COOPERATIVE AGREEMENT NO.
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STANDARD OPERATING PROCEDURE

for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing

PEPFAR
USAID FROM THE AMERICAN PEOPLE
EpiC Meeting Targets and Maintaining Epidemic Control

Identifying and Responding to Intimate Partner Violence

in the Context of Index Testing

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Contents

Abbreviations and Acronyms

GBV	Gender-based violence
HIV	Human immunodeficiency virus
IPV	Intimate partner violence
PEP	Post-exposure prophylaxis
SOP	Standard operating procedure
STI	Sexually transmitted infection
WHO	World Health Organization

Definitions

Sex — refers to the classification of people as male, female, intersex, or another sex based on a combination of sexual and reproductive organs, chromosomes, and hormones.

Gender — social ideas about what traits, roles, responsibilities, and behaviors are acceptable for people born with female or male biological characteristics. The social definitions of what it means to be male or female vary among cultures and change over time.

Gender identity — refers to a person's sense of self as being male, female, nonbinary, or another gender, which may or may not correspond to the sex assigned to them at birth.

Gender-based violence (GBV) — any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e., gender) differences between males and females; used to maintain and reinforce power differences based on gender.

Intimate partner violence (IPV) — a form of gender-based violence that refers to any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in that relationship.[1] It includes:

- Physical aggression (slapping, hitting, kicking, or beating)
- Emotional/psychological abuse (insults, belittling, constant humiliation, intimidation, threats of harm, threats to take away children)
- Sexual violence (unwanted sexual comments or advances; forcing someone to have sex or perform sexual acts when they do not want to; nonconsensual sexual touching; nonphysical sexual acts such as sexting; harming someone during sex; forcing or pressuring someone to have sex without protection from pregnancy or infection)
- Economic abuse (use of money or resources to control an individual; blackmailing; refusing right to work; taking earnings; withholding resources as punishment)
- Other controlling behavior (including isolating a person from family or friends; monitoring their movements; or restricting access to financial resources, information, education, medical care, or other resources)

- IPV includes violence committed by former partners and individuals in dating relationships. IPV also encompasses harmful practices such as female genital mutilation/cutting; child, early, and forced marriage; and dowry-related murders. IPV occurs in all settings and among all socioeconomic, religious, and cultural groups. The vast majority of victims of IPV are cisgender women and girls; however, IPV also occurs against transgender women and cisgender and transgender men. Lesbian, gay, bisexual, and transgender people are at particularly high risk of IPV.

Routine enquiry — an approach to identifying cases of IPV among all clients who present for specific services, without resorting to the public health criteria of a complete screening program. For populations that may be at higher risk of experiencing violence, routine enquiry is recommended in services such as antenatal care, HIV care and treatment, and pre-exposure prophylaxis (PrEP) services.[2]

Clinical enquiry — an approach to identifying IPV by staying attentive to possible clinical cues and other signs and asking about violence if you note these cues. Clinical cues include on-going stress, anxiety, or depression; substance misuse; thoughts, plans, or acts of self-harm or (attempted) suicide; injuries that are repeated or not well explained; repeated cases of sexually transmitted infections (STIs) and unwanted pregnancies.

First-line support — the minimum level of (primarily psychological) support and validation of their experience that should be received by all clients who disclose violence to a health care (or other) provider. First-line support involves five tasks, summarized by the acronym “LIVES” (listen, inquire about needs and concerns, validate, enhance safety, and support).

Cisgender — describes people whose sense of gender identity corresponds with their sex assigned at birth.

Transgender — describes people whose gender identity is different from the sex assigned to them at birth.

Background

This standard operating procedure (SOP) is intended to be adapted and used by programs offering index testing. The SOP's aim is to guide programs in 1) preparing their clinics to ask about and respond to violence, 2) identifying clients who are experiencing intimate partner violence (IPV), and 3) providing appropriate violence response services.

Evidence has shown that GBV is a barrier to HIV services. Furthermore, it is possible that violence can result from index testing. In order to link survivors of violence to violence-response services and to avoid adverse events related to index testing, USAID requires that all PEPFAR-funded index testing sites conduct routine inquiry for IPV with all clients engaged in index testing. After conducting routine enquiry for IPV, staff must then offer appropriate support and referrals to violence response services, per WHO clinical guidelines.

Important Note:
The SOP **must** be adapted by each program to reflect local laws, policies, resources, and procedures. The SOP should be formatted using the program's standard template, including dating and assigning a version number at the time of adaptation. The SOP should be reviewed by the relevant staff and updated as needed after implementation.

WHO clinical guidelines[3] state that the following minimum requirements must be in place before providers can ask clients about violence:

- A protocol/SOP for conducting routine enquiry.
- Providers who are trained on how to ask about IPV.
- Providers who are able to offer first-line support when violence is disclosed. First-line support "refers to the minimum level of (primarily psychological) support and validation of survivors' experience that should be received" by those who disclose violence to a health care or other provider. It shares many elements with "psychological first aid" in the context of emergency situations. The WHO uses the acronym LIVES to help providers deliver first-line support:
  - Listening with empathy
  - Inquiring about the client's immediate needs and concerns
  - Validating the client's experience
  - Assessing and helping Enhance the person's safety
  - Linking the client to other Support
- A private setting with confidentiality assured where providers can ask about IPV.
- A process for offering referrals or links to other services.
- A standard set of questions to which providers can document responses.[a]

[a] USAID, Office of HIV/AIDS, Gender and Sexual Diversity Branch provides additional guidance noting that standard questions are required.

When adapted to the local context, this SOP helps index testing programs meet the requirement for having an SOP in place for conducting routine enquiry for IPV. The SOP also outlines how programs can ensure compliance with the other minimum requirements. Programs can use this document as a stand-alone SOP or integrate it into a larger SOP on index testing.

Purpose

This SOP defines procedures for using routine enquiry to identify index clients who are experiencing IPV and for providing clients who disclose violence with adequate first-line support, referral, and follow-up.

Scope

This procedure applies to all program staff involved in index testing services (including health care workers, clinic support staff, and outreach workers who collaborate with the site conducting index testing) as well as staff who are involved in the support, referral, or follow-up of clients who report IPV (including social workers, support group leaders, and counselors). This SOP covers creating an enabling environment to conduct routine enquiry, taking steps to identify individuals experiencing violence, and then providing "first-line support" to those who disclose violence. The final step of first-line support is appropriate referral, to both clinical and nonclinical services.

This SOP does not cover provision of comprehensive clinical services available onsite or via referral (e.g., treatment of injuries, emergency contraception, post-exposure prophylaxis [PEP] for HIV and sexually transmitted infections (STIs), mental health screening and treatment for depression and post-traumatic stress disorder, and forensic examination). A pathway to guide the provision of clinical violence response services at the index testing site is outlined in Appendix A. This SOP also does not cover the provision of nonclinical services to which a client may be referred. However, setting up a referral system for these services is described.

For more information on clinical services, please see *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines* and *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*. For more on nonclinical services, please see Section 8.2: Establish Coordination and Referrals between Health Services and Services of Other Sectors in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*.

Responsibilities

- All staff who conduct index testing or supervise staff who conduct index testing are responsible for understanding and following this SOP. In particular,
- *[Program to fill in appropriate position(s)]* who is responsible for establishing and maintaining the referral network.
- *[Program to fill in appropriate position(s)]* who is responsible for training program staff to work with clients in accordance with this SOP and for day-to-day oversight and support of relevant staff.
- Program staff who offer index testing should be trained to conduct IPV routine enquiry and the provision of first-line support.
- All program staff who directly interact with clients including *[counselors, clinicians, clinic support staff, and community workers]* should be trained to provide first-line support to clients who spontaneously disclose violence.
- *[Program to fill in appropriate position(s)]* who is responsible for 1) monitoring and assessing the effectiveness and efficiency of routine enquiry; IPV identification; and provision of first-line support, referral, and support activities; and 2) working with program staff to improve strategies, including through supportive supervision, to provide the best possible violence-related support to clients, as outlined in this SOP.
- *[Program to fill in appropriate position(s)]* has the ultimate responsibility for ensuring that all applicable staff members follow this SOP.

Procedures

1.0 Preparation

1.1 Review local laws, policies, and guidelines to determine the obligations of the health system to care for survivors, including female, male, and transgender survivors, and to understand any situations in which mandatory reporting of violence is required. A checklist of local laws is available in Job Aid 6.1 of *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*. If mandatory reporting to law enforcement is required or there are any other limitations regarding confidentiality, providers must share this information with a client before asking that person about violence.

1.2 ***Develop and maintain a referral network.*** See Appendix B. Steps for Establishing and Maintaining a Referral Network. Programs should develop and maintain an accurate and current referral network of local organizations that provide services to people who have experienced violence. Relevant services are listed in Appendix C: Referral Network Template. A template of a referral letter is available in Appendix D and should be adapted as needed.

1.2.1 Ensure that program staff are generally familiar with referral organizations and aware of referral processes. *[Site to specify responsible people*] will ensure that team members get relevant updates on this information by *[insert process and timeline for information sharing within the team].*

1.2.2 Make informational materials on violence response services from relevant organizations available in clinic rooms, waiting areas, and online as appropriate. *[Facilities to add applicable locations that are accessible and/or potentially more private for clients, such as restrooms or the pharmacy.]*

1.3 Create private spaces for index testing within the facility where no other clients or staff can hear conversations taking place.

1.4 Ensure the safe management of information related to clients' experiences of violence. Refer to Appendix E. In addition, the facility should have an index testing register that includes places to document:

1.4.1 That each client was asked about IPV perpetrated by each named partner

1.4.2 Each client's responses related to IPV for each named partner

1.5 Train staff who are conducting index testing on routine enquiry and first-line support (also known as psychological first aid) according to WHO's standards.

1.5.1 Train all program staff (including peers and other community workers) who directly interact with clients how to conduct LIVES. Use the relevant portions of *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-Care Providers* or another curriculum that covers LIVES. This training will help to ensure that all PEPFAR-funded programs are able to correctly, consistently, and compassionately respond to disclosures of violence. While the WHO materials were designed to address the needs of cisgender women, the general steps for routine enquiry and the provision of first-line support are relevant beyond this population. For training materials that include examples tailored to key populations, see the health care worker training in the *LINKAGES Violence Prevention and Response* series of resources.

1.6 Tailor routine enquiry questions. If you are working with key populations or translating questions into a local language, work with staff and beneficiaries to adapt the questions in Appendix F as needed to ensure that the questions are clear and relevant to the experience of the target populations. This can be accomplished by conducting focus groups or more informal discussions with members of the target population(s).

1.7 Ensure that all locally required forms, such as police referral and forensic forms as relevant, are available and that safe information storage procedures are in place. For more information, see Appendix E of this SOP and also Annex 11: Privacy and Confidentiality in Documentation in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*.

1.8 Develop or identify a system to support staff who work with survivors. Depending on the program resources and staff preferences, this may include finding external mental health service providers to whom program staff can disclose their concerns or identifying internal mental health providers who feel comfortable counseling their colleagues. See Section 5 for more information.

1.9 Convene all relevant staff to review and discuss the SOP and ensure they know their roles, responsibilities, and support available, and that they have the appropriate coordination mechanisms in place to implement the SOP.

2.0 IPV Routine Enquiry in Index Testing

A job aid for IPV screening during index testing is provided in Appendix G, and a script to help providers discuss violence with their index testing clients is in Appendix H.

2.1 ***Routine IPV enquiry process.*** During the index testing process, the health care provider who solicits contacts and obtains the client's consent to participate in index testing must ask the client whether each named partner has committed violence against the client.[b]

2.1.1 [Insert program staff member positions or names who will be responsible for routine enquiry; this should be everyone who initiates index testing] will conduct routine enquiry with all clients as a part of index testing. This can occur only if the client is alone or if any children accompanying the client are under the age of 2.

2.1.2 ***Limits to confidentiality.*** Based on the legal review conducted as part of preparation (Step 1.1), program staff must communicate any limits to confidentiality, such as mandatory reporting requirements, to each client before asking about violence. The staff should tell the client what acts require the staff to report information the client has shared and to whom the report would be made. [Program to include examples of situations that according to local laws must be reported, such as violence with a firearm or harm to minors or the elderly.]

2.1.2.1 If the client shares an experience that requires mandatory reporting, the provider should follow all local procedures and let the client know what those procedures entail.

2.1.3 When bringing up the issue of violence, the staff person should explain why questions about violence are being asked—1) out of concern for the client's well-being, 2) due to the effects of violence on HIV-related outcomes, and 3) for assurance that index testing can be done safely. Staff should also share that these questions are asked of everyone, and that many people experience problems at home.

2.1.3.1 Consider using this language: "Many people experience problems with their spouse or partner. This may include violence. Violence from a partner can negatively affect many aspects of your life, including your health, and because I care about your health and well-being, I want to ask you the following questions before we talk about partner notification. I want you to know that I will keep anything you tell me between us, unless you give me permission to share it. [If mandatory reporting is required, add language such as, 'The only circumstances under which I will share what you tell me are….'] Because your safety is important to me, I would like to ask you the following questions."

[b] Please note that violence is broadly defined to include physical, sexual, economic, and emotional/psychological abuse. You can see this reflected in the example questions under 2.1.4. In this way, threatening to cause physical harm is committing emotional violence as the survivor is harmed psychologically by the threat, even if the physical abuse does not occur.

2.1.4 Use a standard set of questions to ask about violence from each named partner, one partner at a time. Consider using the text below, adapted from PEPFAR guidance:[c]

> Has [partner's name] ever made you feel afraid, bullied or insulted you, threatened to hurt you, or tried to control you (for example, not letting you go out of the house)?
>
> Has [partner's name] ever hit, kicked, slapped, or otherwise physically hurt you?
>
> Has [partner's name] ever forced you into sex or forced you to have any sexual contact you did not want?

2.1.5 If working with key population members, consider developing questions tailored to their experiences (see Appendix F).

2.1.6 If violence is not disclosed, remind the client that you and the other staff are there to provide support if violence occurs in the future or if the client remembers an event later that they wish to share. In addition, tell clients who do not disclose violence about existing violence response services so that they understand that help is available if it is ever desired.

2.1.6.1 If the client does not disclose violence, but you suspect that violence is occurring or that the person is simply reluctant to share at this time, tell the client that the conversation can continue during future visits. You may also decide to offer an additional visit in the near future so that the client can come back sooner than may be necessary for other clinical services.

2.1.6.2 However, do not pressure someone to disclose violence even if you believe it is occurring.

2.2 If violence is disclosed, after completing the steps in Section 3 below, recommend that the client not initiate index testing. If the client wishes to initiate index testing and the provider believes it can be done safely, choose a method of index testing that does not require disclosure.

2.3 When the client returns for their own HIV care, after index testing, if the provider handling their care was the person to whom they disclosed violence, the provider should adapt their counseling to take into account their knowledge of this additional barrier to HIV services. Other providers may not be aware of the violence in the client's life; if they are aware, they also should adapt their counseling.

2.3.1 For example, the provider may ask if the client needs help thinking about a safe place to hide ARVs from a partner who may become physically violent, or the provider may ask if the client foresees any challenges to attending future appointments, such as may occur in the case of a controlling partner.

[c] These questions were adapted from the "Partner Information Form," referenced in the PEPFAR 2020 Country Operational Plan Guidance for all PEPFAR Countries, which includes an illustrative set of IPV screening questions. Available at: link.

3.0 Provision of First-line Support to Clients Who Disclose Violence

3.1 ***First-line support.*** If the client discloses violence during routine enquiry, program staff should provide first-line support, which includes basic counseling or psychosocial support. The WHO defines "first-line support" using the acronym "LIVES," which consists of:

Listen	Listen to the client closely, with empathy, and without judging.
Inquire about needs and concerns	Assess and respond to the client's various needs and concerns—emotional, physical, social, and practical (e.g., childcare).
Validate	Show the client that you understand and believe them. Assure the client that the client is not to blame for the violence they have experienced.
Enhance Safety	Discuss a plan to protect from further harm if violence occurs again.
Support	Support the client by helping them connect to information, services, and social support.

For detailed information about implementing first-line support using LIVES, see *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook,*[3] Part 2: First-Line Support for Sexual Assault and Intimate Partner Violence. Because the client is using ARVs, during safety planning (step "E"), include ARVs as an item to pack if the client decides to leave their home.

3.2 ***Additional information on referrals***. When making referrals, staff should only share the information that the client has agreed can be shared; all other information about the client must be kept confidential. In addition to the guidance on making referrals on pages 29–31 of the WHO clinical handbook, the following is recommended.

3.2.1 ***Accompaniment.*** When possible, [insert relevant staff] should accompany clients for walk-ins [insert relevant transport considerations as needed]. Provide the referral agency a referral letter (see Appendix D), including a detailed reason for referral (only if the client gives permission for this information to be included in the referral letter). This is an important option to offer the client because it can help the referral agency know the client's general situation and needs without the client having to recount their experiences of violence.

3.2.2 ***Other active referrals.*** In the absence of accompaniment, other active referrals must be offered. This can include offering to help the client make an appointment by calling for them (ask the client in advance what information about their experience or needs should be shared with the referral organization), making a call with them, or offering a private place where the client can make a call. Offer the client a completed referral letter (see Appendix D) to take to the referral agency. In this situation, the reason for referral should be general (for example, something like: "the client is being referred for additional counseling and psychosocial support") to reduce the risk of harm if someone else found the letter.

3.2.3 ***Offering printed copies of the referral list.*** Program staff can offer printed copies of the referral list to clients, if safe and appropriate. Note that sometimes having a referral list may put a client in danger. Alternatively, you could offer to send it to the client by WhatsApp or email or have the client record some of the most relevant numbers in their phone (these can be recorded under false names to limit the risk to the client). Be sure to assess the client's comfort and safety related to accepting a referral list or receiving/storing information in their phone before taking this step.

3.2.4 ***Referral follow-up.*** Program staff should note client preferences for follow-up (phone or in person). Clients who give permission to be contacted should be contacted by the agreed-upon staff member(s) to determine whether the client received the services for which they were referred and what their experience was like at the referral organization. This will be documented [insert facility's referral documentation procedures and forms]. If clients report negative experiences, this information should be used to update the service directory. Clients who do not accept referrals or who do not agree to be contacted about the issue again will be reassured that resources are available for them in the future if they change their minds.

3.3 Each site should define a referral process for both services offered inside the facility and those provided beyond the facility. The referral process should prioritize services that are time bound—such as PEP and emergency contraception—if relevant and desired by the survivor. [Appendix B provides more information on establishing a referral process for clinical and nonclinical services.]

3.4 Spontaneous disclosures of violence.

3.4.1 Some clients may disclose experiences of violence to program staff, including community workers, without being asked. Therefore, it is preferable that all program staff are trained on LIVES.

3.4.2 If a spontaneous disclosure is made to an individual who has not been trained on LIVES, the untrained individual should thank the client for sharing, provide information on the services available to survivors, and offer to go with the client (or provide information to allow for connection via phone) to link them with someone who has been trained on LIVES.

3.4.3 When a spontaneous disclosure is made to someone who has been trained on LIVES and the conversation can occur privately, the trained person should listen empathetically, inquire about their immediate needs and concerns, and validate their experience (L-I-V in LIVES).

If a staff person is available who has expertise counseling clients on IPV (such as a therapist or social worker), the program staff who initially received the spontaneous disclosure may listen, inquire, and validate. Then the staff person can offer to accompany the client to the more experienced staff person who can complete E (enhancing safety) and S (link to support) in LIVES.

This may be appropriate when the person receiving the spontaneous disclosure does not have time to go through all the steps of LIVES.

However, the final decision as to whether the client will receive steps E and S from another staff person with more expertise must be made by the client. To limit the need for clients to repeat themselves, the person who receives the spontaneous disclosure should offer to summarize what the client disclosed for the staff person with more expertise.

4.0 Staff Experiences of Trauma

4.1 Working with violence survivors can increase the risk of staff experiencing burnout and vicarious trauma. Health care providers' thoughts and beliefs may change as a result of empathy for and/or repeated engagement with violence survivors.[4] For example, staff may start to believe that no relationship can be healthy. This is particularly a concern for staff who have themselves experienced violence. The site will work to reduce the effect of vicarious trauma on staff in the following ways.

4.1.1 ***Debrief sessions.*** The team should hold group debrief sessions facilitated by [insert relevant staff] to discuss client experiences (without naming the clients) and the staff's/facility's capacity to respond. One goal of these sessions is to identify lessons learned and potential improvements that can be made in response. If attendees mention challenging situations, these debrief sessions can also include time to discuss the well-being of staff members involved in the case. [Insert frequency of sessions or outline how timing of sessions will be organized.]

4.1.2 ***Supportive supervision.*** Those who supervise staff working with survivors should check in with staff during regularly scheduled supervisory meetings. Supervisors should enquire about their team's well-being and their feelings about the work with survivors and also ensure that staff know about the services available to them if they would like additional support.

4.1.3 ***Referral.*** Site leadership [or insert relevant staff] should work with any staff members who have been affected, such as by providing referrals to relevant organizations for further support. [Insert any additional support to be offered to staff, such as one-on-one time with colleagues or individual debriefing sessions, as appropriate.]

4.1.4 ***Additional paid leave time.*** If possible, give additional paid leave time to staff who are experiencing vicarious trauma.

5.0 Documentation

Document the reporting of IPV and provision of care and referrals in the following places [site to adapt to their reporting procedures].

- Index testing register: Note whether IPV risk assessment occurred and what clients said in response to questions about violence (simply noting yes or no, but not providing details).
- Referral log: Provide initial referral and follow-up information.
- The GEND_GBV PEPFAR MER indicator: Use in clinics with GEND_GBV targets to document the number of clients who receive post-violence care, the type of violence that was reported (sexual or emotional/physical), and PEP provision and completion as relevant.

6.0 Adapted Procedures Due to COVID-19

6.1 ***IPV during COVID-19.*** During COVID-19, the risk of IPV has increased. At the same time, many violence response services have been forced to change their operations, which affects the services available and how they can be accessed.

6.2 ***Key messages for clients about IPV during COVID.*** Talk to clients about the increased risk of violence occurring during COVID-19 and remind them that they may call the facility at any time to be linked to violence response services.

6.3 ***Client follow-up***. For clients already identified as experiencing violence, arrange for safe follow-up via phone to help them make a plan to stay safe at home during lockdown or while living in quarantine. This should include tips on how to access support.

6.3.1 ***Safe communication.*** If program staff follow up by phone with clients who previously disclosed violence, establish a safe/code word that helps the survivor end a call quickly or alerts the program staff member of the need to change topics. Calls to the survivor should only be made if they have indicated this can be done safely and may include special instructions, such as not identifying the organization that the program staff is associated with.

6.4 Update the local referral directory more often than normal, following the steps outlined in Appendix B. Ask about changes in hours that services are available and for any advice on safe transport during lockdown/curfews so that this can be communicated to survivors.

6.5 ***Resources for staff.*** Provide additional phone/internet credit to program staff tasked with responding to violence, such as psychologists, because they make their services available virtually.

Appendices

Appendix A. Content Recommendations for SOPs Describing Clinical Violence Response Services

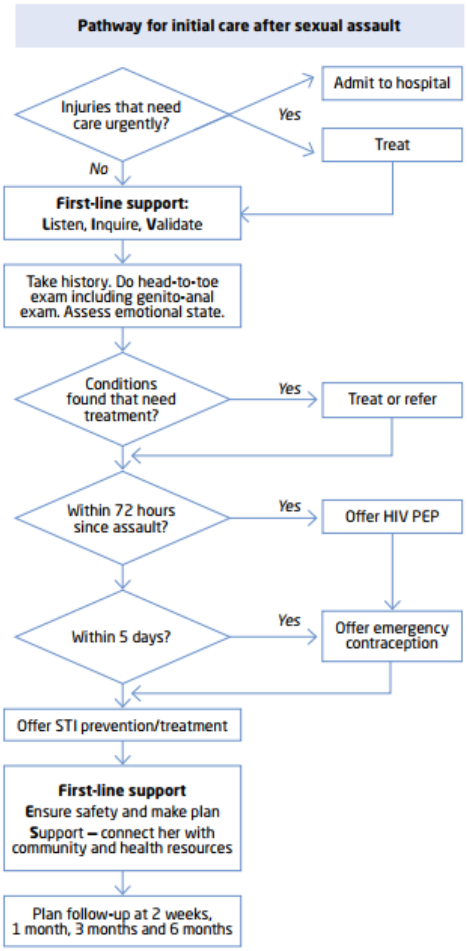
According to the WHO Manual for Health Managers,[5] a complete SOP covering the clinical response to violence should:

- Specify the role of each health worker who interacts with a client from the time the individual who discloses violence enters the facility to the time they leave. This will be specific to the site; as needed, describe referrals that will be made for other clinical and non-clinical services that cannot be provided onsite.
- Indicate how providers will be supported in self-care and coping with burnout.
- Define the core elements of an essential package of services for survivors of violence (see list below). Offer as many of these services as possible onsite.
- Describe patient flow and procedures that promote privacy and eliminate waiting time for individuals who have experienced violence.
- Provide a simple pictorial reference for health-care providers that depicts the flow diagrams or algorithms.

The SOP should be shared with staff who provide the following essential services onsite:

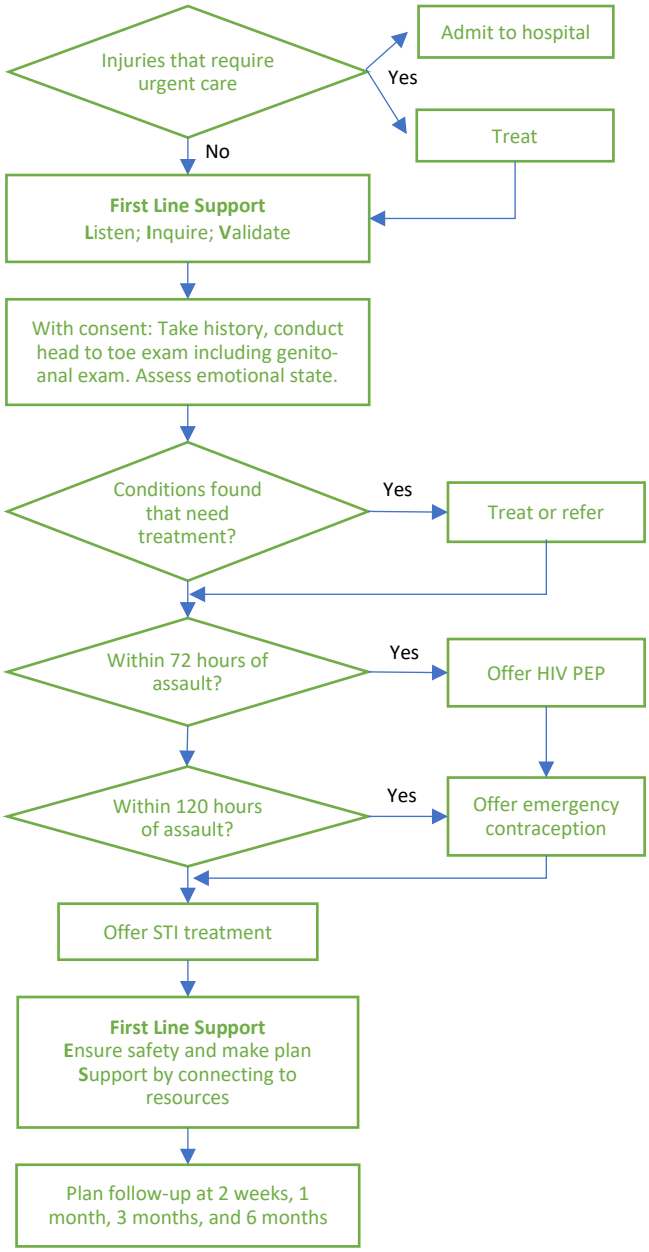
- **Identification** of those subjected to violence
- **Management/treatment** of any immediate or urgent medical conditions associated with violence.
- **Provision of first-line support** to individuals subjected to intimate partner violence and sexual violence—includes supportive listening, safety planning, and enhancing social support through referrals.
- **Clinical care for sexual assault—**includes taking history; providing medical examination and, where appropriate, forensic examination and investigations; providing tests and treatment for management of injuries; offering services/commodities to prevent pregnancy, STIs, and HIV; and providing follow-up care.
- **Provision of mental health care** to individuals subjected to intimate partner violence or sexual violence—includes basic psychosocial support as well as assessments, management, and referrals for more severe mental health problems.

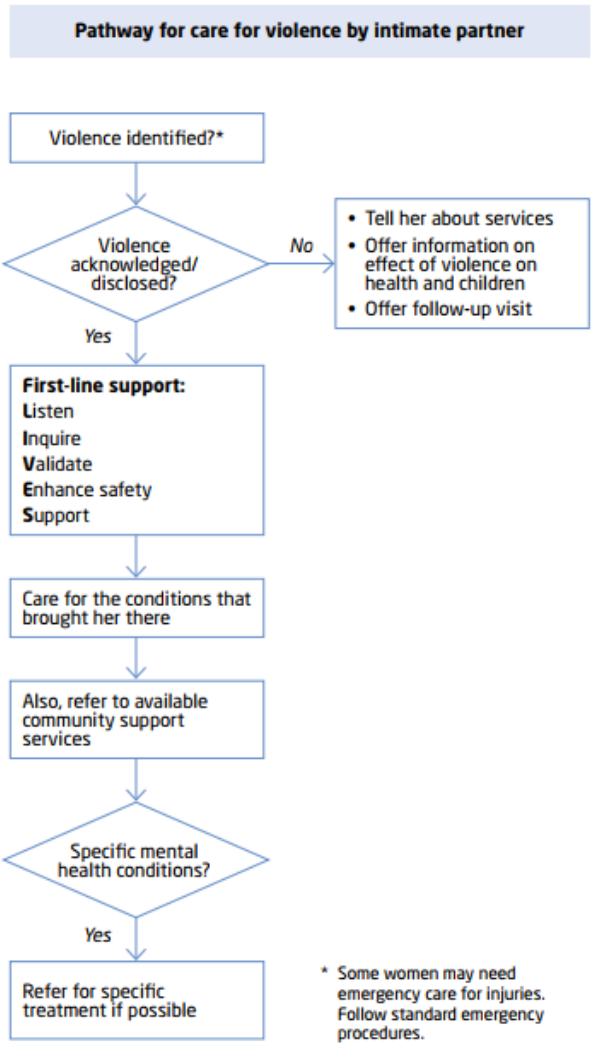
The SOP should be designed to facilitate access to services in an order that is based on clinical need. See images below regarding pathways of care for victims of sexual assault and IPV.

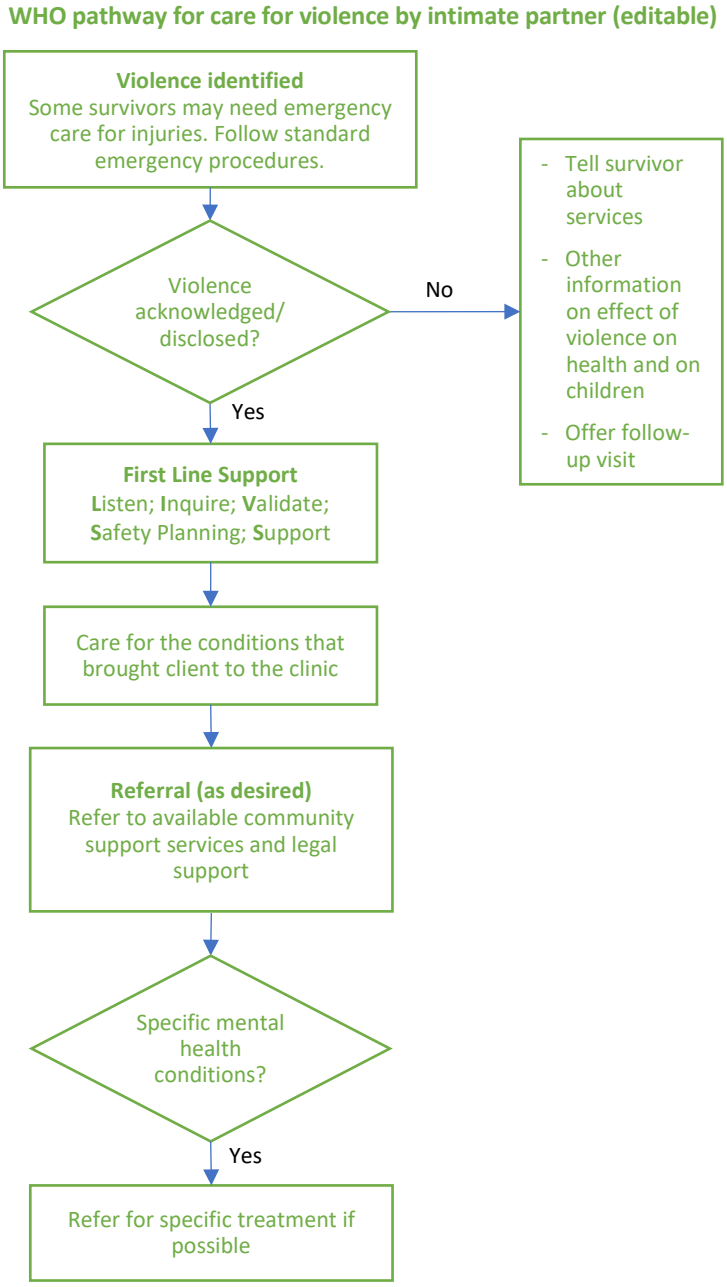


[1] Health care for women subjected to intimate partner violence or sexual violence. Geneva: World Health Organization; 2014 (http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/).

WHO Pathway of care for sexual assault (editable)




Pathway for care for violence by intimate partner
Violence identified?*
Violence acknowledged/ disclosed?
No
Tell her about services
Offer information on effect of violence on health and children
Offer follow-up visit
Yes
First-line support:
Listen
Inquire
Validate
Enhance safety
Support
Care for the conditions that brought her there
Also, refer to available community support services
Specific mental health conditions?
Yes
Refer for specific treatment if possible
* Some women may need emergency care for injuries. Follow standard emergency procedures.


WHO pathway for care for violence by intimate partner (editable)
Violence identified
Some survivors may need emergency care for injuries. Follow standard emergency procedures.
Violence acknowledged/ disclosed?
No
Tell survivor about services
Other information on effect of violence on health and on children
Offer follow-up visit
Yes
First Line Support
Listen; Inquire; Validate; Safety Planning; Support
Care for the conditions that brought client to the clinic
Referral (as desired)
Refer to available community support services and legal support
Specific mental health conditions?
Yes
Refer for specific treatment if possible

Appendix B. Steps for Establishing and Maintaining a Referral Network

1. **Identify referral liaison.** Clinic leadership should identify a point person — the referral liaison— who is responsible for establishing and maintaining contact with referral organizations.
2. **Identify a diversity of services.** Efforts should be made to include organizations offering the services listed in Appendix C: Referral Network Template. Identify as many of these services as possible, but some services may not be available.
3. **Local standard of care for sexual assault.** Review *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook* Part 3: Additional Care for Physical Health after Sexual Assault and identify the local standard of care for recent victims of sexual assault, including HIV PEP, STI prophylaxis, emergency contraception, and forensic testing. Determine which of these services are available at your clinic and to which services clients will need to be referred.
4. **Preliminary contact.** Potential referral organizations should be contacted in advance of any first referral. Meetings between the referral liaison and a point person at the referral organization should occur in order to determine, at minimum, the following: type and range of services provided, requirements and qualifications needed to receive services, preferred referral pathways, contact information, and any informational/publicity materials provided by the organization. Meetings should also assess whether the referral organization provides survivor-centered, stigma-free services and what services are available for specific key population members, citizens, noncitizens, and asylum seekers. Referral organization names, addresses, contact details, and populations served will be listed in a completed version of Appendix C: Referral Network Template.
5. **Assess and provide training requirements**. If an organization that has historically served women in the general population is open to serving key population members but has not been sensitized on how to do so, training on the unique needs of key populations should be provided to the organization's focal point.
6. **Establish linkage relationship**. The referral liaison should meet with the point person at each referral organization every [program staff to determine specified time frames based on relevance of service, frequency of referrals, and likelihood of updates] to maintain a working relationship with the referral organizations and update important information as needed. Program staff should also visit the organization as needed to collect publicity materials such as informational brochures or cards.
7. **Establish technical working group (if feasible).** One way to continually gather information about referral organizations is to convene all local organizations that offer violence response services on a regular basis (either virtually or in person) in a technical working group dedicated to a coordinated violence response. These organizations can provide updated information on the services they currently offer and any changes to the services they offer. The technical working group can also be attended by community representatives and/or individuals who accompany

victims to services. These representatives can share anonymous feedback from those who have sought services and highlight issues such as poor treatment of survivors. Those who offer those services can describe the activities that will be undertaken to address any issues, or a decision can be made to remove this service from the list of referrals available. After each meeting of this group, the clinic can update the referral directory according to the changes described. This information should be shared with all program staff as part of regular staff meetings.

Appendix C. Referral Network Template

HEALTH SERVICES Includes post-exposure prophylaxis (PEP), forensic exams, family planning, emergency contraception, STI screening and treatment, OB/GYN, mental health screening and treatment, psychological support/counseling, substance abuse treatment		
[Organization/Facility Name] Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]
SOCIAL SERVICES Includes GBV-focused services, child protective services, psychosocial support including crisis counseling and support groups, women's groups, organizations working with marginalized or special needs populations, child care, housing/shelters, transportation assistance, food assistance, employment training and financial aid		
[Organization/Facility Name] Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]
LEGAL/JUSTICE SERVICES Includes legal aid (representation and provision of information), police/law enforcement, child protective services, local courts, prosecutor's office		
[Organization/Facility Name] Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]

Appendix D. Referral Letter Template

Date:_____ **Referral to:** _____

To whom it may concern,

Kindly attend to the following client whose details are listed below:

Name:_____

Address:_____

Telephone No.:_____

Reason for referral:

_____

_____

_____

_____

_____

_____

Referred by

Name:_____ **Signature:**_____

Please do not hesitate to contact us at *[insert organization name and add phone number]* should you require further information. If your facility or program is unable to assist this client, please refer her back to our facility or a suitable alternate facility that will be able to assist her.

Appendix E. Safe Storage of Information

Text in this section taken from Annex 11, Privacy and confidentiality in documentation, from *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*.

This checklist will help you make sure that records are secure.

How can we create secure records in practice?

- ❑ All staff members understand the importance of confidentiality and secure record-keeping, and staff members who routinely care for women subjected to violence have been trained to keep records secure.
- ❑ Identifying information about a woman, including her name and contact information, is not visible or accessible to those not caring for this patient.
- ❑ Staff members do not leave documents where a patient (unless requested), those accompanying the patient or anyone else might see them. Staff members do not carry charts open or lay them on shared desks or counters.
- ❑ When documenting information from women about their experience of violence, staff members avoid asking for or writing this information on records in a public place.
- ❑ Staff members do not write a notation indicating intimate partner violence or sexual violence on the first page of a record, which is more likely to be seen if flipped open.
- ❑ Staff members use a code, such as an abbreviation or symbol, to indicate cases of intimate partner violence or sexual violence on charts (recommended option). They do not write "DOMESTIC VIOLENCE SUSPECTED" or "RAPE" or other explicit wording in large print across the chart. Some countries use a color-coding system on medical records that is known only to the relevant health staff.
- ❑ Any sensitive information that needs to be destroyed is shredded by an authorized staff member.

How can we create secure records in storage?

- ❑ We have a secure site to store files.
- ❑ Documents are locked up at all times.
- ❑ Only a limited number of designated staff members have access to patient records.
- ❑ Staff members who need access to records have received training on record confidentiality and storage practices.
- ❑ Staff members authorized to access stored files have a means of access that is not available to others. (As the setting allows, this may be a key to a room, an electronic password or a security code to enter a room, or another method of obtaining access to a restricted area.)

Appendix F. IPV Routine Enquiry Questions for Key Populations (to be adapted as needed for your local context)

These adapted IPV questions include additional questions (1a-d) about forms of IPV that members of key populations may experience. If you further adapt these questions for your context, ensure that the questions:

Provide specific examples of violent actions instead of simply asking, “Has a partner been violent?” as people understand “violent” to mean different things, and

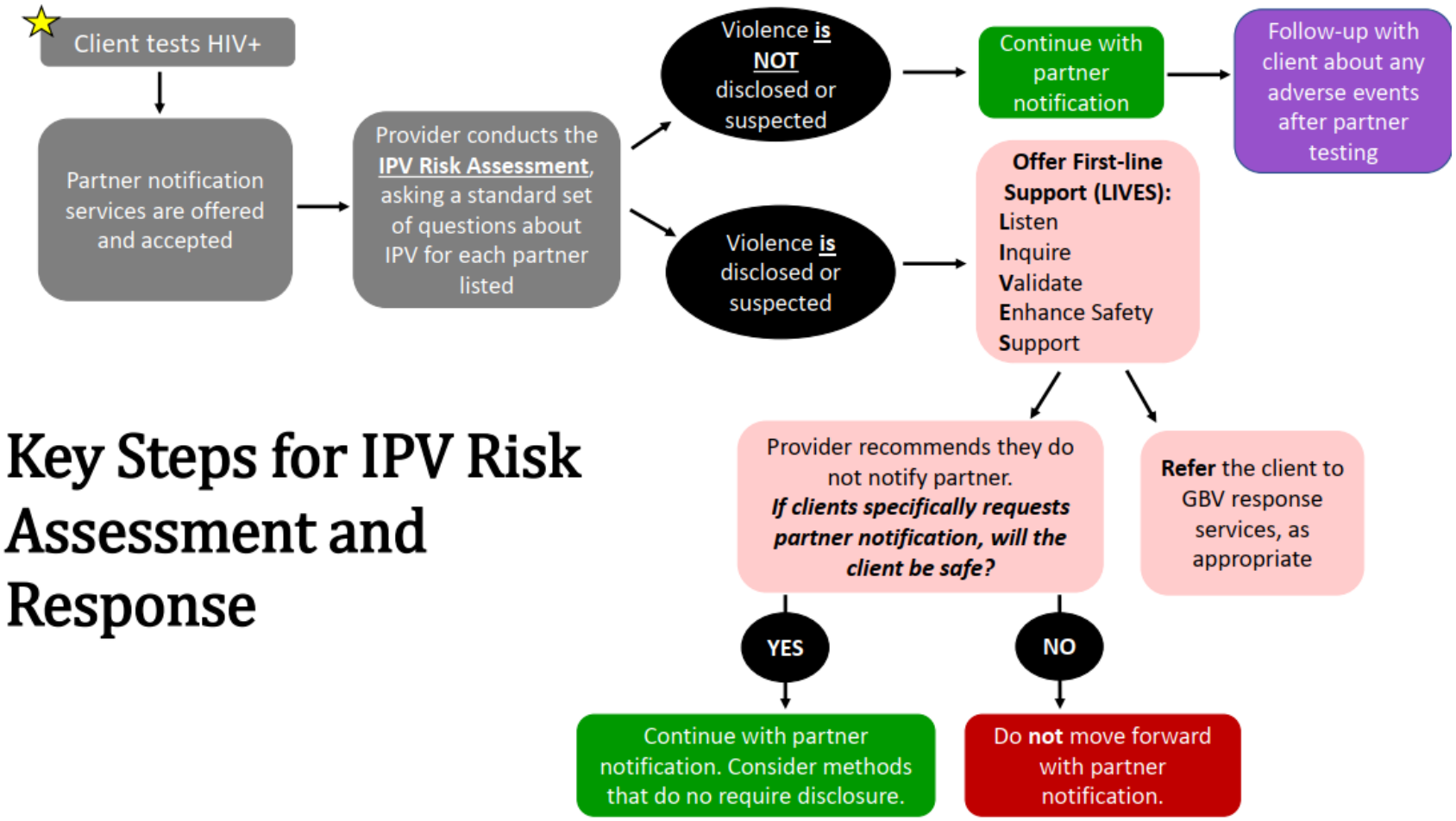
Are direct instead of general, such as, “How is your relationship?” which may be interpreted in different ways.

1. Has your partner ever made you feel afraid, bullied or insulted you, threatened to hurt you, or tried to control you (for example, not letting you go out of the house)?
    a. [For men who have sex with men, transgender women, sex workers]: Has your partner ever called you names, used slurs against you, or threatened to out you?
    b. [For men who have sex with men and transgender women]: Has your partner ever criticized your sexual performance, criticized your clothing, or asked you to act more masculine?
    c. [For transgender clients] Has your partner tried to control your transitioning process?
    d. [For transgender clients] Has your partner ever told you that no one else would want to be with someone like you because you are transgender?

2. Has your partner ever hit, kicked, slapped, or otherwise physically hurt you?

3. Has your partner ever forced you into sex or forced you to have any sexual contact you did not want?

Appendix G. Job Aid for IPV Screening and Response as Part of Index Testing



Appendix H. Index Testing Script

This script is designed to help you introduce and conduct index testing, including violence identification and response and adverse event monitoring. It can be adapted.

This script should be used with your SOPs for index testing. The bullets below in quotations are meant to guide what the provider says to the client. Italicized sub-bullets provide guidance on how to adapt what is said. Non-italicized bullets are instructions to the provider.

Before bringing up the topic of index testing/partner notification, make sure that the client is alone (no one other than a child under the age of two should be with them). Make sure that no one can overhear the conversation between the client and the provider.

If the provider does not already know the client, begin with introductions and creating a safe space.

Introducing index testing (use in all settings)

- "Your sexual partners (regular and casual partners), biological children, and/or people with whom you inject drugs may be living with HIV. They could benefit from HIV testing and counseling services."
- "I would like to talk to you about offering HIV testing to these individuals. We believe everyone should know their HIV status in order to access treatment and live a healthy life, but we would never contact someone without your consent. If you would like them to get tested, I can help you reach out to them, or I contact them myself, to encourage them to come in for services or be linked or referred to testing services elsewhere."
- "With your consent, I would like to ask you about your partners, biological children, and your injecting partners. You will have the chance to tell me if each person named should be contacted, and how that contact should occur."
- "If I contact them, your information will be kept confidential; no information about you will be disclosed to the people concerned and these people will not know that we spoke with you. Regardless of whether you decide to share the names of your partners and children, the services that you receive here will not change. You will continue to receive the same level of care. Would it be OK if I ask you the names of your partners, biological children, and your injecting partners? Giving their names does not mean you have provided permission for me to contact them. It is just the first step in the conversation."
- If consent to begin partner elicitation is given, ask about all sexual and injecting partners within the past 12 months. Ask about any biological children under the age of 19. Make sure to document their age, sex, and the relationship to the index client.

Introducing the topic of violence (use with all index clients)

- "Thank you for sharing your partners' names with me. As I said earlier, we will only contact these individuals with your consent. Your safety is important for us to consider before we decide whether we can contact these individuals."
- "Many people experience problems with their spouse or partner. This may include violence. Violence from a partner can negatively affect many aspects of your life, including your health. Because I care about your health and well-being, I want to ask you the following

questions before we talk further about partner notification. I want you to know that I will keep anything you tell me confidential unless you give me permission to share it."

- *Remember, if there is mandatory reporting in your context, the underlined text above must be revised to reflect any limits on confidentiality.*

- "Because your safety is important to me and because your safety directly affects your health and well-being, I would like to ask you the following questions:

  Has [partner] ever hit, kicked, or slapped you?

  Has [partner] ever threatened to harm you, humiliated you, or controlled your movements?

  Has [partner] ever forced you to do anything sexual that made you feel uncomfortable?"

  - *Ask these questions about each named partner. You can revise these questions or add others as needed. Questions should be standardized across providers at the facility.*

- If the client discloses violence <u>from any partner</u>, follow your clinic's SOP regarding violence response or a specific SOP related to violence detection and response within index testing. In both cases you will follow the LIVES technique described in the SOPs.
- After completing LIVES, recommend that the client does not move forward with index testing with any partners who have been violent or who have ever threatened violence. If the client wishes to move forward with index testing anyway, AND you believe it can be done safely, consider an option that does not require disclosure of the client's status to the violent partner. If it cannot be done safely, do not move forward with index testing of the partners who have perpetrated violence.
- If the client does not disclose violence and you do not suspect violence from a named partner or partners, with the client's permission continue with index testing for those nonviolent partners.

Helping clients decide how to contact partners (use when clients want to go forward with index testing)

- "There are different ways to invite partners and children to come for testing that protects you and the partners and children. You can use different options for each partner as needed. Choose whichever you think is best for each person. Here are some of the options:

  1. "You can encourage your partner to come for a test. This may or may not involve sharing your HIV status."
  2. "A counsellor or other health care provider can call or visit your partner and inform them they need to test for HIV. They will not share your name with the contact."

     - *If the client wants to know what will be shared with a partner who is contacted by a health care worker, note that there are options such as, 'We are reaching out to everyone in this community to offer HIV testing (or more generally health services) as part of X campaign,' or 'We received your contact information anonymously as someone who could benefit from HIV testing.' The client's recommendation on messaging that can safely be used should guide what the provider says when reaching out to the index case.*

3. "You and a counsellor can work together to notify your partner. You will have 30 days to tell them, after which, with your permission, the counsellor will contact your partner."
4. "The counsellor can sit with you and your partner and help you talk about getting tested. This may or may not involve telling your partner about your HIV status."

- "Now that you understand the options, do you have any questions? Are you comfortable moving forward with index testing for the individuals we have agreed are safe to contact?"
- Document consent in the index testing register.

Make a plan for moving ahead (use relevant approach based on client preference)

OPTION ONE: Index client informs their sexual partner:

- "Let's make a plan for how to talk to your partners. Think about these questions."
- "When and where is a good time and place to help you feel safe?"
- "How might your partner react?"
- "What questions will they have? What can you say in response?"
- "Consider having someone nearby for support if you need it. Also, we can practice until you feel comfortable."

OPTION TWO: Provider contacts the index case*:*

- "Let me explain how I will contact your partners."
- "We can help contact your partners."

  "We need a phone number or other form of contact. If you have it, we need a physical address."
- "We'll call first and follow up in person if that doesn't work."
- "We will not share your name or any information about you."
- "Please know that to protect your partners' confidentiality, we cannot tell you the results of the contact and, if they get tested, their test result."

OPTION THREE: Provider speaks to index client and index case together:

- "Let me describe how we can have this conversation together with your partner."
- "Talking with a partner about a sensitive topic can be hard, but you don't have to do it alone. I can help you have this discussion, but we need to plan how to do this."
- "Where would you feel most comfortable having this talk?"
- "When would be the best time to have this talk?"
- "In order for me to best support you, I need to know a bit more about how I can help."

  "What do you want me to say to your partner?"

  "Is there anything you want to ensure I do not say?"

- "What do you see as some of the challenges we might face having this discussion with your partner?"

    "How do you think they might react?"

    "What questions might they ask?"

- "How do you think we can overcome these challenges?"

    "When you have had these kinds of problems in the past with your partner, how were you able to address them?"

Wrapping up an index testing conversation (use when the client consents to having a partner and/or child contacted)

- "Thank you for taking time to talk with me today about how we can get your partners and/or children tested for HIV. I know it can be a difficult topic, but you've shown you are the type of person who looks out for others, even when it isn't easy!"
- Briefly review the conversation with your client:
    - "You said that: [*summarize client's key reasons for wanting to help with partner notification*.]"
    - "You mentioned a few worries: [*briefly summarize client's key concerns*.]"
    - "We agreed that to overcome those barriers, you/we will: [*summarize the key plans*.]"
- "Does what I shared seem correct to you? What would you add or change?"
- "After discussing all of this, how are you feeling now?"
- "Is there anything else I can help you with today?"
- "I'd really like to talk with you again, to see how you are doing and how it has been going referring your partners. When would be a good time to do that?"

Following up regarding adverse events (use for all who participate in index testing)

- Facilities should routinely ask index clients if they experienced any adverse events (described below) after participating in index testing services.
- Follow-up should be done during the client's first two to three clinic appointments OR through follow-up (phone or otherwise) four to six weeks after testing the client's contact(s) by asking the question below. Because an unintended negative outcome as result of HIV disclosure could still occur in the future, follow-up should occur while all contacts are being actively traced.
    - "In the time since you participated in index testing services, did you experience any harm from your partner, health care provider, or anyone else at this facility [or site]? This includes physical, emotional, sexual, or economic harm?"
- Document any adverse events following the procedures and using the forms outlined in your facility's Adverse Events Related to Index Testing SOP.

By adverse events related to index testing, we mean:

1. Threats of physical, sexual, or emotional, harm to the index client, their sexual or drug-injecting partner(s), or family members or the index testing provider
2. Occurrences of physical, sexual, or emotional harm to the index client, their sexual or drug-injecting partner(s), or family members or to the index testing provider
3. Threats or occurrences of economic harm (e.g., loss of employment or income) to the index client, their sexual or drug-injecting partner(s), or family members
4. Abandonment or forced removal of children < 19 years old from the home
5. Withholding HIV treatment or other services
6. Forced or unauthorized disclosure of client's or contact's name or personal information
7. Failure to obtain consent for participation in index testing and/or for notifying partners
8. Stigma or criminalization perpetrated by health site staff (e.g., sharing personal information with the criminal justice system about a KP member and/or person living with HIV seeking care)

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