned from: family, friends, opinion leaders, religious and cultural institutions, schools, the workplace, advertising and the media. They reflect and influence the different roles, social status, economic and political power of women and men in society.

Sex: refers to the physical/biological differences between males and females, which are determined by biology and do not change overtime.

Violence is the threatened or actual use of force against a person or a group that either results in or is likely to result in injury, death, emotional damage or coerced behavior (Governor's Task Force on Violence as a Public Health Problem, 1996). It takes place in the home, on the streets and in other public settings, in the workplace and in institutions such as schools, hospitals and residential care facilities. Violence consists of the use of physical force or other means of coercion such as threat, inducement or promise of a benefit to obtain something from a weaker or more vulnerable person.

Gender–Based Violence (GBV); In 1993, the United Nations General Assembly defined violence against women as follows: "Violence against women means any act of gender-based violence (GBV) 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 deprivations of liberty, whether occurring in public or private life (1993 UN Declaration on the Elimination of Violence against Women).

The General Assembly went on to present a partial list of what they felt

constituted gender-based violence, including:

- Physical, sexual and psychological violence within the family
- Child sexual abuse
- Dowry-related violence
- Marital rape
- Female genital mutilation
- Rape and sexual abuse
- Sexual harassment in the workplace and educational institutions
- Trafficking in women
- Forced prostitution.

Violence against women (VAW); "is a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of women's full advancement" (United Nations, 1996, p. 75). Within this definition other harmful acts are included, such as early marriage, honor crimes and deprivation from inheritance rights. Thus the terms GBV and VAW are terms used interchangeably

Family and intimate partner violence is that usually, though not always, taking place inside the home. It is defined as any behavior within an intimate relationship that causes physical, psychological or sexual harm. Such behaviors include:

- Acts of physical aggression—such as slapping, hitting, kicking and beating.
- Psychological abuse—such as intimidation, constant belittling and humiliating.
- Forced intercourse and other forms of sexual coercion.
- Various controlling behaviors—such as isolating a person from their family and friends, monitoring their movement and restricting their access to information or assistance.

Sexual violence: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances... using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. Sexual violence includes rape, defined as physically forced or otherwise coerced penetration of the vulva or anus, using a penis or other body parts or an object. Sexual violence can include other forms of assault involving a sexual organ, including

coerced contact between the mouth and penis, vulva or anus.

Community violence occurs in institutional settings such as schools, workplaces, prisons and nursing homes.

Abuse is a term that generally refers to a pattern of behavior. A one-time incident may not constitute abuse, but incidents occurring on a regular basis could be considered abuse. Intermittent and unpredictable incidents can also be considered abuse, because the woman lives in constant fear of what may happen.

Women's abuse is the intentional and systematic use of tactics to establish and maintain power and control over the thoughts, beliefs, and conduct of a woman through the inducement of fear and/or dependency.

Violence victim: refers to battered woman, who are being abused by their intimate partners.

Consent: Consent means saying "yes," agreeing to something. Informed consent means making an informed choice freely and voluntarily by persons in an equal power relationship. Acts of gender-based violence occur without informed consent.

1.2 Contributing factors to GBV including political, cultural and social issues

Palestinian women in the oPt have lived all or most of their lives under Israeli occupation and have been facing a triple challenge to establishing their rights: as Palestinians living under Israeli military occupation which controls every aspect of their lives, as women living in a society governed by patriarchal customs, and as unequal members of society subject to discriminatory laws.

The title "Occupied" Palestinian territory reflect the meaning of discrimination by itself. Being occupied by Israel means violation of the Palestinian people's sanctity, and trampling the dignity of individuals and groups – males and females. According to Amnesty International (2005), the basic and fundamental human rights of Palestinian people have been violated by Israel and the basic protection promised to Palestinian civilians under the Geneva conventions has also been denied. Under the Geneva conventions, Israel as the occupying power, has the obligation to ensure protection of Palestinians living under the occupation. However, it has ignored these obligations and instead, continues to commit grave breaches of the conventions.

Living under decades of Israeli occupation has dramatically curtailed

developmental opportunities for the Palestinian population in general and has increased violence and discrimination against Palestinian women in particular (Amnesty International 2005). The political conditions imposed by the Israeli military occupation coupled with the subjective shortcomings of the Palestinian Authority itself, have hampered the development of effective formal structures that can impose the rule of law and order and allow for an efficient operation of the judicial system (Human Right Watch, 2006).

The Palestinian population is subjected to two legal structures; the formal legal framework and the informal societal and traditional culture. The laws in force in the West Bank and Gaza strip today are a combination of unified laws that the Palestinian Legislative Council (PLC) promulgated since 1996 and the president ratified, and the existing Jordanian and Egyptian laws that continue to be in force in the West Bank and Gaza Strip, respectively. In addition there is no clear-cut separation between the executive and judicial powers; besides it lacks adequate and well-trained personnel (Human Rights Watch, 2006). Up to date, the legislation of laws is still incomplete, the drafts of a unified Palestinian penal code and a unified family law have been widely debated in civil society circles on a number of provisions that maintain and perpetuate Palestinian women's unequal status (Human Rights Watch, 2006). The provisions of the applied family law and penal code relevant to the issue of women's killing do not guarantee gender equality and in comparison to men, women's human rights are not legally protected. To the contrary, women are disadvantaged and discriminated against by both effective laws (Human Rights Watch, 2006, Amnesty International, 2005).

Given all these circumstances and coupled with the existence of internal conflict among political groups, the informal legal framework including the traditional and tribal structures have been enhanced to gain greater authority in Palestinian society, thus strengthening the existing gender inequality and pressures on women to conform with certain interpretations of traditional or religious norms in order to preserve the family honor (Shalhoub-Kervorkian 2004, Human Rights Watch Report, 2006). These structures are the primary contributors to the regulation of the social behaviors, roles, responsibilities and relations of the members of the society in general. By placing women in a subordinate position in relation to men, they reflect the root causes of gender discrimination and gender-based violence.

For discussion:

- "Violence against women in the Occupied Palestinian Territories (oPt) is widespread and chronic, yet it remains under the radar. Women find it difficult to report abuses because there is little or no legal framework in place to protect them, and because the "honor" of their families is considered more important than the crimes committed against them" (Palestine Monitor, 2 August 2007).
- According to Human Rights Watch (HRW) "Palestinian women and girls who report abuse to the authorities find themselves confronting a system that prioritizes the reputations of their families in the community over their own well-being and lives." (Palestine Monitor, 2 August 2007).
- According to our staff, and through clinical observation, there was increased violence against women and children during and after the war on Gaza (winter 2008-2009). "We can attribute this to the fact that most people were exposed to traumatic incidents during the war, and one way people react to stress is to become violent." said public relations coordinator for the Gaza Community Mental Health Program (GCMHP), Husam al-Nounou. (Palestine: UN tracks rising violence against women in Gaza, 2009).

1.3 Human Rights

This section includes; the UN human rights, introduction to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the UN Security Council resolution 1325 (SCR 1325) set to strengthen women in armed conflict situations in order to follow for the protection of the Palestinian women.

- Human rights are universal, inalienable, indivisible, interconnected and interdependent.
- Everyone is entitled to all the rights and freedoms, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
- Prevention of and response to gender-based violence is directly linked to the protection of human rights.
- Acts of gender-based violence violate a number of human rights principles enshrined in international human rights instruments. These include, amongst others:
    - the right to life, liberty and security of person,

- the right to the highest attainable standard of physical and mental health
- the right to freedom from torture or cruel, inhuman, or degrading treatment or punishment
- the right to freedom of opinion and expression, to education, to social security and to personal development.

1.3.1 The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, is often described as an international bill of rights for women. Consisting of a preamble and 30 articles, it defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination.

The Convention defines discrimination against women as "...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

By accepting the Convention, States commit themselves to undertake a series of measures to end discrimination against women in all forms, including:

- to incorporate the principle of equality of men and women in their legal system, abolish all discriminatory laws and adopt appropriate ones prohibiting discrimination against women;
- to establish tribunals and other public institutions to ensure the effective protection of women against discrimination; and
- To ensure elimination of all acts of discrimination against women by persons, organizations or enterprises.

The Convention provides the basis for realizing equality between women and men through ensuring women's equal access to, and equal opportunities in, political and public life -- including the right to vote and to stand for election -- as well as education, health and employment. States parties agree to take all appropriate measures, including legislation and temporary special measures, so that women can enjoy all their human rights and fundamental freedoms.

The Convention is the only human rights treaty which affirms the repro-

ductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations. It affirms women's rights to acquire, change or retain their nationality and the nationality of their children. States parties also agree to take appropriate measures against all forms of trafficking in women and exploitation of women.

Countries that have ratified or acceded to the Convention are legally bound to put its provisions into practice. They are also committed to submit national reports, at least every four years, on measures they have taken to comply with their treaty obligations.

1.3.2 UN Security Council resolution 1325 (SCR 1325)

The first resolution on women, peace and security, Security Council Resolution 1325 (SCR 1325), was unanimously adopted by United Nations Security Council on 31 October 2000. SCR 1325 marked the first time the Security Council addressed the disproportionate and unique impact of armed conflict on women; recognized the under-valued and under-utilized contributions women make to conflict prevention, peacekeeping, conflict resolution and peace-building. It also stressed the importance of women's equal and full participation as active agents in peace and security.

SCR 1325 is binding upon all UN Member States. The adoption of the Resolution marked an important international political recognition that women and gender are relevant to international peace and security.

The Resolution seeks to increase women's participation in all efforts related to peace and security, and to strengthen the protection of women in armed conflicts. Palestine, although is not a member state, has been committed like all member states to develop a national action plan for implementing SCR 1325 within its acts and laws. As a result, the efforts of governmental and non-governmental organizations have been considerably strengthened, and awareness of the importance of women's roles in general and in conflict situations, and the value of their experience as well as the need for their empowerment has been set at the front of their agendas to improve women's status and gender equality at all spheres.

Key Provisions of SCR 1325

Increased participation and representation of women at all levels of decision-making.

- Attention to specific protection needs of women and girls in conflict.
- Gender perspective in post-conflict processes.
- Gender perspective in UN programming, reporting and in SC mis-

sions.

- Gender perspective & training in UN peace support operations.

1.4 The scope of the problem at global and national levels

1.4.1 at global level

- At least one in every three women around the world has been beaten, coerced into sex or otherwise abused in her lifetime—with the abuser usually someone known to her (see the report of the Secretary-General titled "In-depth study on all forms of violence against women 2008")
- Half of all women who die a violent death do so at the hands of somebody they were in an intimate relationship with.
- Interpersonal violence is one of the leading causes of death for women 15-44 years of age.
- Annually, 600,000 to 800,000 persons are trafficked across international borders.
- Approximately 80% of these are women and girls, and up to 50% are minors.
- Studies have revealed increasing links between violence against women and the spread of HIV/AIDS.
- 14.8% of all adult women in the USA said they had been a victim of a completed rape. An additional 2.8% said they had been the victim of attempted rape. (The National Institute of Justice and Centers for Disease Control and Prevention based on a telephone survey of 8,000 men and 8,000 women conducted between November 1995 and May 1996)
- More than 90 million African women and girls are victims of female circumcision or other forms of genital mutilation (L. Heise: 1994)

1.4.2 Palestinian Territories

There are numerous studies and statistical data done in the area of domestic violence in the oPt. According to a Palestinian Central Bureau of Statistics survey of 4,212 households in the oPt conducted in December 2005 and January 2006, only a small number of victims of violence sought any form of redress with Palestinian institutions. In addition, 23% of the women surveyed had experienced physical violence, 61.7% had experienced psychological violence, and 10.5% had experienced sexual violence at the hands of their husbands. (PCBS, Domestic Violence Survey, 2006).

The data provided by women's organizations and researchers dealing with issues of violence in the West Bank and Gaza indicated that they receive hundreds of cases in which unmarried women are victims of sexual, physical, and psychological violence.

Results of a survey on violence, conducted by the Women's Affairs Center in Gaza for the year 2001 showed that husbands are the primary source of violence in 97% of the cases with a definite correlation between violence and marriage to close relatives. The study showed that 16.5% of the women married to first cousins have been subjected to violence by different family members, compared to 12.9% for women married within the same clan (hamoulah), and 10.3% for those married from another clan (i.e., no relations).

Furthermore, the NGO Forum for Combating VAW – Al-Muntada reported that 12 women were killed in 2007 in the name of "honor killing", 10 women were subjected to attempted killing and 1 woman was threatened to be killed. In the same year, 7 women were raped, 2 women were sexually assaulted by a relative, and 39 women were exposed to physical and sexual harassment. The same report indicated that 5 women were kidnapped, 4 women were subjected to restrictions on their freedom, 8 women committed suicide and 17 attempted suicide. In the same year, the Palestinian Independent Commission for Citizens Rights (PICCR), with a mandate to ensure respect for citizens' rights in Palestine reported; 14 women were killed in the name of "honor killing" (8 in WB and 6 in GS), and 44 women were killed because of the internal political chaos (5 in WB and 39 in GS). The Palestinian Minister of Women's Affairs in a press conference pointed to the discrepancy in the data about violent crimes against women as either not reported to police or not documented (Ziad, PICCR, 2007).

The Palestinian Working Women Society for Development (2008) compiled statistical data on violence against women and children in 4 districts of the West Bank indicated that 120 women and 14 children sought help from this society and complained of all kinds of domestic violence; 40 women complained of psychological violence, 33 women complained of physical violence, 3 women complained of political violence, 8 women complained of social violence, and 21 women complained of rape, including 10 women complaining of rape and sexual harassment within their families.

SAWA – All the Women Together Today and Tomorrow, a local non-governmental organization working on domestic violence, indicated in 2008 there has been a progressive increase in the number of women

subjected to sexual and physical violence seeking support and help through their help line. The number increased from 332 calls in 2000 to 1340 calls in 2007, while 636 calls were made from Jan. - Sept. 2008, reflecting an increase in the occurrence of domestic violence as well as increasing awareness among women of the need to seek help toward this matter.

1.5 Categories (forms) of women abuse

1. Physical: The intentional use of physical force with the potential of causing harm, injury, disability or death. It can include a range of threatened or actual behaviors from slapping and hitting to using a gun.
2. Emotional/psychological: The use of coercion, threats, put-downs, insults, and other verbal or nonverbal measures which control another person and result in the loss of self esteem as well as victims believing they deserve the abuse.
3. Sexual: An act of using various aggressive actions for the purpose of sexual abuse and causing harm. Sexual violence is done through sexual harassment, rape, husband's refusal to use contraceptives during sexual intercourse with his wife, using physical force to compel the wife to have sexual intercourse, threatening to use sharp tools and beating to force her to have sexual intercourse, and using violent and harmful means. (PCBS, 2005)
4. Economic abuse, such as using a woman's own money without her permission or undermining her ability to become financially independent.

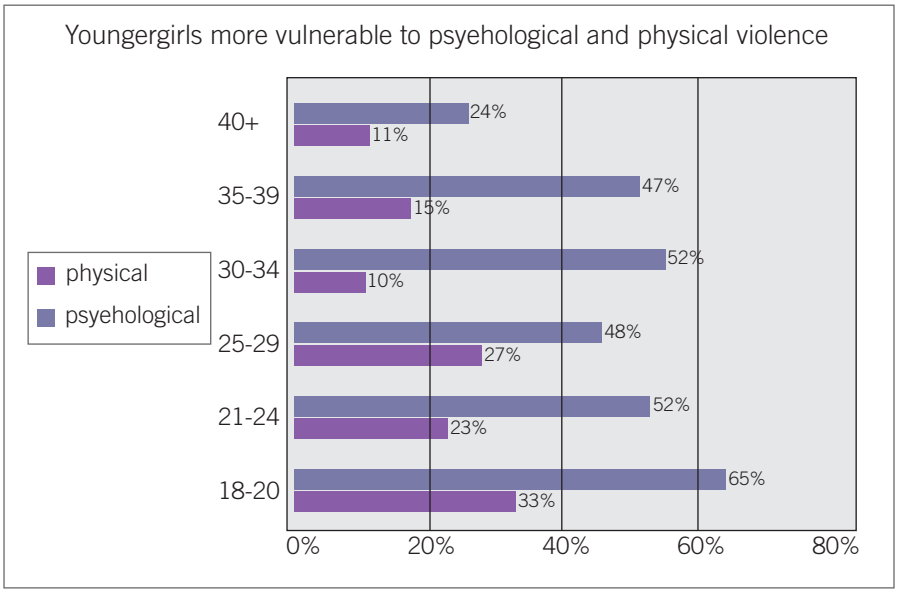
The PCBS survey (2006) on family violence touched upon two categories of family violence experienced by women, namely:

- Psychological violence, measured by instances of cursing, shouting, insults or destroying property; and
- Physical violence, measured through a variety of indicators, ranging in scope and severity, and including but not limited to; throwing dangerous objects, attacks resulting in physical harm, blows to the head resulting in fainting or coma, strangulation or attempt at strangulation, burning, and denying freedom of movement.

Incidences of sexual violence were ignored by the survey, because of the sensitivity of the subject matter and the difficulty in obtaining such information.

It is important to note that women from different age groups (18-40+

years old) have reported being exposed to continuous levels of psychological and physical violence over their lifespan as shown in the following chart:



1.6 Consequences of violence (Impact):

The consequences for victims can be devastating, both for primary victims and secondary victims such as child witnesses. Women who experience violence suffer from a range of health problems and their ability to earn a living and to participate in public life is diminished. Their children are significantly more at risk of health problems, poor school performance and behavioral disturbances.

The experience of physical, sexual and psychological violence can lead to a range of negative and harmful effects on women's health and mental well being:

- Psychological: anxiety, fear, guilt, shame, grief, depression, sadness, low motivation, low confidence, isolation, worry, anger, repetitive nightmares, disturbed eating patterns and psychosomatic symptoms such as headaches, stomachaches, decreased self-esteem, substance dependency, self-ham and suicide.
- Social: stigma, rejection, further exploitation, punishment and isolation
- Physical: chronic pain, pregnancy/abortion, vaginal tears, urinary tract infections, broken bones, bruises, bleeding, disfigurement, hearing and visual impairment, and organ dysfunction.

Across many countries, some common themes emerge when women are victims:

- Domestic violence and sexual assault (including sexual assault of children) are significantly underreported to the criminal justice systems (and other systems such as health and child welfare).
- When cases are reported to the justice system, victims are not always treated with gender sensitivity, including in their access to legal aid and health care;
- Perpetrators of gender-based violence are often not reported to the authorities.

Cultural/societal attitudes, beliefs and myths

- Violence against women is not an inevitable or natural act, but rather an expression of certain values and standards related to a specific behavior and culture, which requires great efforts to fight against it and to work towards changing it.

Community responses towards VAW

- Fear, blaming the victim, feeling that it is a "private" problem, happens to others, happens only to women, sexual violence is the result of uncontrolled sexual desire, "boys being boys", a reasonable way to keep wives under control .

Discussion of the following societal attitudes:

- "Women and girls revealed that their feelings of insecurity are related to the society's implied acceptance of violence against women." March 2010 report by the Geneva Centre for the Democratic Control of Armed Forces (DCAF).
- "Women and girls explained that they were reluctant to resort to women's organizations, human rights organizations, or security and justice providers, such as the police and courts, because of the strong social stigma attached to reporting abuse." March 2010 report by the Geneva Centre for the Democratic Control of Armed Forces (DCAF).

1.7 Patterns of Violence

- Isolation: for example locking the telephone, being offensive to her friends so that they leave, etc.
- Distorted Perspective: for example self-reproach like "I'm worthless", excuses like "his jealousy is a way of showing love," etc.

- Disability / Exhaustion: for example checking on her at home by telephone, not letting her sleep, etc.
- Degradation: for example verbal abuse and repetition of statements like "You're no good."
- Enforcing Trivial Demands: for example insisting that the towels are folded in a particular way, the soles of the shoes are cleaned, etc.
- Threats: for example destroying things, threats like "I'll find you wherever you go," etc.
- Exercise of Total Control: for example barring access to a joint bank account, making her ask for money, forbidding her to do certain things, etc.
- Occasional Indulgences: for example unexpected gifts, surprise family outings, etc.

(Source: WAVE Manual for Training and Resource Pack, London 1991)

1.8 Considerations of Violence for various populations

1.8.1 Pregnant women

Lack of control over reproductive decision making, a higher likelihood of engaging in unprotected intercourse, sexually transmitted infections and HIV/AIDS infection, pain on intercourse, vaginal bleeding or infection, decreased sexual desire, genital irritation, unplanned/unwanted pregnancy (forced sex, lack of reproductive control), threat to maternal and (or) fetal health and risk of death of the mother, fetus or both from trauma complications of pregnancy and childbirth may lead to the following consequences on pregnant women

Effects of violence during pregnancy

Maternal	Pregnancy	Fetal
Delayed prenatal care Insufficient weight gain Maternal infections (vaginal, cervical, kidney, uterine) Exacerbation of chronic illness Maternal stress Maternal depression	Abdominal trauma Miscarriage Ante-partum hemorrhage Premature rupture of membranes Premature labor and birth Abruptio placenta Complications during labor	Low birth weight Fetal injury Fetal death

1.8.2 Children who witness family violence

There is a significant correlation between intimate partner abuse and abuse of children. Children's responses to witnessing adult domestic violence vary considerably depending on the child's age, gender, level of violence in the home, degree of the child's exposure, whether or not they are abused, and the presence of other risk and protective factors. Some children have such resilience that they are able to cope with the chaos of a violent home in constructive ways. While children are affected by violence in their lives, not all experience long-term negative consequences.

Studies of children who witness domestic abuse have shown that the experience can have long lasting emotional, behavioral, cognitive, spiritual, and physical effects. Children in violent homes may experience harmful circumstances:

- Observing a parent being abused, which some have suggested may be as harmful as being abused themselves;
- Being abused themselves and being neglected. It is often assumed the abuse in these circumstances is perpetrated by the abuser of the parent. However, sometimes the victimized parent is the one who abuses the child.

1.8.3 Adolescents

Adolescence is a time when independence, autonomy, sexual identity, and intimacy are attitudes and skills to be mastered at this stage of development, all of which can be disrupted by an abusive relationship. Adolescents whose major social goal is to "fit in," are often very reluctant to reveal abuse when it occurs. Some may not even know that they are being abused. Denial is often the only coping mechanism in their repertoire. While they attempt to suppress the cognitive recollection of the abuse, it becomes manifested in their actions. At least 10% will attempt suicide after the abuse (Pharris & Nafstad, 2002). A nurse who develops rapport with adolescents and specifically asks about victimization will be able to guide the teen toward healing.

A more effective way of dealing with adolescents' violence is to prevent it. Nurses must look for opportunities to teach adolescents to differentiate between respectful and violent behavior, several good resources exist for teaching them about sexual abuse, healthy dating relationships, and teen dating violence

1.8.4 People with disabilities

People with disabilities have more frequent contacts with health care professionals. It is important not to make any assumptions about people

with disabilities and the nature of their relationships with others.

The greater the degree of dependence on others, the greater the likelihood of abuse and exploitation of people with disabilities is experienced (Pharris, 1999). Surveys and studies of women with disabilities in many areas of the world found that women with disabilities were more likely to experience abuse by health care professionals and personal assistants, family members, intimate partners, or friends. Children and elders with disabilities are also more likely to be abused by people responsible for their care.

Factors to consider regarding the abuse of people with disabilities include:

- Leaving abusive relationships may be more difficult because of the presence of a disability.
- The traumatic stress of the abuse often compounds the sense of vulnerability that some people with disabilities feel. Coming to terms with this can be intense and further disabling.
- People who have just gained some independence may be at risk for losing their newly gained independence and self-confidence.
- Prosecuting a legal case may depend on proving the extent of the disability, in which case the person may become further stigmatized by the system in the process.

1.8.5 Caregiver stress related to violence

Caregiver stress is commonly used to explain why a person is abused by a family member on whom they are dependent for care.

Three problems with naming this dynamic caregiver stress include:

- it absolves the abusive party of responsibility for their abusive behavior;
- it suggests that if the victim were not dependent on the caregiver, there would be no stress or abuse, thus blaming the victim for the situation; and
- It prevents appropriate interventions from taking place (e.g. making a mandatory report to protective services, safety planning, offering information about power and control, and resource options) (Practice Guidelines Education and Training Committee, 1998).

Module two
Theories and dynamics of violence

Objectives: At the end of the module participants will be able to:

1. Understand theories of violence.
2. Discuss terms survivors, victims and perpetrators.
3. Understand the dynamics of violence within relationships (myths and facts).
4. Analyze power and control cycle.
5. Demonstrate understanding of change process.
6. Identify the effect of domestic violence on health.

Teaching and learning Activities

- Power and control discussion: Introduce the concept of the power and control wheel. Define and/or give an example of one of the quadrants (e.g. the economic abuse section). Then ask the students to give examples of economic abuse (e.g. "can you think of examples of economic abuse in a power and control situation?"). Continue group discussion on other quadrants of the wheel.
- Quiz: Have you ever...: A series of questions designed to increase student awareness of abuse dynamics (Appendix B).
- Case study (اعتقلت ودفعت ثمن اعتقالي): Ask students in groups to read through the case and then identify economic, emotional, physical, and sexual abuse. Then ask them to identify the abusers in each incident (Appendix C).
- Medical power and control discussion: Ask the students to give examples of violating confidentiality if they witness that in their previous clinical experience. Continue group discussion on other quadrants of the wheel.

Estimated time- 6 hours
Content

2.1 Domestic Violence Theories

All of these theories have some truth or meaning to many people. The theory you believe will shape how you respond to violence. However, theories and academic studies on the cause of violence can easily distract from the real purpose of violence: It works! In the short term, violence is the most effective tactic to get your way.

Pathology;
Men's violence is seen as a symptom of biology, deviant personality types, abusive family of origin, alcoholism or drug addiction. Psychopathology sees violence as a symptom of mental illness. Clinical categories are diagnosed using a medical model. Intervention may include medication or psychiatric treatment.

Psychodynamic concepts;
In this perspective, violence is considered as a symptom of an underlying psychological disorder. Poor impulse control and rage attacks resulting from childhood trauma or family inadequacies are other reasons. In-depth diagnosis and long term therapy are considered the most appropriate way to heal the sickness.

Family systems approaches;
This theory explains violence as a symptom of a dysfunctional relationship. The violence is addressed by creating healthier interaction between the parties. A skill training of both parties is a key intervention.

Cycle of abuse theory:
Violence is seen as being expressive of "impulsive forces from within." This is explained as an instinctive or genetically inherited trait, sometimes seen as stronger in males. The cycle is described in three phases: tension building, acute battering incident (explosion), and honeymoon. While individuals in abusive relationships may relate to some or all of the elements of this cycle, many survivors experience only parts. Identifying and anger management skill building, for example "time-out," is seen as the most effective response to manage tension and to break the cycle.

Social structure theory:
This theory sees violence as more prevalent in "lower socio-economic groups" as a symptom of frustration over limited life opportunities, lack of education and skills. Violence can therefore be addressed by policies that address poverty, inequality and unemployment.

Violence as learned behavior:
This means if nonviolent behaviors have not been modeled or taught, and violence has been reinforced (especially in the family of origin), then an individual uses violence to get what they want. Anger management aims to relax and reduce stress, identify emotions and think about them differently and develop interpersonal communication skills that stop the violence.

Violence as a consequence of the social system:
This theory sees men's violence as a result of patriarchal norms of the

societies in most countries. Men are violent to women as a result of shared beliefs about their superiority over women and their innate right to dominate. Sex role stereotypes and cultural traditions that devalue women are all parts of the culture. Exploring shared belief systems and hierarchical social systems is a step towards building relationships based on equality. The Domestic Violence Centre believes that men's violence against women is best explained by this theory.

2.2 Survivors, victims and perpetrators

"Survivor" is the preferred term for a person who has lived through an incidence of gender based violence. It is useful to visually demonstrate with your body language what a "victim" looks like and what a "survivor" looks like:

- The word "victim" conjures an image of someone who is weak, sick, small, hunched over, crying, and clothed in rags, unable to function in the world. It is a sad, disempowering word.
- The word "survivor" conjures an image of someone who stands straight and tall, uses eye contact, walks with confidence, lives life to the fullest. It is a powerful, empowering word.

Survivors/victims can include:

- Women because they are usually second class, culturally considered inferior
- Unaccompanied females, without male protection
- Single women, female headed households
- Females and males with intellectual and/or physical disabilities
- Economically disempowered people
- Male and female junior staff, students, less privileged community members
- Minority groups; e.g., ethnic, religious
- Children, especially fostered children.

A perpetrator; is a person, group, or institution that inflicts, supports, or condones violence or other abuses against a person or a group of persons. Characteristics of perpetrators are:

- Persons with real or perceived power
- Persons in decision making positions
- Persons in authority.

Categories or groups of people who are potential perpetrators:

- Intimate partners (husbands, boyfriends)
- Influential community members (teachers, leaders, politicians)
- Security forces, soldiers, peacekeepers in armed conflict situations
- Humanitarian aid workers (international, national, refugee staff)
- Strangers
- Members of the community
- Relatives (brothers, uncles, parents, aunts, sisters, etc.)
- Anyone who is in a position of power.

For any incident of GBV, there is a survivor and a perpetrator. Therefore, all our actions in prevention and response need to address both the survivor and the perpetrator.

2.3 Dynamics of violence

The ability to provide supportive care is dependent upon understanding the factors influencing individuals in abusive relationships from a cultural/societal attitudes, beliefs, and myths.

2.3.1 Survivor myths and facts

There is a great deal of misinformation and many false assumptions about individuals in abusive situations and abuses. Health care professionals who understand the error of these myths are better equipped to provide care, support, and resources to individuals who indicate they are experiencing abuse.

Myth	Fact
1. Love and violence cannot exist together in a relationship.	Many abusers act in loving, caring ways some of the time. Many survivors love the abuser and just want the battering to stop. However, over time, the loving periods lessen, change or fade as physical damage, learned helplessness and post traumatic stress disorder develop.
2. Abusers and survivors are crazy, lower-class, uneducated people with few social or job skills and no religious belief. It could never happen to anyone you know.	Lack of education or wealth, or social background does not make battered people. Perpetrators and survivors come from every walk of life. Many doctors, ministers, psychologists, police, attorneys, judges and other professionals are abusers.

3. Women would not get beaten if they did not nag. Men are forced to be violent because women do not behave properly.	Battering is an individual issue. Many men who batter have acted that way with several women (sisters, wife, daughters..). Men in poor relationships have a choice not to batter. Battering is not about how women do or do not behave, it is about poor choices involving power and control on the part of the abuser.
4. Once a batterer, always a batterer.	Some men do stop their violent behavior after therapy. Men have more success at stopping physical violence than they do at stopping verbal and emotional violence. It is estimated that it will take between three and five years of weekly therapy for a man to make a significant, lasting change in all aspects of his violent behavior.
5. "I just lost it.»	Batterers often say they could not stop themselves from using violence. Most batterers use other methods of dealing with frustration, anger, or «provocation» when it is convenient for them to do so. Angry batterers do not beat up the boss, secretary, neighbor, or a stranger on the street.
6. Stress causes violence.	Neither stress nor drugs nor heredity cause domestic violence. Domestic violence is «caused» by a person choosing to use violence. That person has learned from the culture and interpersonal relations to use violence and that violent behavior is legitimate, necessary and appropriate at that moment in time. Like drug and alcohol abuse, many people use stress as an excuse to be violent. Many people who experience stress do not use violence.
7. People who batter must be sick.	Battering is a learned behavior, not a mental illness. The perpetrator›s experience as a child and messages received from society contribute to a batterer›s perception that violence is an effective and appropriate way to achieve power and control over a partner›s behavior. Anyone who batters is accountable for any actions.

Many believe that only 'sick', 'evil' people are abusive. On the contrary, abusers usually lead 'normal' lives in most respects except they believe they are entitled to use violence and abuse to control the lives of their partners and families. Abusers come from every walk of life, every

culture, and every socioeconomic level. They do not recognize their behavior as being violence. Often, these unacceptable behaviors are not challenged by society

The primary treatment objective for abusers is for the abuser to take responsibility for the abusive behavior and to be held accountable through a variety of measures such as legal consequences and reeducation programs.

According to the standards set by CEDAW and Security Council Resolution 1325, the Palestinian governmental and non-governmental organizations are working to have an effective GBV prevention and response, utilizing the UN treaties as framework for their moves toward reducing GBV. They adopted the multi-sectoral approach seeking to have effective violence awareness, and advocacy for policies and strategies to combat violence (will be mentioned in next section).

2.3.2 Power and control vs. equality cycle

Power and control

Domestic violence is much more than simply physical violence. Emotional and psychological abuse is present in all family violence situations. Many survivors of emotional abuse describe it as being more difficult to name, access support for, and ultimately overcome than physical abuse.

There is various Power and Control Wheels that describe the dynamics of violence (see Power and Control Wheels). The behaviors, which form the spokes within the wheel depend on and reinforce each other. Sexual and physical violence, forming the outer rim, reinforce the entire system of control. Physical and sexual violence are not always present in abusive relationships; however, emotional abuse is always present. The wheels illustrate the interdependent and systematic nature of violence in relationships.

Economic abuse prevents victims/survivors from gaining financial freedom, which could help them escape the violence. Isolation destroys the support system of relatives and friends who might be able to provide information, support and resources. Threats instill fear. The interweaving of these dynamics builds barriers that prevent escape from an abusive relationship.

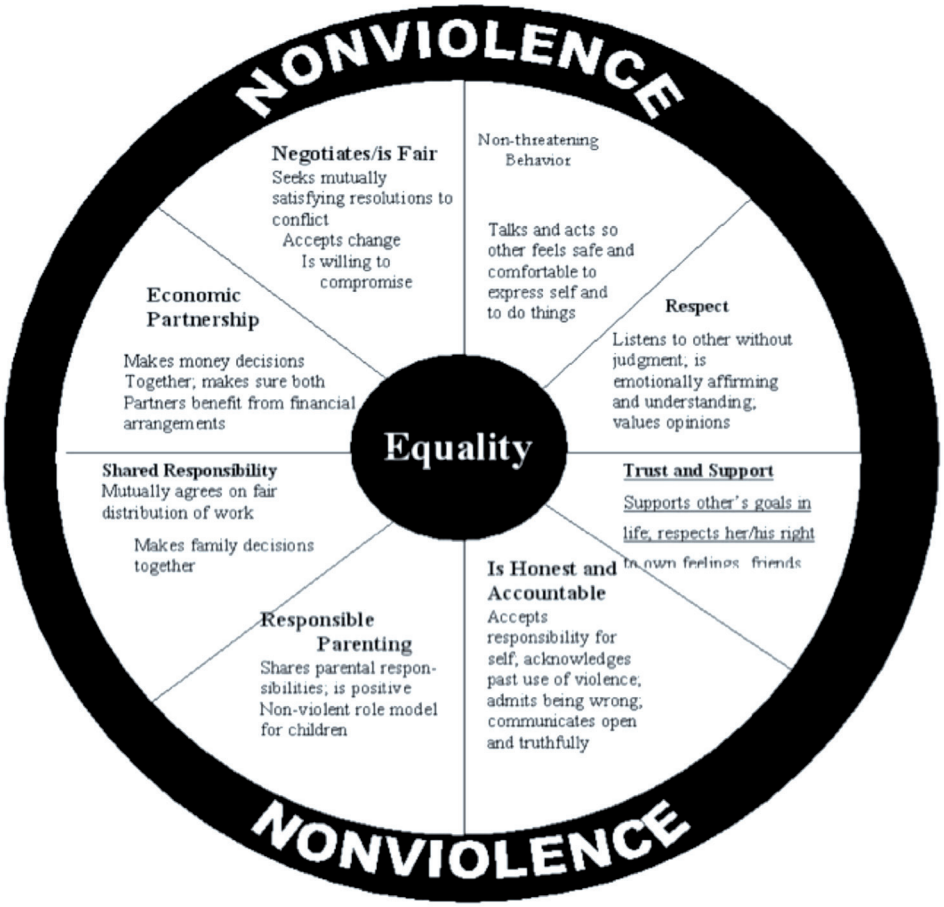
Duluth Power and Control Wheel

Equality Wheel

Wheels have also been developed to illustrate how to achieve relational health.

Healthy relationships are based on the belief that two people in a relationship are partners with equal rights to have their needs met, and equal responsibility for the success of the relationship. The dignity of both partners is strengthened in a relationship that is based on equality, as shown in the Equality Wheel below.

Source: Domestic Abuse Intervention Project, Duluth, Minnesota.



2.4 Understanding the process of change

It is very important that health care professionals recognize that their role is not to prescribe, decide, or judge what women should do, but rather to partner with the patient to provide information and resources for informed decisions. In perhaps no other health care situation is respect for patient self-determination as critical.

When working with people in abusive relationships, there is a temptation to jump to a "you've got to get out!" approach. This judgmental stand deprives patients of the right to their own choices and creates a barrier between the health care professional and patient that may never overcome this relationship.

Key elements of health care professionals' partnership include the following caring actions:

- Talking with the victim/survivor in private
- Accepting patient choices in a nonjudgmental manner

- Expressing concern for safety
- Making supportive statements (e.g. “you don’t deserve this,” “I’m sorry this happened to you,” etc.)
- Offering assistance when the women are ready.

Actions which could be harmful include

- Telling people what to do
- Blaming the victim
- Violating confidentiality
- Talking to the abuser about the abuse.

2.5 Trans-theoretical model of behavior change

The Stages of Change Model assumes that changing behavior is a dynamic process and describes a progression through a continuum of predictable stages as individuals try to modify their behavior.

This model encourages practitioners to assess their patient’s readiness to implement changes in their lives and to tailor interventions to be of maximal help. The trans-theoretical model presents behavior change stages: pre-contemplation, contemplation, preparation, action, and maintenance.

1. Pre-contemplative - unaware

   The woman is not aware of the problem and does not associate it with the abuser.

2. Contemplative - thinking about it

   The woman identifies abuser motivation and behavior, but cannot decide how best to react.

3. Preparation - doing homework

   the woman starts learning about violent behavior, deciding what works for her and developing some skills.

4. Action - making it happens

   The woman is looking for situations to develop her new skills and behaviors to deal with the problem and looking to improve her situation.

5. Maintenance - focus on success

   The woman focuses on her new situation and maintains confidence in herself.

Module Three
Screening, Assessment and Documentation

Objectives: At the end of the module participants will be able to:

1. Diagnose battered women (screen, assess & interact).
2. Perform physical, psychological, and socioeconomic assessment and intervention.
3. Identify barriers to abuse assessment and intervention.
4. Document all findings related to VAW thoroughly.

Teaching and learning activities

- Discuss reasons why professionals may "fail to notice" abuse
- Listening skills exercise (Appendix D)
- Presenting 2-3 case examples to show signs of abuse (Appendix E)
- Role play: conducting patient screening and assessment (Appendix F)
- Practice in clinical settings

Estimated time: 4 hours
Content

3.1 Introduction to basic concepts of screening, assessment and interaction

Screening is the process you can use to determine whether a person is or may be involved in a violent relationship with an adult, husband or family member.

Assessment is the act of gathering information or data at a given moment of time and evaluating it for the purpose of making an appropriate decision about what course of action to take. Assessment uses the process of inquiry; is based on evaluation of data; and depends less on your own opinion. Assessment prevents assumptions; creates grounds for developing an appropriate plan of action; and helps identify survivors' strengths.

Diagnosis is based on a series of observed symptoms or data; and should be made only by trained professionals.

Interaction Techniques are ways to communicate to a battered women that you are actively listening to encourage them to share informa-

tion about their experience so that you may make a more informed assessment.

Remember that supportive and non judgmental attitudes by the health care professionals are important for women to disclose the abuse

Empathy vs. Sympathy

Sympathy is personal, emotional identification with a survivor's experience implying that the service provider feels sorry for the survivor. It is an emotional state that leaves the service provider vulnerable to over involvement and can take power away from the survivor.

Empathy implies intellectual/personal understanding from a realistic/professional distance. It involves compassion and objectivity and leaves room for empowerment of the survivor.

Active Listening Skills

Involve listening with understanding and with total attention. It means paying attention to all the different ways in which an abused woman expresses herself, including nonverbal behavior (posture, speed of speech, silences), the woman's voice (tone and quality), the woman's words, the meaning behind the words and what is not said. In order to be able to listen with total attention, you need to be relaxed when talking with an abused woman.

This means that you lay aside your own concerns and preoccupations while you are with the abused women, and create a space for them to reveal what is troubling them.

Try to relax physically; allow your manner to be natural; follow what the woman is saying and do not be afraid to ask clarifying questions; and let your verbal and nonverbal responses indicate to the woman that you are following what she is saying.

In working with abused women in crisis: be supportive; validate their believe,wokwiththeabusedwoman to help her become aware of her responses to her experience, especially in terms of her coping skills; take time to find out what she wants; and help her identify options rather than giving her advice.

3.2 How to prepare for Screening

Setting the stage

Consider opening the conversation, when time permits using a funneling technique. You can begin with a statement such as "So I can better understand and meet your needs, I'd like to ask you a few questions

about your background." Then ask a few broad, non-threatening questions such as:

- "How are things going at home, (or) in your family? (or) with your husband?"
- "How do you feel about the way differences are solved in your family/relationship?"

If there is an indication of potential family violence, follow with more direct questions. Because some patients may react negatively to the words "abuse" and "violence," naming a range of abusive behaviors and experiences may be more useful. For example:

- "Are you experiencing any stress or anger problems in your relationships?"
- "All people argue, how do you and your husband handle disagreements?"
- "Do your fights ever become physical?"

The preface statement
When introduced to the questions in this manner, the patient is more likely to view abuse screening as a reflection of your concern rather than feeling singled out.

- We at X hospital/clinic are concerned about the effect that difficult or harmful relationships have on the health of our patients, so we ask everyone the following confidential questions OR
- We recognize that many people experience events in their lives that affect their physical and mental health, such as difficult or harmful relationships.

Screening questions
- Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?
- Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?

3.2.1 Principles of Effective Screening

Phrase questions so as to invite disclosure and not convey judgment.

Asking a patient, "You are not being abused, are you?" is both leading and potentially stigmatizing and unlikely to elicit an honest response.

Ask questions specific enough so the patient understands exactly what is being asked. Many authors suggest asking; "are you safe?" yet this

question may be misinterpreted. (i.e. are you using safe sexual protection or do you have a burglar proof house). Questions as stated above are more appropriate.

When someone responds with a vague answer, follow up with a clarifying question. For example, if a patient responds to question #1 with: "well, not really..." one can respond with a clarifying question, such as, "you sound uncertain about that, would you tell me more about what you mean by not really."

Many victims who acknowledge abuse for the first time may be suddenly placed in a position they have never been in before: that of making a decision to share something very personal for the first time in their lives.

Supportive Response during screening: General Suggestions

- Be accepting, nonjudgmental and supportive of their decisions
- Listen thoughtfully; believe the victim/survivor's story.
- Use clear, direct communication.
- "Help is confidential, free, and all choices are yours."

DO NOT

- Tell the victim/survivor what to do or that you know how he or she feels
- Confront or criticize the abuser.
- Be hurt if the abused person reacts in anger.
- Assume a counselor role. Leave that to the experts.
- Remain silent. It may feel like rejection or judgment.

Victims of Violence: Health Care Providers Needs Assessment and Intervention

Developed by Marlene Jezierski, R.N., B.A.N. and modified to suit the Palestinian society by Asma Imam

Domain	Assessment	Education/Intervention	Community Agencies
Physical	Brief head to toe assessment	Appropriate Medical care and follow-up	Primary and secondary health facilities
Nutritional habits	Healthy dietary practices Basic food groups Food Availability	Referral to social affairs services	Ministry of Social Affairs and NGOs
Sleep patterns	Impact of sleep deprivation	Referral to counseling services	Psychologist
Chemical dependency/ use	Encourage access to counseling/support groups	Referrals to counselors, Appropriate NGOs, Supporting rehabilitation	Counselors, Appropriate NGOs
Sexual assault	Assess for immediate physical needs	Referral to sexual assault advocates	
Psychological-Socio-cultural	Self esteem	Affirm: You don›t deserve it/ You didn›t cause it	Battered Women›s Resources
Coping skills/needs	Need to take care of self Relaxation techniques Pursue things she enjoys	Encourage participation to community Women›s activities, groups	Women related NGOs
Support system (family, friends)	Emphasize need to access Provide opportunity to call Help identify support sources	Discuss and teach stress management technique Referral to battered women's Resources	Battered women›s Resources
Depression	Offer support Validate: it is part of the abuse cycle Evaluate severity: candidate for PTSD? (post-traumatic stress disorder)	Referral to counseling, psychotherapy	Counselors, Appropriate NGOs
Educational	Understanding / perception of abuse	Definitions/characteristics: what constitutes abuse, escalating characteristics	Battered women›s resources
Financial	Is there need for money? (transportation, food, medical care, basic needs)	Referral to social affairs services	Social services within the institution Ministry of Social Affairs and NGOs Battered Women's Resources
Legal	Facilitate contact of law enforcement Advise of resources available	Battered women›s advocates Law enforcement	Battered Women›s Resources Institutions working with battered women Institutions inventory guide
Safety		Discuss safety plan: Self defense Emergency numbers Self protection during abuse *curl into ball, hold head, scream loudly	Institutions working with battered women. Institutions inventory guide Women's shelter and advocates

Signs that you need to look for during "abused women" assessment: There are a variety of ways in which battered women may present to the health care setting and a variety of reasons for which they may seek care.

Physical Symptoms: Bruises, contusions injuries (burns, cuts, bite marks, head wounds), missing teeth, fractures (ribs, nose, other bones), dislocations (particularly jaw and shoulder), hearing problems, genital problems, skull injury.

Psychosomatic Symptoms: symptoms of fear (heart palpitations, hyperventilation, trembling, sweating, dizziness, stomach pains, pains in the cardiac region, shortness of breath, insomnia), symptoms of powerlessness (weakness, depression, dejection, fatigue), symptoms of tension (headaches, sleeping disorders, stomach pains, menstrual disorders).

Psycho-social Symptoms: feelings of guilt, shame, watchfulness, lack of concentration, negative self-image, social isolation, relational problems, problems with sexuality, suppressed emotions, conflicting emotions.

Behavioral Symptoms: numb and / or submissive behavior, apparent nervousness, frequent cancelling or missing of appointments, staying close to the husband at all times, use of phrases like: "my husband will ... / won't let me…"

Psychiatric Disorders: multiple personality disorder, suicidal tendencies (self-destructive behavior), dissociate symptoms, psychotic behavior.

3.3 Psychological assessment of victims

GATHER Model

Greet: establish rapport; clarify goals of meeting; explain confidentiality

Ask: ask client for a brief explanation of how you may assist her, i.e., why she is seeking assistance. Ask specific questions about exposure to violence.

Tell: If survivor acknowledges experiences of violence, offer validation and support. Reassure her that you will try to assist her.

Help: Once basic rapport has been established and you have identified the basic concerns of the survivor, it is important to conduct a more thorough assessment so that you better understand her experience of GBV and identify her related needs.

Educate: Reflect back to survivor what you have understood are her needs and what you have heard is possible stress reaction. Provide information to survivor that will help normalize her reactions.

Refer / Return / Review: Be prepared with list of referrals that may assist survivor. Schedule follow-up if possible and review plan with survivor.

3.4 Barriers to abuse assessment and intervention

Health care related barriers

- It isn't my job attitude
- I don't know how to ask, I don't know what to say and how to respond if they say yes
- Fear that the patient will become angry
- It doesn't really happen that much... It isn't that likely
- I don't have the time (It takes 30 seconds to say the preface statement and two recommended screening questions. It takes another 30 seconds to make affirming statements and offer resources or call an advocate.)

Battered woman related barriers

- Reluctance to disclose unless asked directly
- Fear of the abuser
- Feeling of shame
- Perception of the professional as hurried or not really wanting to hear about the abuse

System related barriers

- Non-supportive workplace
- Lack of specific institutional policies
- Lack of privacy

Module Four

Overview of healthcare team responsibilities

Objectives: At the end of the module students will be able to:

1. Identify health-related responsibilities.
2. Identify psychosocial responsibilities.
3. Apply both health and psychosocial responsibilities.
4. Understand and complement other healthcare team members roles.

Teaching and learning Methods

- Group discussion: divide students into groups and ask each group to discuss one healthcare professional's roles. Then each group will present their findings in front of the class and further discuss the roles and their complementarities to other roles.
- Have students assess clinical settings for adherence of healthcare professionals to their roles as they relate to screening, assessment, treatment, and referral.

Estimated time: 3 hours
Content:

4.1 Allocated responsibilities of health care professionals

A comprehensive strategy of service development and prevention of VAW requires the coordinated response of all health care team at primary (including community health workers), secondary and tertiary levels.

Related	Responsibilities	Healthcare team
Health	Actively screen clients (Identification, assessment & initial response)	Nurses and physicians
	Respond to immediate health and psychological needs (intervention & treatment)	Nurses and physicians
	Collect forensic evidence	Nurses and physicians
	Collect forensic evidence, examine thoroughly and provide expert testimony	Forensic medicine specialists
	Offer referrals and follow up	Physicians and nurses
	Confidentially collect, document, and analyze health data	All healthcare team
	Identifying "high risk" women in the community	Community health workers, nurses in primary health clinics
	Health teaching and raising awareness of battered women	All healthcare team
Psychosocial	Provide supportive and ongoing basic psychological assistance*	All healthcare team
	Confidentially collect, document, and analyze client data	All healthcare team
	Offer referrals and follow up	Physicians and nurses
	Carry out community education and outreach programs	Nurses and community health workers
	Intervene in order to ensure the safety of the patient	In charge person & according to the institution policies
	Development of a safety plan	All healthcare team
	Advocating for public policy regarding VAW	All healthcare team
Legal & ethical	Show respect and recognition	All healthcare team
	Implement and comply with policies and protocols for the appropriate management of VAW	All healthcare team
	Apply ethical principles (confidentiality, beneficence, privacy, autonomy... etc.)	All healthcare team

**In addition to counselors &social workers*

Actively screen clients (Identification, assessment and initial response)

Screening:

- Initiate active screening for abuse among selected patient populations, e.g. in prenatal care clinics, casualty departments, mental health clinics, primary health clinics.
- Ask questions about abuse in a health history/assessment process.

Assessment: (medical support)

- Take a complete history.
- Perform detailed assessment of current and past violence (refer to module 3).
- Carry out gentle physical examination.

Initial response:

- Acknowledge the abuse.
- Treat all injuries.
- Validate the woman's experience.
- Assess immediate safety.
- Explore options.
- Refer to VAW services at the woman's request.
- Document the interaction.

Respond to immediate health and psychological needs

- Listen carefully.
- Reassure woman that the abuse is not her fault.
- Validate her feelings of shame, anger, fear and depression.
- Provide treatment as needed or refer to social worker or counselor.

Collect forensic evidence & provide expert testimony (Appendix G)

- Provide medical care to victims who had traumatic experiences while collecting forensic information that may serve as evidence in courts.
- Provide expert testimony in court about trauma or processes for investigating death as requested by law.

Offer referrals and follow-up

- Identify the key agencies in the community that serve abused women such as shelters, legal counsel, and personal psychological counseling (Institutions inventory List??).
- Provide information and telephone numbers for local resources and hotline
- Offer referrals to other specialized services and follow-up.
- Make appropriate referrals for victims of abuse and neglect.
- Ensure that a follow-up appointment is scheduled.

Confidentially collect, document, and analyze health data

- Interview in private, without woman husband or family members being present.
- Document consistently and legibly.
- Distinguish between your observations and battered women reports.
- Record information on the first, the worst, and the most recent abusive incident.
- If more than one person has abused the woman, distinguish between the abusers and the specific injuries or health effects of each incident.
- Indicate the frequency of abusive incidents, as well as any increase or decrease in frequency and seriousness.
- Avoid subjective statements and speculations that might undermine the woman's credibility.
- Use the woman's own words, in quotation marks, as frequently as possible.
- Use diagrams and/or photographs where possible to document physical injuries.

Identifying "high risk" women in the community

- Screen suspected high risk women (refer to module 3).
- Conduct risk assessment if woman disclose being abused (Appendix H).
- Provide information to women who are at risk

Health teaching and raising awareness of battered women

- Educate about abuse and its health effects.
- Help woman to understand that she is not alone.
- Attempt to engage woman in long-term continuity of care by offering appropriate referrals and follow-up.
- Inform woman about available community resources.
- Provide woman with brochures and other available information about woman abuse.
- Provide woman with information about the Abused Women's Help Line.

Carry out community education and outreach programs

- Conduct public discussions of violence via community events (International Women's Day, World Health Day, International Worker's Day…etc
- Prepare and distribute brochures and posters and present VAW videos
- Hold workshops to change community norms and attitudes.
- Use media in presenting VAW issues in national newspaper articles, radio interviews, and television interviews
- Conduct violence prevention workshops and trainings.

Intervene in order to ensure the safety of the battered woman

- Make sure the work environment (clinic, hospital,…) is safe.
- Provide appropriate treatment and services.
- Call security or police according to the law order or institution policy.
- Help woman to gain access to appropriate safe services and facilities.

Development of safety plans

- Assist woman in identifying safety measures she can take to prepare for the possibility of further violence. (In some circumstances, the health professional may be the only source for safety planning).
- Refer woman to an experienced counselor for assistance in creating a safety plan.
- Get yourself familiar enough with components of the safety plan to provide support and reinforcement.
- Encourage woman to familiarize herself with the plan by reviewing and (or) revising it regularly.

Advocating for policy development and adoption regarding VAW

- Policies to strengthen the capacity of health providers to address VAW (integrating violence issues into the healthcare services, provider training, coordination with other sectors, create awareness at community level of the health effects of VAW)
- Laws and policies regulating the medico-legal system (Policies governing forensic medicine; provider obligations, abortion, and patient confidentiality).

Show respect and recognition to clients

- Respect the integrity and autonomy of the woman's life choices.
- Recognize that she must deal with the abuse at her own pace.
- Recognize that an abused woman is an expert about her own abuse and abuser.
- Affirm her strengths and the survival skills she has demonstrated.
- Do not try to tell her what to do but help her understand the options available to her; she must choose the options to meet her own goals and priorities.
- Do not label her resistant or non-compliant if she decides not to accept your advice; make it clear you respect her right to choose and will continue, as her caregiver, to support her.
- Make sure any medications you offer/ or offered by other healthcare personnel, to help her deal with stress and/or sleep problems do not impair her ability to act appropriately on her own behalf.
- Help her to recognize that she cannot control actions of others but can only decide her own.

Apply relevant ethical principles (confidentiality, privacy,...etc.)

- Provide a private space for examinations, treatment, and counseling
- Respect client confidentiality by not telling others what clients revealed during the session or even whether the client received services.
- Keep confidential documents about woman in a secure place.
- Protect woman's rights
- Respect legal rights of privacy and confidentiality
- Ensuring auditory and visual privacy
- Protect patient information against unauthorized disclosures.
- Ensure that woman exercise adequately informed and free choice in releasing her confidential information to others.

4.2 Reporting

Article 8 of the Jordanian law obliges citizens as well as public and private sector providers to report on witnessed or suspected cases of family violence or child abuse. It places special emphasis on nurses and doctors at primary healthcare centers and hospitals, teachers in nurseries and schools, as well as social and community development centers. To ensure such cases are reported without fear or reluctance, Article 10 of the law guarantees their protection, as they are not required to identify themselves unless required to give testimony in court.

Article 8 stipulates the following: "(A) Medical, social or education service providers from the public or private sectors shall notify the relevant authorities as soon as they become aware of, or witness effects of violence and are being informed that they result from family violence.

(B) The commissioned employees shall adopt the necessary measures to guarantee the safety of the affected family members as soon as they are informed of cases of family violence."

Article 9 stipulates that, "Judicial Police officers of the Public Security Directorate shall move to the claimed Family violence scenes in any of the following cases:

A) When there is a report that a family violence case is in progress or is about to take place. B) When there is a report of a violation of a current protection order according to the provisions of this law".

Article 10 stipulates that, "Commissioned employees, under legal responsibility, shall guarantee the protection of the informant of the victim by keeping his/her name and identity confidential."

Module Five

Legal, ethical and cultural issues of reporting and treatment of abused women

Objectives: At the end of the module participants will be able to:

1. Be aware of related legislations and laws related to women's rights and violence prevention.
2. Know the ethical principles that apply to abused women.
3. Define breaches of privacy and confidentiality.

Teaching and learning Methods

- Presentation.
- Discussion of some articles in the laws, the Universal Declaration of Human Rights and World Conference on Women.
- Brainstorming on ethical principles and breaches of privacy and confidentiality.
- Exercises: Secrets and Privacy (Appendix I), Privacy and Confidentiality: Not One and the Same (Appendix J).
- Discussion of visual and auditory privacy: A checklist for providers (Appendix K).
- Discussion of confidentiality of client information (Appendix L).

Analysis of Case Study: Nimeh's Story (Appendix M).

Resources & references

- Bruce. L. Ensuring Privacy and Confidentiality in Reproductive Health Services manual, Global health council: A training manual and guide for service providers, Global Health Council, 2003. http://www.path.org/publications/details.php?i=821 accessed on 6/8/2010.
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- Family violence Nursing Curriculum, 2004
- http://www.mincava.umn.edu/documents/nursing/nursing.
- html#id429823) accessed on 29/7/2010
- American Health Lawyers Association. (2000). Kringen v. Boslough and Saint Vincent Hospital: A new trend for healthcare professionals who treat victims of domestic violence? [Electronic version.] Journal of Health Law, 33 (4), p.629.
- The Universal declaration of Human Rights. http://www.un.org/en/

documents/udhr/ Accessed on 23/8/2010.

- The United Nations Fourth World Conference on Women: Action for Equality, Development and Peace Beijing, China - September 1995 http://www.un.org/womenwatch/daw/beijing/platform/violence.htm
- Guidelines for medico-legal care for victims of sexual violence . World Health Organization, Geneva, 2003
- Intimate partner violence during the perinatal period: Obstetric Guideline 13. British Columbia Reproductive care program. July, 2003.
- دليل إدماج الإرشاد النفسي والاجتماعي والقانوني في خدمات الصحة الإنجابية: مركز المرأة للإرشاد القانوني والاجتماعي، ٢٠٠٨.

Estimated time: 3 hours
Content

Rights and laws related to violence

The Universal Declaration of Human Rights

Article 1.

All human beings are born free and equal in dignity and rights.

Article 2.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Article 3.

Everyone has the right to life, liberty and security of person.

Article 5.

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Fourth World Conference on Women (1995): Platform for action

112: Violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms.

114: Other acts of violence against women include violation of the human rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery and forced pregnancy.

قانون العقوبات الأردني رقم ١٦ لسنة ١٩٦٠

المادة ٣٣٣ باب إيذاء الأشخاص

"كل من أقدم قصداً على ضرب شخص أو جرحه أو إيذائه بأي فعل مؤثر من وسائل العنف والاعتداء نجم عنه مرض أو تعطيل عن العمل مدة تزيد على عشرين يوماً، عوقب بالحبس من ثلاثة أشهر إلى ثلاث سنوات".

مشروع قانون العقوبات الفلسطيني ٢٠٠٩

المادة ٢٤٨ باب الضرب والجرح الجسيم والبسيط والإيذاء الخفيف

"كل من ضرب أو جرح شخصاً عمداً ونجم عن ذلك إصابة أو عجز عن الأشغال الشخصية مدة تزيد عن ١٥ يوماً يعاقب بالحبس مدة لا تزيد على السنة".

Legal issues

According the American Health Lawyers Association (2000) the health care professionals should satisfy several duties to their patient, including:

- duty to evaluate, diagnose, and intervene appropriately to ensure the patient's safety
- duty to implement and comply with policies and protocols for the appropriate management of domestic violence

- duty to appropriately intervene in order to ensure the safety of their patients.

Ethical considerations

Violence against women violates human rights, has a major impact on health and causes great suffering. Physical and sexual abuse is illegal; emotional abuse is unethical and robs people of their basic rights to dignity and individuality.

Ethical principles that apply to VAW include:

- Patient well being
- Patient advocacy
- Patient respect and dignity
- Patient safety
- Patient self-determination
- Fairness
- Non-malfeasance (non-infliction of harm)
- Beneficence (production of benefit)
- Confidentiality and privacy

Privacy is "the right and power to control the information (about oneself) that others possess" (WHO 2000b). Privacy also commonly refers to the privacy of a person and the rights of individuals not to be physically exposed against their will.

- Visual privacy includes protection from unnecessary bodily exposure, which may occur during a physical examination. No one who is unnecessary to the procedure or examination should be allowed into the exam room without the explicit permission of the client. The client must agree to any compromise of her/his right to privacy. For example, to bring an observer in the room, the provider must comply with the client's wishes.
- Auditory privacy means that, to the extent possible, individual consultations should be conducted in private and nobody should hear what patient is saying , including family members

Confidentiality is "the duty of those who receive private information not to disclose it without the patient's consent" (WHO 2000b). Confidentiality is the mechanism through which the client's right to privacy is protected.

Beneficence is action that is done for the benefit of others. Beneficent actions can be taken to help prevent or remove harms or to simply improve the situation of others. Health care professionals do have an obligation to 1) prevent and remove harms, and 2) weigh and balance possible benefits against possible risks of an action.

Non-malfeasance means to "do no harm." Health care professionals must refrain from providing ineffective treatments or acting with meanness toward patients.

Advocacy is a process which involves information-gathering, making the information accessible, discussing choices, facilitating decision-making by the individual and monitoring outcomes. The health care professionals have an important role in this process since it involves diagnosis, prognosis, treatment options, treatment decisions and treatment review. Health care professionals have a responsibility to protect the patient's interests, even (where necessary) defending those interests against a perceived threat from other members of the team.

Respect includes both autonomy and the respect for self-determination of those who are capable of deliberating about their personal goals, and protection of persons with impaired or diminished autonomy.

Patient Self-Determination rights include:

1. The right to make their own health care decisions
2. The right to accept or refuse medical treatment

Breaches in Privacy and Confidentiality

Examples of **unintentional** breaches:

- A staff member enters a room thinking it is empty while a partially dressed patient is being examined.
- Non-medical staff inadvertently overhears a conversation between medical staff
- consulting about a client's condition.
- A client is observed in the waiting room of a clinic that provides sensitive health services (e.g. treatment of injury as a result of violence, abortion, etc.).

Examples of **intentional** breaches:

- Gossiping about a client in the community.
- Sending confidential client information to others without the client's authorization.

- Walking into an exam room knowing that another health provider is examining a client.
- Bringing an unauthorized visitor into an examination room before getting the client's

consent.

Module Six
Violence prevention

Objectives: At the end of the module participants will be able to:

- Discuss public health approach to understanding and preventing violence.
- Identify levels of VAW prevention.
- Promote programs and activities that address prevention of VAW.

Teaching and learning Activities

- Presentation of ecological model (figure 2.2 &2.3)
- Case scenarios
- Based on a hypothetical community situation, have the students develop a community prevention plan incorporating all three levels of prevention.
- Guest speaker: to discuss ways of conflict resolution and building healthy relationships
- Visiting institutions that provide services to victims of violence.

Resources & references

- Family violence Nursing Curriculum retrieved on 18/7/2010 from http://www.mincava.umn.edu/documents/nursing/nursing.html#id429823)
- Krug EG, Dahlberg LL, Mercy JA et al., eds. (2002). World report on violence and health. Geneva, WHO. Also available on the Internet at http://www.who.int/violence injury prevention/
- World Health Organization, Department of Injuries and Violence Prevention, 2005. To download the TEACH-VIP Users' Manual, and to order the free CD-ROM containing the entire curriculum (including lesson plans and PowerPoint presentations), go to: http://www.who.int/violence_injury_prevention/capacitybuilding/teach_vip/en/index.html.
- Handbook for the documentation of interpersonal violence prevention programs. Geneva, World Health Organization, 2004.

Estimated time- 3 hours

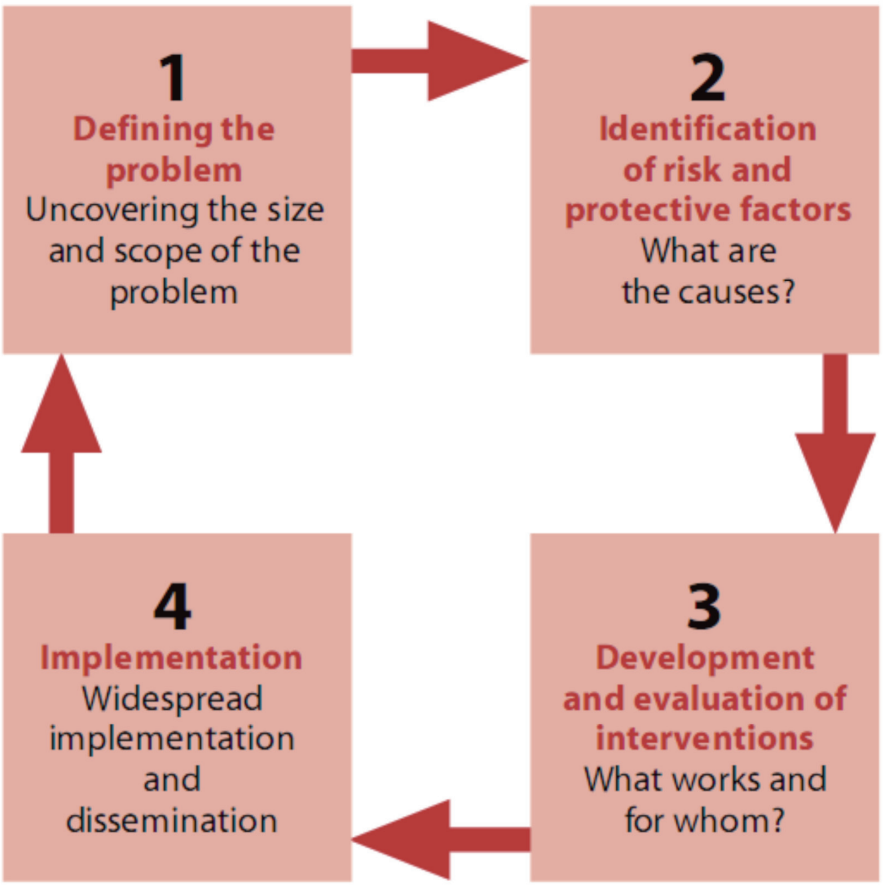
Contents

Prevention means to stop acts of interpersonal violence from occurring by intervening to eliminate or reduce the underlying risk factors and promote protective factors, or to reduce the recurrence of further violence and its ill effects (WHO, 2004).

6.1 The Public health approach to understanding and preventing violence

The public health approach is a multidisciplinary approach for use by the different actors in violence prevention, including educators, health care workers, police, NGOs, employers and government ministries responsible for social policy, and not just public health professionals (WHO, 2004). It consists of four stages as shown in figure 2.1

FIGURE 2.1 THE PUBLIC HEALTH APPROACH TO INTERPERSONAL VIOLENCE PREVENTION



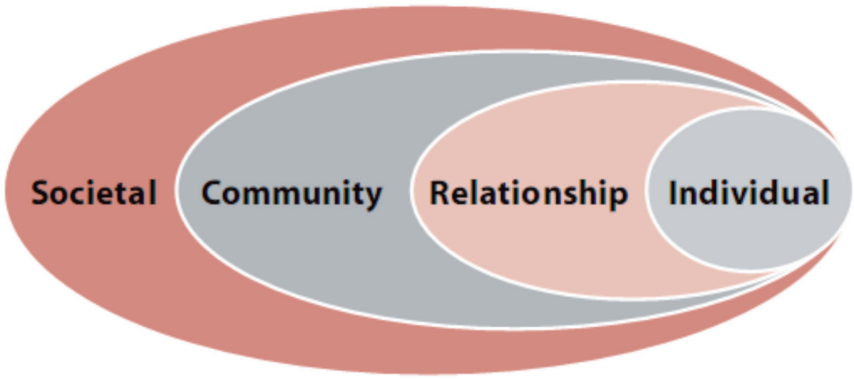
Source: Handbook for the documentation of interpersonal violence prevention programs. Geneva, World Health Organization, 2004.

Step 1: Defining the problem: In this step the public health model examines the how, when, where, and what of violence.

Step 2: Identification of risk and protective factors: Risk factor identification looks at the why of violence. Keep in mind that violence is the outcome of a complex interaction among many factors that need to be examined. The World Report on Violence and Health offers an ecological model to help understand the root causes and risk factors of violence that need to be identified and addressed by prevention strategies (WHO, 2004).

This ecological model for understanding violence is shown in Figure 2.2. The model identifies risk factors at four levels: individual, relationship, community, and societal.

FIGURE 2.2 ECOLOGICAL MODEL FOR UNDERSTANDING RISK FACTORS FOR VIOLENCE



Source: Krug et al., 2002 in Handbook for the documentation of interpersonal violence prevention programs. Geneva, World Health Organization, 2004.

Examples of risk factors at the different levels are:

a. At the individual level, such as early developmental experiences, demographic characteristics (age, sex, education, income), stress, psychological or personality disorders, physical illness or disturbances, substance abuse, and a history of behaving aggressively or having experienced abuse.

b. Personal relationships such as family, friends, and peers may influence the risks of becoming a victim or perpetrator of violence.

c. Community contexts such as the level of unemployment, population density, mobility, and the existence of a local drug or gun trade.

d. Societal factors such as political situation, economic, and social policies that maintain socioeconomic inequalities between people, the availability of weapons, social and cultural norms such as those around male dominance over women and cultural norms that endorse violence as a normal method to resolve conflicts, in addition to high unemployment rate, siege and isolation caused by the apartheid wall.

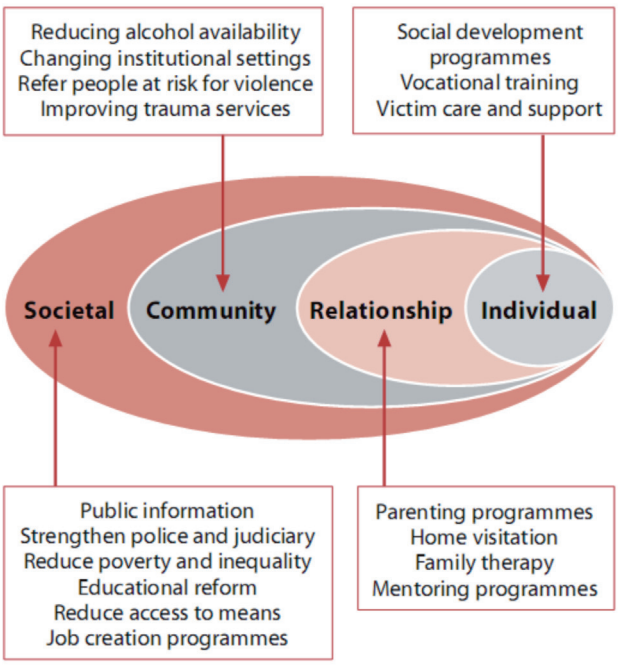
Step 3: Development and evaluation of intervention (What works and for Whom). The effectiveness of strategies for preventing interpersonal violence will depend on a combination of the type of intervention, the timing of its delivery and the population at risk. Our intervention could target women who suffer from violence, the violent person, adolescent women through counseling, education, empowerment program, and dealing with stressful situation for both men and women.

Step 4: Implementation (widespread implementation and dissemination). This step deals with the translation of effective programs into wide-scale implementation.

Prevention opportunities at multiple levels

Figure 2.3 shows prevention strategies at the four different levels: the individual, relationship, community and societal levels

FIGURE 2.3 ECOLOGICAL MODEL FOR INTERVENTIONS TO PREVENT VIOLENCE



Source: Handbook for the documentation of interpersonal violence prevention programs. Geneva, World Health Organization, 2004.

6.2. Levels of Prevention

The generally accepted approach to addressing health care issues in community health includes three levels of prevention: primary, secondary, and tertiary.

- Primary prevention involves any programs, intervention or strategies aimed at stopping violent events from taking place, and is thus related to the time before violence actually occurs.
- Secondary prevention focuses on screening people who are at risk. It also includes any strategies aimed at minimizing the harm that occurs once a violent event is taking place and immediate post-violence intervention aimed at preventing re-victimization.
- Tertiary prevention is aimed at preventing further negative health outcomes for people already impacted by the health care problem (clinics, hospitals, etc). It includes all efforts aimed at treating and rehabilitating victims and perpetrators and facilitating their re-adaptation to society

Primary prevention incorporates:

1. Education: childbirth education, positive parenting, healthy relationships, conflict resolution, harassment prevention, advocacy for positive culture norms and beliefs, etc.
2. Creating nonviolent environments/role modeling of respectful, nonviolent behavior in health care settings, schools, community agencies, etc.
3. Creating outreach programs to support parents in raising their children and to educate on the roots of violence, conflict resolution, and healthy relationships.
4. Issuance of legislation against the practice of violence.
5. Creating awareness programs through the media and religious leaders.

Secondary prevention incorporates:

1. Routine screening for abuse among all patients in every health care setting and informing suspected cases about community resources.
2. Identification of families at risk (violence in the family of origin, excessive family stress, inadequate family resources).
3. Provision of family counseling to create a violence-free family.

4. Identification of children at risk as a result of witnessing violence in the home and provision of early, age-appropriate intervention.

Tertiary prevention incorporates:

1. Referral to community resources (safe houses, counseling, etc).
2. Home visiting of families in which abuse has occurred.
3. Assessment and treatment of co-morbid conditions.

Module Seven

Health care responses to perpetrators of domestic violence

Objectives: At the end of the module participants will be able to:

1. Determine when and how to respond when they encounter perpetrators of domestic violence in their future practice.
2. Identify strategies for maximizing the safety of the victim when interacting with a patient who is the perpetrator.
3. Identify the ways by which healthcare professionals learn about perpetrators.
4. Discusses the specific factors to consider in evaluating the lethality of domestic violence and the risk of future injury or death.
5. Determine crisis intervention strategies.

References

- Ganley, A. Health care responses to perpetrators of domestic violence. In Warshaw, C. & Ganley, A. (1998). Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers. http://www.endabuse.org/section/programs/health_care/_resource_trainersmanual. Accessed on 12/9/2010.

Teaching and learning Methods

- Presentation.
- Discussion of some characteristics of perpetrators **(Appendix N)**.
- Brainstorming on strategies that can be used in the Palestinian context.
- Role play

Estimated Time: 3 hours

Content

Perpetrators: In many settings, particularly in public health, healthcare professionals are working with entire families in which power and control are an issue. Patients who batter their intimate partners appear in a variety of health care settings, including emergency departments, specialty clinics and primary care settings. Some seek medical care for issues directly related to their abusive behavior, while others seek assistance for issues that are unrelated to their violence.

7.1 Strategies for increasing the safety of victims when interacting with perpetrators of domestic violence

A. Information from the victim must be kept confidential

- Sharing information provided by the victim about the abuse with the perpetrator may put that victim in danger.
- Even when a victim asks the provider to talk directly with the abuser about the abuse, the health care worker should first explore with her the possible consequences of such action.
- If the health care practitioner is going to communicate any of a victim's information directly with the abuser, there should be a specific agreement with the victim about which information will be shared and how the discussion will take place.
- Use of information provided by the victim would be an exception rather than a rule and in even these limited circumstances would be used only for victim safety and advocacy.
- Evaluate the danger that you may encounter in sharing information.

B. Discussions with the perpetrator about domestic violence should never be done in the presence of the victim

- When the health care provider wishes to discuss abuse with the perpetrator, the discussion should be carried out with him in private.
- Discussing the abuse with the perpetrator alone is one more way that the provider can emphasize the perpetrator's responsibility for the abuse and for stopping it.

C. Taking care in how domestic violence is discussed with perpetrators

The health care professional must exercise care in how the discussions are carried out. Some approaches will increase the likelihood that the perpetrator will become defensive and retaliate against the victim, while others lower the risk.

The health care provider should use approaches that:

1. View domestic violence as a health care issue.

   When talking directly with the perpetrator about the abuse, the health care practitioner should emphasize that such issues are discussed with patients in order to best meet their health care needs.

2. Emphasize the routine nature of these discussions.

   As with all health care issues, the health care provider is often in the position of educator, providing patients with information necessary

for their health.

3. Focus on descriptions of the abuser's behaviors.

- When initially talking with perpetrators of domestic violence, the provider should use descriptions of their behaviors rather than terms like domestic violence, abuse, or battering. It is helpful with perpetrators to make comments such as: "When you threw her to the couch" rather than "when you abused your wife".
- Terms like "wife beater," "perpetrator," "batterer," and "abuser" should also be avoided in initial contacts about this issue.
- When the health care provider has had multiple contacts with the patient and has established a working relationship with him about the domestic violence, those terms can be used, but not when first encouraging the patient to discuss the abuse.

4. Focus on the abuser's behavior rather than the victim's.

- As abusers talk about their domestic violence, they often focus on the victim's behavior rather than their own. Be aware that making sympathetic comments about these explanations such as, "I can understand why you are mad at her" can be understood as you are agreeing to the act. Health care professionals should focus on the abusers' behaviors and their negative consequences (e.g., "hitting never solves problems," "your violence is destroying all of you," etc).
- Even when the victim is available and has given specific permission for the clinician to share information with the perpetrator, it is safer for the victim when the provider's comments focus on the abuser's behaviors rather than on the victim (e.g., "you said you threw your wife" rather than "your wife told the police officer you threw her").
- The provider can also focus on what the health care worker or third party directly observes (e.g., "your injuries look like someone tried to free themselves from a hold" rather than "your wife said she did this when you were choking her").

5. Use a direct and calm approach .

A health care practitioner who vents his or her anger, disgust or shock about this issue to the perpetrator may well endanger the victim. For some batterers, their defensiveness with the health care provider translates into retaliation against their victim.

D. When perpetrators display anger, resist or reject the discussions of abuse

Remember that the health care system's role is not to force patients,

but to educate them about how to care for themselves and, ultimately, for others. The perpetrator's display of anger and other tactics of control in the session with the health care provider indicates that the perpetrator is not motivated to change at that time. It is more productive to make a summary statement, calmly bring the subject to a close, and then move back to the presenting medical issue:

- "Your use of force against your partner and property is damaging both of you. I am concerned and will be glad to make a referral whenever you want it." Or
- "You've indicated that you are concerned about your violence with your wife. Let me know when you want to talk about it further."

7.2. Learning about perpetrators

Perpetrators of domestic violence are identified in a variety of ways by the health care system:

A. Medical records or written referrals

The domestic violence perpetrator may have been identified by another health care practitioner and this may be noted in the medical records. Such information may be indicated by a clinician such as "patient broke (hand, leg, arm, ribs, etc.) when attacking spouse," or "patient is violent to his family."

B. Reports by victims

The victim may talk about abuse with the health care practitioner in the presence of the abuser or privately. They provide such information seeking medical help for the problem, believing that the abuser's behaviors are caused by a medical issue, or believing that health care professionals have the authority or influence to stop the violence.

It is critical to treat the information seriously and respectfully and to be aware that all parties will observe how the situation is handled by the provider. If the victim tells the provider about the abuse in front of the abuser, it is important for the provider to respond calmly to the information and indicate (a) that some patients act in these ways, (b) that the provider appreciates knowing about it, and (c) that the provider will be glad to be of as much assistance as possible because this kind of behavior hurts the health of the abused person.

C. Reports by third parties

The patient may be identified as a perpetrator of domestic violence by a third party such as the responding police officer, the Emergency Medical Technician, the person accompanying him to the emergency

department, or through phone calls by other family members or friends.

D. Self-Reports by perpetrators

They may do this because they are seeking help for the problem or because they believe that their abusive behavior is a symptom of some medical condition (e.g., patients report increasing fights with their partners in which they strike out or "lose it," report incidents where they hit their partners or furniture, or report that family members are afraid of them).

E. Observation of perpetrators' abusive behaviors in a healthcare setting

Emergency department personnel have described incidents where a perpetrator followed the victim into the health care setting and continued the beating.

F. Observation of the effects of abusive behavior

The health care worker may observe the results of possible domestic violence: scratches, cuts, or bruises to the perpetrator's face, arms or hands secondary to his own violent behavior.

7.3 Assessment of lethality when the patient is the perpetrator

Assessment of risk for injury or death should be conducted every time the health care provider has contact with an identified perpetrator or victim of domestic violence. The lethality assessment is used to determine whether or not there is immediate danger and what steps can be taken to reduce the danger level. The primary source of the information is the patient present, whether perpetrator or victim. A complete assessment of lethality involves gathering information from all who have information relevant to the lethality question. The following are factors to consider in assessing the lethality of the violence

A. Pattern of abuse

A. Frequency and severity of abusive acts in current, concurrent, and past intimate relationships.

B. Possible escalation of frequency and severity.

C. Availability and use of weapon.

D. Threats to kill self or others; credible plans and means to kill.

E. Hostage taking behavior.

F. Use of violence outside family.

G. Stalking behavior.

B. Perpetrator's access to the victim

When the batterer's level of current violence is high and the perpetrator has access to the victim, the danger potential is high. Reduced access, such as when the victim is in hiding or the perpetrator is in jail, reduces the risk of injury or death. Since battering is about having the opportunity to abuse, then not having access reduces the opportunity.

C. Factors that reduce cognitive controls

- Alcohol/drug dependence or abuse.
- Certain medications.
- Psychosis or brain damage.

D. Perpetrator's state of mind

- Obsession with the victim.
- Increased risk taking by perpetrator.
- Ignoring negative consequences to his abusiveness.
- Depression; desperation.

E. Suicide potential of perpetrator, or victim

- assess threats, attempts, plans and means for suicide.
- assess suicide potentials for the victim (s) and perpetrator.

F. Situational factors

- Separation violence.
- Increased autonomy of victim.
- Other major stresses.

7.4. Crisis intervention strategies

When the potential for injury or death is high, there are multiple crisis intervention strategies that can be used with the patient who is the abuser. The crisis intervention strategy selected will depend on: (1) the nature of the threat, (2) who is in danger, and (3) the resources that are available to deal with the crisis.

This section focuses on strategies to use with an abuser who represents a danger to victims or self.

A. Duty to warn when the health care professional believes the victim is in danger

Health care practitioners must be aware of their legal and ethical responsibilities to warn victims about potential assaults against them.

There is a duty to warn when there is a clear and present danger to a specific victim or victims. In domestic violence cases, a specific victim is targeted and thus if the health care provider believes that the patient is a serious threat, then the victim of that patient should be notified. In some circumstances other appropriate authorities must be notified. Health care personnel should be aware of their facility's policies and procedures for duty to warn.

B. Legal recourses and mandatory reporting

At some time, providers may be faced with an abuser who is likely to kill if not contained. Depending on the situation, a mental health commitment or call to law enforcement may be appropriate (according to institution's policies).

C. Recommending temporary separation

Health care providers can recommend that the perpetrator temporarily separates from the victim during a crisis period (e.g., the abuser moves in with a friend, or other family members.). The practitioner can engage the patient in suggesting ways to temporarily separate from the victim.

D. Strategies to diffuse the crisis

When the perpetrator refuses to even temporarily separate from the victim, the health care provider may recommend a different set of strategies: those designed to defuse an immediate episode where the batterer is highly likely to strike out at the victim. Examples of diffusion strategies include: referrals to domestic violence intervention or counseling programs.

7.5. Other health care interventions with perpetrators

A. Patient education and awareness: abusive conduct and health issues

When the patient is a perpetrator of domestic violence, part of that treatment is evaluating how the abuse may be a causative factor in the presenting problem or how it may be a factor in the patient's recovery or how it may lead to future injury or death. In addition to seeing the connection between their behavior and their own health, batterers often need assistance in acknowledging the destructive impact of their abusiveness on victims.

B. Patient education: domestic violence, its impact on victims and children, and perpetrator's responsibility

This patient education can be direct and brief. It can be presented calmly and respectfully.

- Your behavior is damaging to everything that is important to you and the fastest way to stop that damage is for you to change those behaviors (listing specific examples of physical abuse disclosed to the practitioner).
- Using force will never solve the problems in a relationship or family. In fact it makes them worse.
- I see other patients with this problem and they said they were able to change only when they started taking responsibility for what they were doing.

C. Listening to the patient's concerns

In listening to the perpetrator, the health care provider may hear information about all or some of the following:

1. The pattern of abusive conduct:
    - Types of abuse
    - Frequency and severity of the physical force used
2. Impact of the abuse on the victim:
    - Injuries and other health issues
    - Depression, withdrawal, rage, fear
    - Impact on her relationship with others
    - Employment and legal issues
3. Impact of the abuse on children:
    - Injuries
    - Behavioral problems
    - Relationship problems
    - Emotional difficulties
4. Impact of the abuse on the perpetrator:
    - Health issues
    - Impact on his relationship with victim and children
    - Legal issues
    - Employment problems
    - Prior interventions or attempts to get assistance
5. Perpetrator's current motivation to view his abusiveness as a problem he wants to address.

D. Discussing options
Part of the purpose of discussing options such as safety planning with victims is to support their self-empowerment and their safety.

E. Making appropriate referrals
It is important for health care professionals not to encourage perpetrators to seek traditional couples counseling for their abusive behavior. Remember that the perpetrator's violence is not a "relationship problem" that the victim has some responsibility to fix.

F. Establishing a follow-up process
It is important that the health care practitioner follow up with inquiry about abuse in future contacts with the patient. The health care practitioner can raise the issue directly by statements such as: "The last time we talked, we were talking about how you could stop your abusive behavior. I would like to check on how you are doing. Since I saw you, have you used physical force against person or property in fights in the family?"

Also, if referrals were given, ask about follow-through.

Appendices

Appendix A: Family Violence Awareness Exercise

Ask your students to write down the first thing that comes into their mind. After covering some of the basic material, consider asking students to review their initial thoughts and discuss any insights gained.

Reflective questions

1. When I think about abused women I feel_____
2. When I think about families who abuse their women, I feel_____
3. Families who abuse their women should be _____
4. Men batter their wives because _____
5. Employers who abuse female employees should be_____
6. Women who stay in abusive relationships are_____

Source: Modified version of the "Reflective questions" that developed by Judi Sateren, MS, RN, St Olaf College

Family violence Nursing Curriculum Minnesota Center Against Violence and Abuse, January 2004 http://www.mincava.umn.edu/documents/nursing/nursing.pdf accessed on 29/7/2010

Appendix B: Quiz: Have You Ever?.....

- Said you would never forgive someone, then did anyway?
- Said you would never give someone a chance, and then decided it wouldn't be right to refuse one more sincere attempt?
- Thought it wouldn't be reasonable to refuse to talk over a situation that you were clearly wronged?
- Resisted saying what you thought because you might get punished?
- Gone along with your teacher because you want to pass the course?
- Gone along because you didn't want to cause trouble?
- Decided not to point out someone's error because it might embarrass them?
- Inhibited your objections to the behavior of someone who seemed to be "crazy"?
- .....So, why do women stay in abusive relationships?

Source: Modified version of the "Quiz: Have you ever" developed by Gail Holdeman, M.S.W., LICSW, Central Center for Counseling, Blaine, MN"

Family violence Nursing Curriculum Minnesota Center Against Violence and Abuse, January 2004 http://www.mincava.umn.edu/documents/nursing/nursing.pdf accessed on 29/7/2010

Appendix C: Case study (اعتقلت ودفعت ثمن اعتقالي)

الراوية: ز. ن العمر: ٥٧ سنة الحالة الاجتماعية: مطلقة

المهنة: ربة بيت السكن:غزة

دافعت عن وطني واعتقلتني قوات الاحتلال، فأصبحت الفتاة المنبوذة والمرفوضة من قبل أهلها ومجتمعها. أجبروني على الزواج للتخلص مما اعتبروه عارا أن تعتقل الفتاة وتتعرض لوسائل التعذيب التي يستخدمها جيش الاحتلال أثناء التحقيق...

ز.ن 57 عاماً، لا زالت تتذكر تفاصيل معاناتها وكأنها نحياها اليوم، بعد أن اعتقلت من قبل وهي في التاسعة عشر من عمرها لدى قوات الاحتلال الإسرائيلي لمدة عامين، قائلة: " اعتقلت ستة أشهر وخرجت لأني لم أعترف بأي شيء، وخلال هذه المدة لم يقم أهلي بالاتصال بي خوفاً من أن يعرف الناس أنني معتقلة. وبعد فترة أخرى، اعتقلت وحكم علي لمدة عامين قضيتها بين جدران الزنازين".

وتضيف ز.ن: "وبعد خروجي من المعتقل، أجبرني والدي على الزواج من شاب يسكن في بئر السبع رغم اعتراضي عليه، فكان رده: "القطاع اللي بننشتم فيه انا وأنتي مش رح أخليكي فيه". فالمجتمع لم يرحمني وقتها، وكنت مقيدة وذللك لأنني اعتقلت لدى الاحتلال وكأنني ارتكبت جرماً، وتناسوا أنني عندما اعتقلت كنت أدافع عن وطني، وكل ما فكروا به هو أنني فتاة "عاملة حالها زي الشباب وانو أنا السبب في أنو جيش الاحتلال كل يوم بيجي على حارتنا"، فغصبوني على الزواج من شخص لا يناسبني في شيء".

وتابعت "اشتراني العريس بفلوسه، خرجت من بيتنا وكأنني ذاهبة الى القبر. والدي كان الحاكم والناهي وكانت كلمته هي الماشية. لما قلت له: "مش عايزه أتزوج"، حط الموس بصدري وقال لي: "إذا بتكسري كلامي حدبحك وأرميكي بالحمام". وضربني أبي وقال لي "كل يوم اليهود جايين علينا، شو يقولوا عنا الناس". وتزوجت بالإجبار، حملت في ابنتي ص. فصار معي فقر دم. كان يمتلك المال ولكنة لم يكن ينفق علي. أنجبت ابنتي وبقيت أسبوعاً كاملاً بعدها في غيبوبة".

وتواصل ز.ن حديثها قائلة: "استمر الوضع على ما هو عليه مدة ستة أشهر. وبعدها هربت من أهلي وأخذت معي ابنتي وبقيت عندهم فترة، ومن ثم جاء ليعيدني. ونتيجة لضغوط الأهل وافقت على العودة على الرغم من معرفة الأهل مدى معاناتي. وبعدها أخذت معاناتي تزداد يوماً بعد يوم، وصار يضربني ضرباً شديداً الى أن طلبت الطلاق، فرد علي: "ما بطلقك لحتى تتنازلي عن الأولاد". وقتها كنت قد أنجبت ولداً وبنتاً، فرجعت إلى أهلي وبقيت خمس سنوات رايحين جايين على المحكمة. وبعدين طلقني بعد معاناة طويلة ذقت خلالها الأمرين".

تابعت ز.ن حديثها وعيناها تذرفان الدموع: "أمي صارت أكبر عدوة لي بعد ما رجعت بابني وبنتي ومن ساعة ما تطلقت ما لقيت حدا واقف بجانبي، وكانت تحكي لي كلام بذيء وتقول: "أبصر على مين حاطة عينها؟ أكيد على واحد من اللي انحبسوا معها". إضافة إلى أن والدي حكى لي انو مش مجبور يصرف على أولادي. فكان يضغط علي علشان ارجع الاولاد لأبوهم لكنني رفضت. وفي يوم ما كنت بالبيت، رجعت ما لقيت البنت. أخذها أبوها بالخفية. ودخلت في غيبوبة، وفي الليلة ذاتها أتى وأخذ ابني تحت تهديد السلاح.

Source: Unequal Rights, unequal Opportunities: 30 Years of CEDAW, 30 Stories of Women in the Occupied Palestinian Territory. INIFEM, Occupied Palestinian Territories, 2010.

Appendix D: Reasons why professionals may "Fail to Notice" Abuse/ Listening Skills Exercise

Think of a time when you really felt listened to.

- What was going on for you at the time that made you decide to talk to someone? It may have been a problem, difficulty, concern, or something you wanted to share with someone else.
- How did you feel about talking to this person?
- What were your fears, anxieties and thoughts about how it might be received?

Think of the person you spoke to.

- What qualities did this person have that made you decide that it would be safe to talk to
- them?
- What were some of the things that they said to you?
- How did you know that the person really listened?
- What was it about them that made you feel comfortable?
- How would you describe the experience of having really been listened to?

Source: WAVE Manual, Patterns of abuse from: London Borough of Hammersmith and Fulham Community Safety Unit, Challenging Domestic Violence. A Training and Resource Pack, London 1991

Appendix E: Cases to show signs and symptoms of abuse

Case 1:

A 34-year-old woman had been seen by several different physicians for jaw pain. Finally, a primary care physician diagnosed temporomandibular joint (TMJ) syndrome and referred her to a specialist. This specialist, knowledgeable about domestic violence, determined the TMJ syndrome had been caused by repeated episodes of battering, during which the woman's brother had grabbed her by the jaw and forcefully yanked it from side to side.

Case 2:

A 30-year-old woman was seen by a cardiologist after presenting to the ED with chest pain, dyspnea, palpitations, diaphoresis and dizziness. Her ECG revealed sinus tachycardia with no ischemic changes. Further questioning elucidated a history of panic attacks which had begun after her father threatened to kill her if she ever tried to leave.

Case 3:

A 23-year-old woman was brought to the ED by her mother. She was acutely psychotic. Her mother told the psychiatrist on call that she thought her daughter's state was related to how her husband is treating her. The patient had no prior psychiatric history and was not using any drugs. She was hospitalized and treated with antipsychotic and anxiolytic medication. As her thinking became more coherent, she described repeated episodes of physical abuse, sexual coercion and controlling and threatening behavior on the part of her husband.

Case 4:

A 25- year-old woman had two visits to her family physician over a two-week period. She complained of left-sided chest pain, tremors, vomiting and headaches. After an unrevealing medical workup, she was referred to a mental health center with the diagnosis of "Adjustment Disorder with Depressed Mood." She returned a week later with symptoms of left arm numbness, difficulty concentrating and a loss of appetite. On this visit she also mentioned there were arguments at home. Direct questioning revealed she was being battered.

Source: Improving the health care response to domestic violence: A resource manual for health care providers. Produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence ,March 1996.

Appendix F: Responses to Victims of Violence

Key Principle
When working with abused women, the best, highest standard for practice lies in the adoption of an attitude and tone that will allow the professional to "start where the victim is at". A key, supportive element, is understanding that there is variability in patient response depending on how the patient views her intimate husband relationship.

To accomplish this, it is helpful to approach victims from an individual or family-centered attitude rather than from a "problem-oriented" attitude, always remembering that generalizations should never be made.

Educator Instructions: Explain to students that the case studies are guidelines only, and the intent is to respond to the scenario as they would in practice. Encourage them to "go with the flow" rather than following the scenario to the letter.

Case Study One: Clinic or ED – Female, multiple problems
Instructions

1. Determine who will be the patient and who will be the physician.
2. Review the case study.
3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.
4. Group discussion will follow.

A 42-year old woman presents to the ED or Primary Care Clinic with a week-long history of generalized abdominal pain, nausea and diarrhea. She has been seen in various health care settings for numerous complaints over the past year including insomnia, anxiety, headaches, back pain and GI problems. Her husband is with her. He expresses a need to stay with his wife to support her.

Setting the stage

Physician/Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your husband?"

Patient: Following the scenario above, say something like: "Oh, we're both getting sick of my health problems."

Physician/Nurse: Using your instincts, follow with other comments and questions.

Patient: Respond with reservation, perhaps by saying "Oh I'm such a terrible person... who could live with me and take it for long?"

Preface statement and screening questions

Physician/Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may affect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "A couple of times maybe but not anymore."

Physician/Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: "We kind of yell at each other. Oh he might say he's going to shut me up for good but he doesn't mean it."

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need?

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case study Two: Clinic or ED – Female with urinary tract infection
Instructions

1. Determine who will be the patient and who will be the physician.
2. Review the case study.
3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.
4. Group discussion will follow.

A 23 year old woman and mother of five children presents with pain and burning on urination, her fifth visit for urinary tract infection in three months. Previously she has been in numerous times over the past year with various complaints, mostly relating to pelvic pain and UTI's. You note horizontal, linear bruising on her upper thighs.

Setting the stage

Physician/Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your husband?"

Patient: Following the scenario above, say something in a quiet voice like: "We're doing OK... the benefactors help a lot."

Physician/Nurse: Using your instincts, follow with other comments and questions.

Patient: Indicate you are tired a lot and busy with the kids.

Preface statement and screening questions

Physician/Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may affect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Why are you asking me those questions?"

Physician/Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: If it feels right, tell the nurse you do get hit once in a while, but he doesn't mean any harm OR: home is a hard place to be, sometimes you are afraid. Be reluctant to share much due to shame.

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need?

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Cases for Midwife students

Case study one: Post partum clinic visit

Instructions

1. Determine who will be the patient and who will be the health care professional.
2. Review the case study.

3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.
4. Group discussion will follow.

You are conducting a routine post-partum care for a 20 year old primipara. Her husband is currently a daily paid worker and they live in tiny apartment in a camp. You note the patient is very quiet and oppressed. Her responses to your questions are short. She demonstrates little interest in her newborn. She is pale and complains of excessive bleeding and vaginal tenderness. You are able to evaluate her bleeding and pelvic area. While doing so you note a quarter-sized bruise on the inner aspect of each of her knees.

Setting the stage

Midwife/Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your husband?"

Patient: Following the scenario above, say something in a quiet voice like: "Oh... not too bad."

Midwife/Nurse: Using your instincts, follow with other comments and questions.

Patient: Respond with reservation, perhaps by saying "Well, he is good to me a lot of the time."

Preface statement and screening questions

Midwife/Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may affect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Oh not really I guess. But sometimes my husband gets angry at me."

Midwife/Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need?

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be helpful?

Case Study Five: Clinic visit – Uterine cramping

Instructions

1. Determine who will be the patient and who will be the health care professional.
2. Review the case study.
3. Use the script or your own words based on the patient's responses and your assessment of the situation.
4. Group discussion will follow.

A 23-year old woman is seen in the clinic with moderate, frequent, low abdominal cramping. She is 30 weeks pregnant. With her are her mother-in-law and her three children ages 5, 3 and 2. She lives with her family in a refugee camp. Other findings include: a row of four horizontal dime-sized pale yellowish marks just below her umbilicus, signs of depression, and a history of weight loss of 2 kilos in the past week.

Setting the stage

Midwife/Physician: Introduce the subject asking a stage-setting question such as: "I often see patients with problems in the family. We have ways of helping them and improving their health. So just I'm going to ask you a few questions about your home life. How are things going between you and your husband?"

Patient: Following the discussion, say something like: "Oh, we both work hard to have a good home and family."

Midwife/Physician: Using your instincts, follow with other comments and questions.

Patient: Respond perhaps by saying something about the busy house and family and making a good home.

Preface statement and screening questions

Midwife/Physician: "Often people experiencing poor health or having problems healing are in a relationship that may affect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Well, no, not really."

Midwife/Physician: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: "I try to be a good wife and take good care of my children. I keep trying hard."

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need?

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Source: Family violence Nursing Curriculum Minnesota Center Against Violence and Abuse, January 2004 http://www.mincava.umn.edu/documents/nursing/nursing.pdf accessed on 29/7/2010

Appendix G: Forensic Evidence

Forensic evidence includes any combination of the following: hair; seminal fluid; saliva; blood; urine and non-biological evidence, such as clothing, traces of soil, etc.

There are four purposes of collecting forensic evidence:

- To identify the attacker (blood. saliva, semen, skin cells can all be tested for DNA).
- To confirm recent sexual contact (injuries/soreness around the genital area; seminal fluid, saliva and internal injuries).
- To determine used force (documentation of internal and external injuries, torn/soiled clothing, and positive toxicology tests).
- To confirm the victim's story (are findings consistent with it?).

Healthcare professionals (physicians & nurses) responsibilities include:

- Collecting data on the date and time of the assault/s; where it took place and who the attacker was; pertinent recent medical history, including last prior consensual sex and stage of menstrual cycle; the sexual acts involved; the nature of force and threats used; whether there is loss of memory, or was loss of consciousness; whether ejaculation took place and where; whether a condom and/or lubricant was used; any alcohol or drugs consumed during the last 12 hours; actions taken since the assault, such as washing, drinking, smoking.
- The physical examination begins with careful examination of clothing, which is often removed whilst the woman stands on a piece of collection paper. A Woods Lamp may be used at this point: the ultraviolet light enables identification of stains.
- Clothing should only be sent for forensic testing if it is likely to have evidential value.
- Collection paper will also be used for the initial external examination, where any debris on the skin and hair combings from the head and pubic area are undertaken.
- Careful documentation of visible injuries such as bruising, scratches and bite marks is vital. All injuries should be described, documented on body charts and photographed if possible.
- Swabs will also be taken if there is a likelihood of saliva or semen being found on outer body surfaces.
- Follow up examinations should be considered, especially where the

initial exam is soon after the assault, to document bruising which emerges later. They can also be used to document healing of internal injuries.

- The next stage is the external and internal genital examination which involves looking for injuries or other findings (in the case of girls, a broken hymen, or forms of reddening and/or tenderness of the skin/tissue) as well as collecting samples which might document the presence of sperm.

The following issues are critical in ensuring appropriate forensic examinations

1. Speedy response.
2. Avoiding the triage system in hospital emergency departments.
3. A private, dedicated space.
4. A well equipped examination room.
5. Trained and skilled practitioners.
6. Female examiners.
7. Time to move at the speed the victim/survivor is comfortable with.
8. Protocols and evidence kits.
9. Space to discuss the process (privacy and confidentiality).

A sexual assault evidence collection kit contains commonly available examination tools, such as:

- Detailed instructions for the examiner
- Forms for documentation
- Tube for blood sample
- Urine sample container
- Paper bags for clothing collection
- Large sheet of paper for patient to undress over
- Cotton swabs for biological evidence collection
- Sterile water
- Sterile saline
- Glass slides
- Unwaxed dental floss
- Wooden stick for fingernail scrapings

Envelopes or boxes for individual evidence samples

- Labels.

Other items needed for a forensic/medical exam and treatment that may not be included in the rape kit are:
Wood's lamp – ultraviolet light

- Toluidine blue dye
- Drying rack for wet swabs and/or clothing
- Patient gown, cover sheet, blanket, pillow
- Needles/syringes for blood drawing
- Speculums
- Post-It Notes used to collect trace evidence
- Camera (35 mm, digital, or Polaroid), film, batteries
- Medscope and/or colposcope
- Microscope
- Surgilube
- Acetic acid diluted spray
- Medications
- Clean clothing and shower/hygiene items for the victim's use after the exam.

The Colposcopic Examination: Visualization with Colposcopy, http://www.medscape.com/viewarticle/579947_4 accessed on 21/8/2010
Three primary mechanisms exist for the rape exam: direct visualization, staining, and colposcope.

A colposcope magnifies genital tissue and helps in the identification of genital trauma. Photographic equipment, both still and video, can be attached easily to the colposcope.

Tray with all instruments used in colposcopy

Colposcope

The MedScope is a video colposcope used for the documentation of forensic evidence in cases of suspected sexual and physical abuse.

Surgilube – Lubricating jelly

Appendix H: Risk Assessment

1. When did the violence start?
2. How often does the violence/abuse occur?
3. Has the violence increased in frequency or severity in the past year?
4. Have you recently separated from or stopped seeing your abuser?
5. Have you ever felt afraid for your physical safety or life?
6. Has your abuser threatened to kill you, your children, your relatives, or themselves?
7. Has your abuser planned or attempted suicide?
8. Does your abuser have access to weapons? Is the weapon in the home?
9. Does your abuser abuse alcohol or use drugs?
10. Is your abuser violent outside the house?
11. Does your abuser harm others?

Appendix I: Exercise/ Secrets

Time: 15 minutes

Preparation: Prepare a (flipchart) page with two columns—the first column labeled "Feelings" and the second column labeled "Consequences."

Instructions:

A. Telling secrets (Note: List responses on the flipchart.)

12. Have participants think of a secret in their lives.
13. Ask them to write down one or more reasons why they might reveal this secret to someone.
14. Then ask participants what their reasons for revealing the secret were.
15. Reassure participants that it is natural to want to confide in someone for the many reasons that they just discussed.

B. Revealing Secrets

1. Ask participants how they would feel if they confided their secret in someone and that person told the secret to someone else without their permission.
2. List responses on the flipchart paper under the column labeled "Feelings."
3. Ask what might be the consequences of telling their secrets to other people without their permission.
4. Ask how an abused woman might feel if sensitive information about her were revealed to another person who did not need to know the information.
5. Compare the responses with the participants' list of feelings.
6. Ask what would be the consequences of revealing this sensitive information to others the on health institution, the woman's health, and provider's reputation.
7. Mention that revealing private information about an abused woman to someone else without her authorization is a violation of her rights.
8. Explain that an abused woman is entitled to know her provider is not allowed to give any of her information to anyone else without her written permission.

Source: Bruce. L. Ensuring Privacy and Confidentiality in Reproductive Health Services manual, Global health council: A training manual and guide for service providers, Global Health Council, 2003. http://www.path.org/publications/details.php?i=821 accessed on 6/8/2010.

Appendix J: Exercise: Privacy and Confidentiality: Not One and the Same

Time: 10 minutes

Preparation:
Prepare a flipchart page with the definitions of "Privacy" and "Confidentiality" beforehand.

Instructions:
1. Explain that privacy and confidentiality are not one and the same.
2. Ask participants what privacy is. (Note: List responses on a flipchart.)
3. Discuss the World Health Organization's (WHO) definition of privacy.
4. Ask participants what confidentiality is. (Note: List responses on the flipchart.)
5. Discuss WHO's definition of confidentiality.
6. Initiate a discussion around participants' definitions of confidentiality and WHO's definition.
7. Review the differences between privacy and confidentiality and explain that the ways we ensure privacy are different from the ways we ensure confidentiality.

Source: Bruce. L. Ensuring Privacy and Confidentiality in Reproductive Health Services manual, Global health council: A training manual and guide for service providers, Global Health Council, 2003. http://www.path.org/publications/details.php?i=821 accessed on 6/8/2010.

Appendix K: Ensuring visual and auditory privacy: A checklist for providers

Provider's behavior

Visual privacy

Honor clients' right to privacy.

Place a "Do Not Disturb" sign on the door to discourage others from entering while counseling or examining a client.

Ask the client's permission before bringing in another health professional for consultation or observation of the client.

Ask permission before bringing in husband, mother-in-law, other family members.

Give contraceptive supplies or medications in a private area out of sight and earshot of others.

If possible, use universal precautions (i.e. wearing gloves, safe disposal of sharps, etc.) with all patients to reduce calling attention to a particular client.

Auditory Privacy

Call out or announce the name of the client to be seen, but never the type of service they are receiving.

Never ask a client in the presence of others what he/she is being seen for.

If others are present, find a private place to ask a client sensitive information.

Speak in a soft voice so that others cannot hear you.

Always close the door when talking to a client.

Discontinue interviews if an unauthorized person enters the room.

Never discuss a client's exam or test result out loud where others can hear.

Source: Bruce. L. Ensuring Privacy and Confidentiality in Reproductive Health Services manual, Global health council: A training manual and guide for service providers, Global Health Council, 2003. http://www.path.org/publications/details.php?i=821 accessed on 6/8/2010.

Appendix L: Ensuring confidentiality of client information- A checklist for providers

Provider's behavior

- Look out for the client's best interests, recognizing that some clients, particularly poor women and adolescents, have difficulty understanding their rights.
- Honor the client's right to privacy and observe the provider's duty to protect information about he client.
- Never coerce a client to give consent to release information.
- If a client has been seen at a health center, take care not to unintentionally disclose that information to a parent or husband or relatives during the client's subsequent visit.
- Call the client into a private room to discuss test results. Never mention test results load.
- Obtain consent form from the client before disclosing information to any other person, including parents, husband, other family members, or to other organization.
- Do not mention the reason to schedule a return visit or anything else related to the nature of the client's visit in the presence of other clients.
- Keep the purpose of the client's visit and any personal information about a client or his/her test result confidential. Do not reveal this to others within or outside of the clinic.
- Do not gossip about a client to co-worker, family members, or friends.
- Never visit the client at home without his/her permission.
- For adolescents: life-threatening situations and emergency conditions may require parental notification. In non-life threatening situations, the provider must carefully weigh the potential harmful consequences for the adolescent before deciding to inform his/her parents. Follow local laws and institution policies in this regard.

Source: Bruce. L. Ensuring Privacy and Confidentiality in Reproductive Health Services manual, Global health council: A training manual and guide for service providers, Global Health Council, 2003. http://www.path.org/publications/details.php?i=821 accessed on 6/8/2010.

Appendix M: Case Study: Nimeh's Story

Nimeh, an illiterate housewife, is a mother of four; 3 daughters and a son. Her youngest baby is four months old. Her husband Sameer is a poor wage worker. She does not want any more children and wants to use a family planning method. Sameer and her mother-in-law do not agree; they insist that Nimeh try again to have another son.

Nimeh visits the camp health center one day using the excuse that she has a headache. She does not inform her mother-in-law or her husband of the real purpose of the visit. At the center, there is no private counseling room. Suha, the midwife, counsels Nimeh on various family planning options in the presence of other waiting clients. Nimeh chooses an intrauterine device (IUD), thinking she can conceal the method from her husband. Another client overhears the conversation between Nimeh and Suha.

Word gets back to Nimeh's mother-in-law that Nimeh has an IUD, and the mother-in-law is furious that Nimeh got a method over her objection. She tells her son and together verbally abuse and beat Nimeh. They force her to return with them to the health center immediately. They confront Suha, demanding that she removes the IUD. They forcefully take Nimeh back home, where she is punished, has food withheld from her and is given extra work to do.

Discuss the following questions:

- How could this incident have been avoided?
- Suha was willing to give Nimeh a method, without telling her husband or mother-in-law, thus respecting Nimeh's right to privacy. Was this correct?
- Is it Suha's fault if she does not have a private space to counsel Nimeh? What could Suha have done differently?
- Should Suha be disciplined for violating Nimeh's auditory privacy and if so, what should be the consequence?
- What issue do the provider/supervisor/manager need to address in this case?
- What impact will this incidence have on the health center?

Source: Bruce. L. Ensuring Privacy and Confidentiality in Reproductive Health Services manual, Global health council: A training manual and guide for service providers, Global Health Council, 2003. http://www.path.org/publications/details.php?i=821 accessed on 6/8/2010.

Appendix N: Characteristics of perpetrators

Abused as children	Most batterers were beaten, verbally abused, or sexually abused as children. They were taught that bigger people get to hit and abuse smaller people.
Believe in traditional sex roles	They believe that a woman is there to take care of them, feed them, bear their children and keep their house clean. Batterers believe that women should be disciplined if they «disobey their husband» or «forget their place».
Controlling	A man who batters may control where his spouse goes, whom she sees, what she reads, when she eats, and what she buys. A batterer fears abandonment, and, therefore, tries to control his mate›s actions by controlling the money and by limiting her access to family and friends.
Deny, minimize and blame	A batterer does not want to be responsible for his violent actions or for the harm he causes. Abusive men learn to deny wrong doing, minimize injury and blame others. Men who batter will blame others for their actions and say things like «If she didn›t want a beating, why did she interrupt me when I was on the phone?»
Have a negative belief system about women	They have negative stereotypes about women such as: «all women are manipulative».
Insecure	Abusive men have a deeply rooted fear that they are inadequate. They don›t believe they have a lot to offer. Batterers are actually very lonely, alienated men.
Jealous	Batterers tend to be extremely jealous and have difficulty trusting others.
Lack relationship skills	Men who batter have had very poor role models for important relationship skills such as problem solving, conflict resolution, and establishing intimacy with a partner.

Master manipulators	A batterer is someone who knows exactly how to convince his partner to feel sorry for him. He becomes very skilled at telling his partner exactly what she wants to hear. He will beg and promise and say all the right things.
Self-centered	Batterers lack consideration for others. They concentrate on their needs and wishes.

Source: Barbara Corry, M.A., 1994 in Family violence Nursing Curriculum Minnesota Center Against Violence and Abuse, January 2004 http://www.mincava.umn.edu/documents/nursing/nursing.pdf accessed on 29/7/2010