Guinea IPV Screening

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Background

- RESPOND – EH was the lead organization on a five-year Cooperative Agreement funded by USAID that sought to increase the use of high-quality FP services
- RESPOND received core funding from Gender GLP to develop and field-test an approach, including a training curriculum and TA, to prepare FP providers to support improved RH to FP clients who have experienced IPV.
- Partnered with AGBEF (the Guinean IPPF MA)
- 62% of women in union have ever experienced severe intimate partner violence (IPV) - 2009 WHO/UNFPA/Unicef
- IPV screening as part of holistic response to clients

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Project contributers

- Maimouna Toliver (EH Gender/MAP staff who ran training)
- Dr. Fatoumata Guilinty (consultant)
- Alexandre Delamou (consultant)
- Ghazaleh Samandari (EH M&E staff who conducted evaluation)
- Kira Laffe (curriculum development consultant)
- Michal Avni and Joan Kraft from USAID
- All AGBEF staff

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Guinea IPV/FP Integration

OBJECTIVE: To support improved reproductive health (RH) by integrating IPV screening and counseling into FP services in an IPPF member association (AGBEF)

Sought to train providers to:

- Screen and discuss IPV with the FP client in a safe and supportive space
- Explore FP options with the IPV survivor, taking into account the potential effect of IPV on method choice and use
- Educate clients about medical, legal, psychosocial, and other services available to IPV survivors
- Discuss personal safety with the IPV survivor and help her develop a safety plan for the future
- Provide relevant medical services on-site and refer the client to other services as needed

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Project activities included:

- Pre-training – 2012-2014
  - Form Steering Committee
  - Conduct formative research (facility audits & interviews) at 4 clinics
  - Selection of one clinic (Conakry) due to lack of support services
  - Developing a curriculum on IPV screening and counseling
  - Agreement with AGBEF on how to integrate screening
- Training Workshop – February 10-14, 2014
- Post-training - February 14-March 24
  - 2-day Practice Workshop
  - Mock client visits
  - TA visits (twice a week) to help AGBEF integrate IPV screening.
  - Visits by staff to GBV services (CONAG and AGUIAS)
- AGBEF begins screening - March 25, 2014
- Evaluation – June 2014

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Formative Research

Data collectors interviewed the facility managers at four AGBEF sites and conducted 10 focus group discussions (FGDs)

- Providers' concerns:
  - Some clients would not be able to afford the cost of services and transportation for referrals.
  - Special counseling training would be needed.
  - Providers do not know where to refer survivors.
  - Some clinics concerned the screening would drive clients away
- Clients' concerns:
  - Most clients come to AGBEF in secret and cannot stay for GBV screening.
  - Few clients would confide in the providers and listen to their advice.
  - Women must have the permission of their husband to obtain health services.
  - Survivors would not accept referrals, for fear of aggravating the conflictof concerns came up, especially at one site:
  -

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Definition of “screening”

SCREENING: Using a series of questions to investigate, evaluate or identify an unrecognized ailment or symptom. In this instance, providers use a series of questions to identify the presence of IPV in FP clients.

IPV screening role play

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AGBEF IPV Screening Questions

1. Has your partner ever said something to you that made you feel badly about yourself, your body or the way you live your life?
2. Has there ever been a time when your partner has ever threatened your wellbeing, made you feel scared, intimated, embarrassed or ashamed?
3. Does your partner respect your family planning needs and desires? For example, if you wanted to use a FP method that prevented pregnancy would your partner allow you to do so?
4. Has your partner ever pushed you to participate in or do things you don't want to do sexually?
5. Has your partner ever used a part of his body or another object to hurt you physically? (Examples may include: scratch, hit, slap, kick, punch, squeeze, pin down, strike with object etc.)

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Screening process

- IPV Screening Protocol was developed specifically for AGBEF Conakry clinic.
- Screening was bundled into their counseling method (GATHER)
- After several consultations, the two midwives were selected as the best staff to conduct screening
- Counselor was also trained in case any clients chose to reveal IPV to her.
- Did not change the order of what happens when client walks into the clinic
- All female FP clients were offered screening
- One of the midwives took leave, so that in the end only one person was doing all the screening.

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Integrating IPV into GATHER

Table 1. GATHER model for FP counseling, with additional steps for IPV screening

	FP model	IPV integration add-ons
G	Greet the client respectfully.	• Explain the clinic's commitment to the holistic care of clients. • Explain the need to ask private and sensitive questions about IPV.
A	Ask the client about her FP needs; assess her risk for HIV and other sexually transmitted infections (STIs).	• Screen for potential incidences of IPV.
T	Tell the client about different FP methods.	• Explain the STI/HIV risks and IPV risks resulting from each option.
H	Help the client make an informed and voluntary decision regarding FP.	• Take into consideration the impact of IPV. • Help the client develop talking points to be used with her partner.
E	Explain and demonstrate how and when to use the method of contraception.	• Take into consideration the impact of IPV, and develop strategies for harm reduction. (safety planning – including FP method safety)
R	Return/refer; schedule a return visit and follow up with the client.	• Remind the client that she may return or call the clinic with any problem or concern. • Discuss a safety plan with the client. • Refer the client to community-based IPV services.

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Training Workshop – February 10-14, 2014

- Facilitated by EH staff person and a consultant (MD).
- 5-day training workshop
- Mix = participatory, PPT, gender reflective, skills-based
- Who participated - AGBEF staff participants: Regional Coordinator; 2 midwives; 1 laboratory assistant; and the clinic's Animatrice/FP Counselor. 2 representatives from JHPIEGO-Guinea attended.
- AGUIAS (Guinean Association of Social Workers), CONAG-DCF (National Guinean Coalition for the Rights of Women), and OPROGEM (National Office for Gender and Child Welfare) attended day five to discuss the IPV services they offer.

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Action items developed during training

Action items identified by trainees:

Activities	Deadline	Person(s) Responsible
AGBEF staff orientation of the IPV screening protocol	End February	EH Consultant
Improving the waiting room area	End February	Regional AGBEF Coordinator
Development of BCC materials on gender, FP, IPV, and SRH (e.g. posters; brochures etc.)	End March	Regional AGBEF Coordinator
Guidelines cheat-sheet for Animatrice	End February	EngenderHealth Gender Team
Development of an external client referral form	End February	AGBEF Midwife
Referral services site visit	End February	EH Consultant
Identification of coding methodology	End February	EH Consultant
Multiplication of IPV screening forms	End February	EH Consultant
Submission of partnership request to potential referral services	Mid-March	AGBEF Midwife
Partnership meeting	Mid-March	AGBEF Midwife
Partnership Protocol/MOU	Mid-March	AGBEF Mid-wife

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Post-training support

- Organize a 1-2 day practice session with AGBEF staff
- Organize mock client consultations to delivering the 5 key services for FP clients experiencing IPV.
- During staff orientation on the IPV screening protocol, include reflection around privacy and confidentiality of IPV-FP clients.
- Provide technical support on documentation and coding.
- Provide support to AGBEF in formulating strategies to ensure the ongoing emotional well-being of midwives
- Following forms were revised:
  - IPV Documentation Tool
  - Safety Plan Form (includes FP method safety)
  - Confidentiality Release Form

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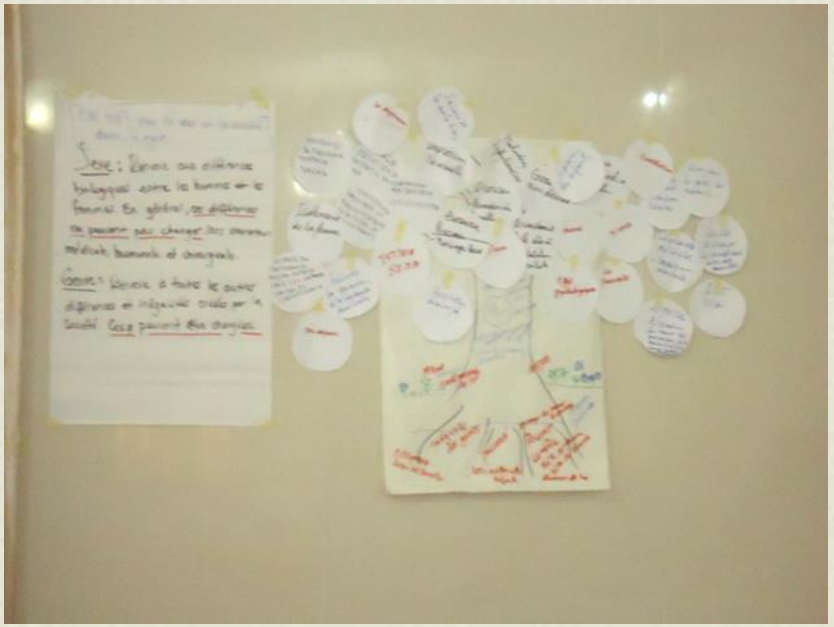
Results

Evaluation included:

- Facility statistics /documentation
- In-depth interviews with providers
- Client exit interviews
- Key stake-holder interviews

IPV problem tree from training



- No change in the FP method mix – between 60-70% of women already used injectables in the previous 8 months. 66.9% at endline.

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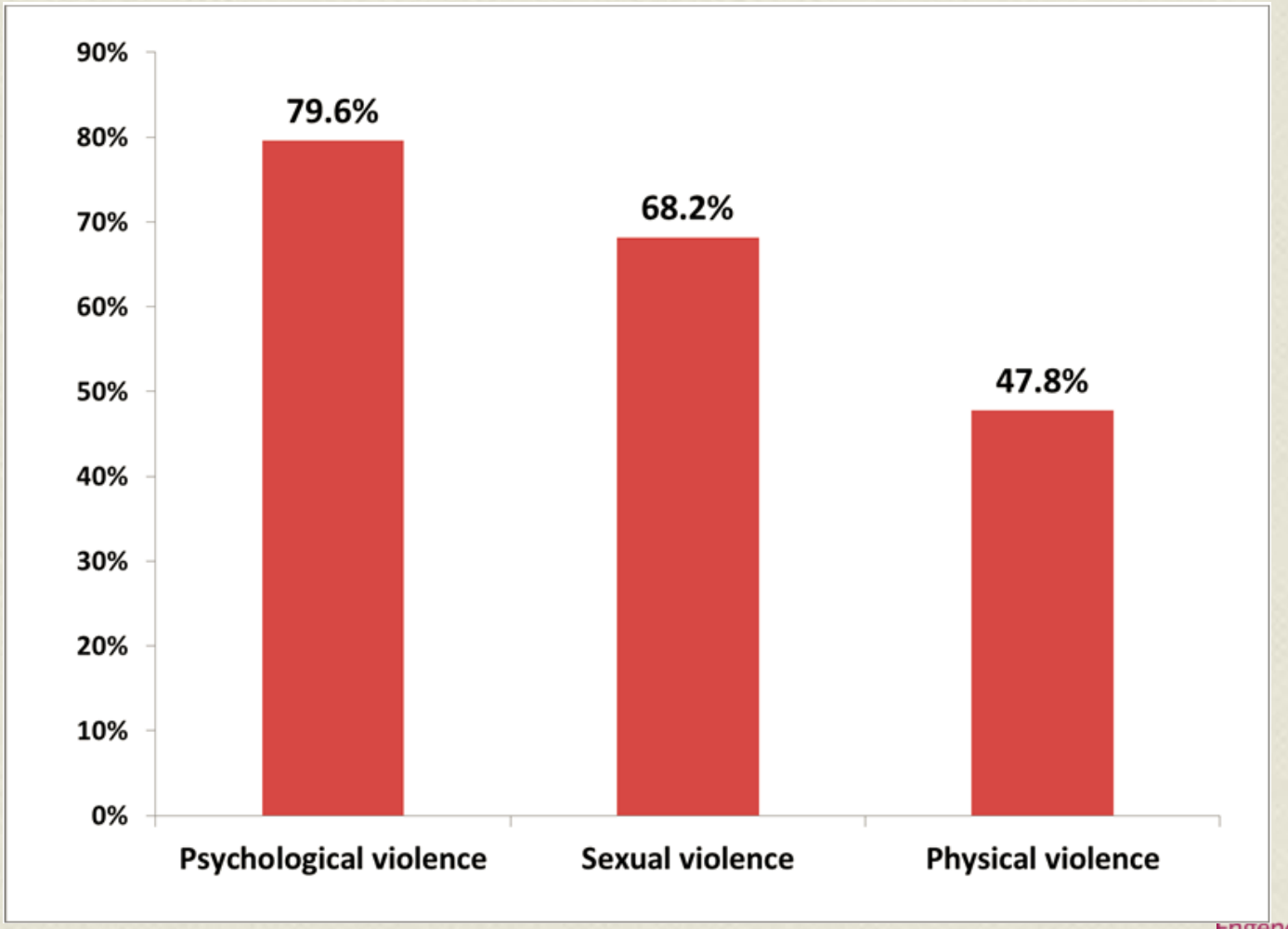
Of the 171 women screened during 3 months, 157 were positive for IPV (92%)



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Client Interviews

Mean score of clients on their experience with IPV screening and counseling, N=59

Statement	Score (out of 4)
The provider explained things in a manner that I could understand.	3.96
The provider took the time to let me ask questions.	3.66
The provider told me that our conversation would be confidential.	3.83
The provider listened attentively when I had something to say.	4.00
The provider did not judge or blame me.	4.00
I believe the information I received is accurate.	3.98
I am confident that the provider will keep our discussion private.	3.74

Note: Scores could range from 1 (strongly disagree) to 4 (strongly agree).

All women interviewed said that they would recommend the clinic to other women.

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Client interviews

"[IPV screening] is a good thing for women. We suffer, but we do not know what to do. Even if we suffer, parents say we must accept it so that our children can succeed tomorrow. What you started here is very good for us."

—Client, age 34, no education

"If a person is suffering like me, I will have to tell her to come here for good advice."

—Client, age 35, no education

"Because this is a problem, we do not talk a lot. At home, a woman must accept everything. So I enjoyed today's discussion. I know that I can now entrust myself to the lady I talked with on this issue."

—Client, age 19, some secondary education

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In-depth Interviews with Providers

Midwife, FP Counselor and consultant were interviewed

"[I felt adequately prepared to provide IPV screening] because I participated in the training, then performed simulations during the follow-on session that took place before the start of clinic activities." —*Nurse-midwife*

"I know that women are interested, and I feel useful to my community. And I help women like me, because we are all victims of violence." —*Nurse-midwife*

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Key Stakeholder Interviews

"Despite the short duration of the project, our conclusion is that the project has not only affected a number of women, but it has strengthened the technical skills of providers and supervisors involved in the project."

—*Steering committee member representing the MOHPH*

"The project has strengthened the institutional capacity of our [member association]. We want to develop the same skills at other clinics."

—*Steering committee member representing an IPPF member association*

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What did not work?

- Referrals – only one woman accepted a referral formally
- 5-day workshop was too short for the amount of information and skills-building that was needed (added 2-day practice workshop, mock client visits and practice with documentation/forms)
- Overburdened staff person - One nurse-midwife was responsible for all IPV screening and counseling, as well as for her regular FP duties
  - Original design included regular debrief meetings with several staff involved in screening so they could share experiences, challenges, and ways to deal with those challenges, including stress management.

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Potential reasons for lack of referral

- Socio-cultural context – stigma associated with IPV
- Discomfort repeating incident to others
- Additional costs in terms of time and money
- May not have perceived an urgent need to seek additional assistance (urgent cases may not have come to AGBEF).
- Simply may not have wanted any referral – need to measure expectations of referral realistically (benefits, etc)

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Lessons Learned

- Design a curriculum that is appropriate for the level of the trainees; ensure that there is enough practice sessions in training
- Allow sufficient time and practice (post-training) for the clinic to integrate IPV screening and counseling into their systems and operating protocols.
  - Mock client visits;
  - TA visits (2 per week);
  - Extra training (refreshers);
  - Practice, practice, practice
- Stipulate that IPV screening begin only when staff are ready
- Adapt the IPV screening and counseling process to local procedures
- Be mindful of staffing levels and provider workload at the clinic
- Be mindful of need to prevent and manage secondary trauma
- Implement this approach as part of a broad multisectoral approach to IPV
  - Address social norms, prevent GBV, improve/develop critical GBV services, address laws and legal response (informal and formal)

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Links to Tools from Project

Report - “Integrating Intimate Partner Violence Screening and Counseling with Family Planning Services: Experience in Conakry, Guinea”:

http://www.respond-project.org/archive/files/6/6.2/Study16-Integrating-IPV-and-FP.pdf

Training manual - “Integration of Family Planning and Intimate Partner Violence Services: A Prototype for Adaptation”

http://www.respond-project.org/archive/files/6/6.3/Integrated-FP-IPV-Guide.pdf

“Responding to the Impact of Gender-Based Violence: An Annotated Bibliography for Integrated Family Planning and Gender-Based Violence Services”

http://www.respond-project.org/archive/files/6/6.3/Responding-to-the-Impact-of-GBV.pdf

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Thank You

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