

ADDRESSING GENDER-BASED VIOLENCE IN PREGNANCY: A Clinic & Community Approach in Rural Kenya



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BACKGROUND AND SIGNIFICANCE

Gender-based Violence (GBV) is increasingly viewed as a driving force of the global HIV/AIDS epidemic, particularly in sub-Saharan Africa where women are disproportionately at risk of both GBV and HIV infection. Between 39 and 47% of Kenyan women experience GBV in their lifetime- among the highest rates in the world.¹ It has been shown that GBV increases risk of HIV infection,^{2,3} and HIV-positive Kenyan women are twice as likely to experience GBV than their HIV-negative counterparts.⁴ GBV towards pregnant women in Kenya is estimated to be 13.5%,¹⁷ a higher prevalence than that of many conditions normally screened for during pregnancy.¹⁸

In addition to adverse effects on women's and infants' health (Fig. 1), our team has found evidence that GBV may worsen uptake of essential maternity and HIV services:

- Women who anticipate partner stigma or violence are twice as likely to refuse HIV testing during antenatal care¹⁹
- Women who fear violence or a relationship break-up are less likely to enroll in HIV care²⁰
- Pregnant women may choose not to deliver at health facilities for fear of being tested for HIV or disclosure²¹⁻²²

These findings have important implications for the success of our HIV care and treatment program in Nyanza Province, a region with the highest HIV prevalence in Kenya²³ where 54.1% of women are estimated to experience GBV.¹

Despite growing recognition of links between GBV and HIV—and the unique vulnerability of pregnant women—there are few best practices for integrating GBV into low-resource, primary health care settings. To meet this gap, our team designed a novel community- and clinic-based GBV intervention within Family AIDS Care and Education Services (FACES).

IMPACT OF GBV ON WOMEN'S HEALTH:

- trauma, pain, and memory loss⁵⁻⁸
- declines in reproductive health^{9,10}
- sexually transmitted infection^{2,6,9,11}
- depression,^{12,13} post-traumatic stress^{14,15}
- psychiatric symptoms^{14,16}
- suicidal ideation^{5,13,24,25}

IMPACT OF GBV DURING PREGNANCY:

- miscarriage^{7,12} premature labor²⁷
- low birthweight^{12,28,29}
- infant illness^{30,31}
- under-2 mortality³⁵

FIG. 1

THE GENDER-BASED VIOLENCE INTERVENTION

The GBV intervention is a multi-sectoral approach to reducing violence by using the clinic as a location for screening and providing community-supported enhanced referrals for pregnant women. In a Pilot Intervention (Fig. 2), we implemented clinic- and community activities designed to be responsive to realities of a rural setting.

In Phase 1, we built the skills of local community partners (headmen, elders, pastors, social workers, and traditional leaders) to respond to GBV. In a two-day workshop, local partners mapped out their neighborhood, discussed existing (often informal) services that could be supportive of GBV victims, and established a referral tree (Appendix A).

In Phase 2, we trained all clinic staff to screen, support, and refer clients through a 40-hour training program. Drawing from exceptional health worker training curricula from around the globe, this training rallied clinic staff around the importance of GBV to health, built practical skills, and taught them to use a new GBV screening tool, developed based on our formative research and existing GBV screening tools.³⁶⁻³⁸ This brief screening instrument that also guides providers on appropriate counseling and referral strategies (Appendix B).



IMAGE 1. Local partners play out the challenging web of GBV referrals, as women get shunted from one service to another, with little guidance.

In Phase 3, the clinic staff began to screen and provide referrals to all women visiting the ANC. In lieu of providing all necessary GBV services in the clinic, lay health workers were trained to offer enhanced referrals to services in the region. Called “Community Referral Persons”, these lay health workers assisted with phoning ahead, escorting women to services, and facilitating reimbursement for transport fare (often a key barrier to accessing support in rural areas).

During Phase 4, we evaluated the program by conducting focus groups and evaluation interviews (n= 25) with health workers and local partners.

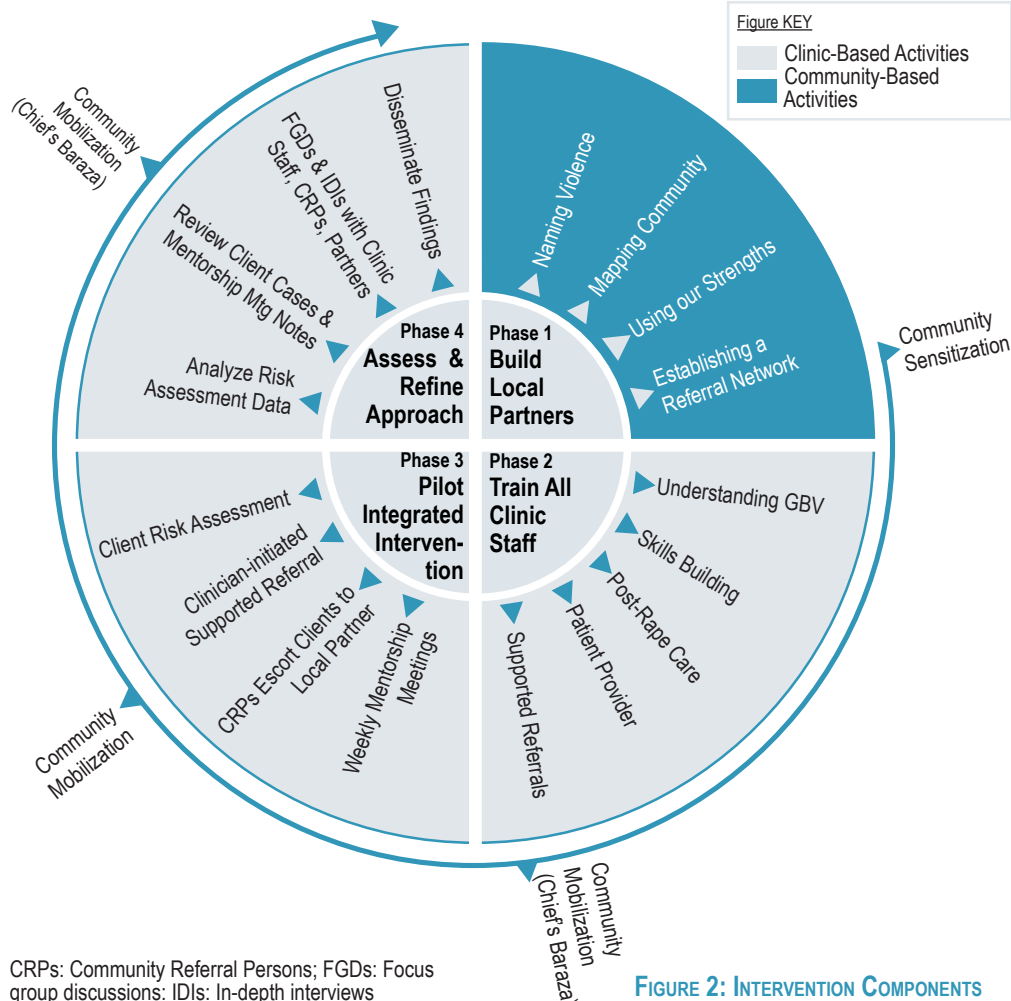


FIGURE 2: INTERVENTION COMPONENTS

OUTCOMES OF THE GBV PILOT EVALUATION

A total of 134 patients were successfully screened for GBV during the months of December 2010-April 2011. Of all patients screened, 39% reported some type of violence by a current partner (physical, sexual, psychological, and/or economic).

The GBV Pilot increased awareness of the issue in the community and empowered Referral Persons. Men in the community, in particular, were reached by community mobilization efforts and appreciated its influence. There seemed to be a noticeable cultural shift in men understanding the consequences of perpetrating violence. The combination of community awareness events and having referral persons located in the communities seemed to be beneficial.

VOICES FROM THE FIELD: EVALUATION FINDINGS

Actually it has really helped women because before the start of GBV Pilot, women were just beaten. They did not take any action; they didn't know where to go. But now, they are given some direction.
 -Community Referral Person

What I know is how men are feeling now. They know there is a law protecting women. And they know in the community that there are people representing women on GBV. And so the rate is going down.
 -Community Referral Person

CHALLENGES AND NEXT STEPS

Through program evaluation, we learned that healthcare workers and community members found the program acceptable and relevant, and that the training for clinic staff prepared the entire clinic for screening and enhanced referrals.

However, over time, clinic staff reduced their amount of screening and supported referrals (or at least the systematic documentation of it) (Fig. 3). They seemed to shift from a universal screening approach to more targeted profiling of clients.

A logistical challenge is the filling of the P3 form (medico-legal proof of GBV that is necessary should victims decide to press charges). Despite the partnership of the nearest Police in filling P3s, this step required multiple trips on the part of patients and staff to get the necessary signatures.

Community mobilization should continue to address restrictive attitudes and norms. Even men who interacted with the study continued to have deeply-rooted cultural beliefs about the role of women. And women feared economic deprivation and community retribution if they did report their partners.

In order to address the challenges of the GBV Pilot, we suggest several technical recommendations to improve the program during scale-up.

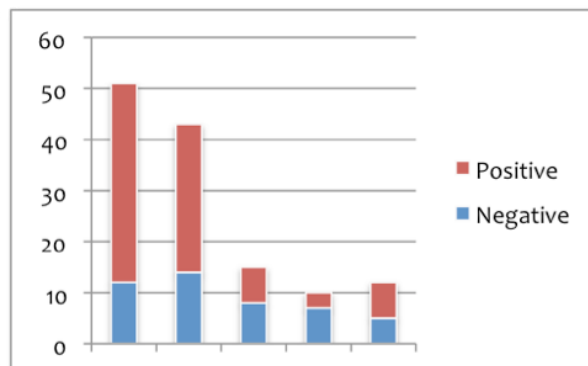


FIGURE 3. GBV Screening by Month, Dec 2010 – April 2011

TECHNICAL RECOMMENDATIONS

1. Provide additional training on counseling for Community Referral Persons
2. Hire a GBV coordinator
3. Interview each client at end of case
4. Hold motivational event every 6 months
5. Increase sensitization of referral tree points
6. Include police in awareness events
7. Link to economic empowerment and a safe house or shelter for women

CONCLUSIONS

A low-cost, integrated GBV intervention, developed and implemented with the participation of the community and primary healthcare workers, is acceptable and feasible, and has potential to contribute to primary and secondary prevention of GBV. This model may be applicable to address GBV in the multitude of rural communities in Kenya and elsewhere in sub-Saharan Africa, where the majority of the African population live and where community attitudes may be more supportive of violence. If this strategy can be scaled-up to other primary healthcare clinics, it has potential to impact on the intersecting epidemics of GBV and HIV.

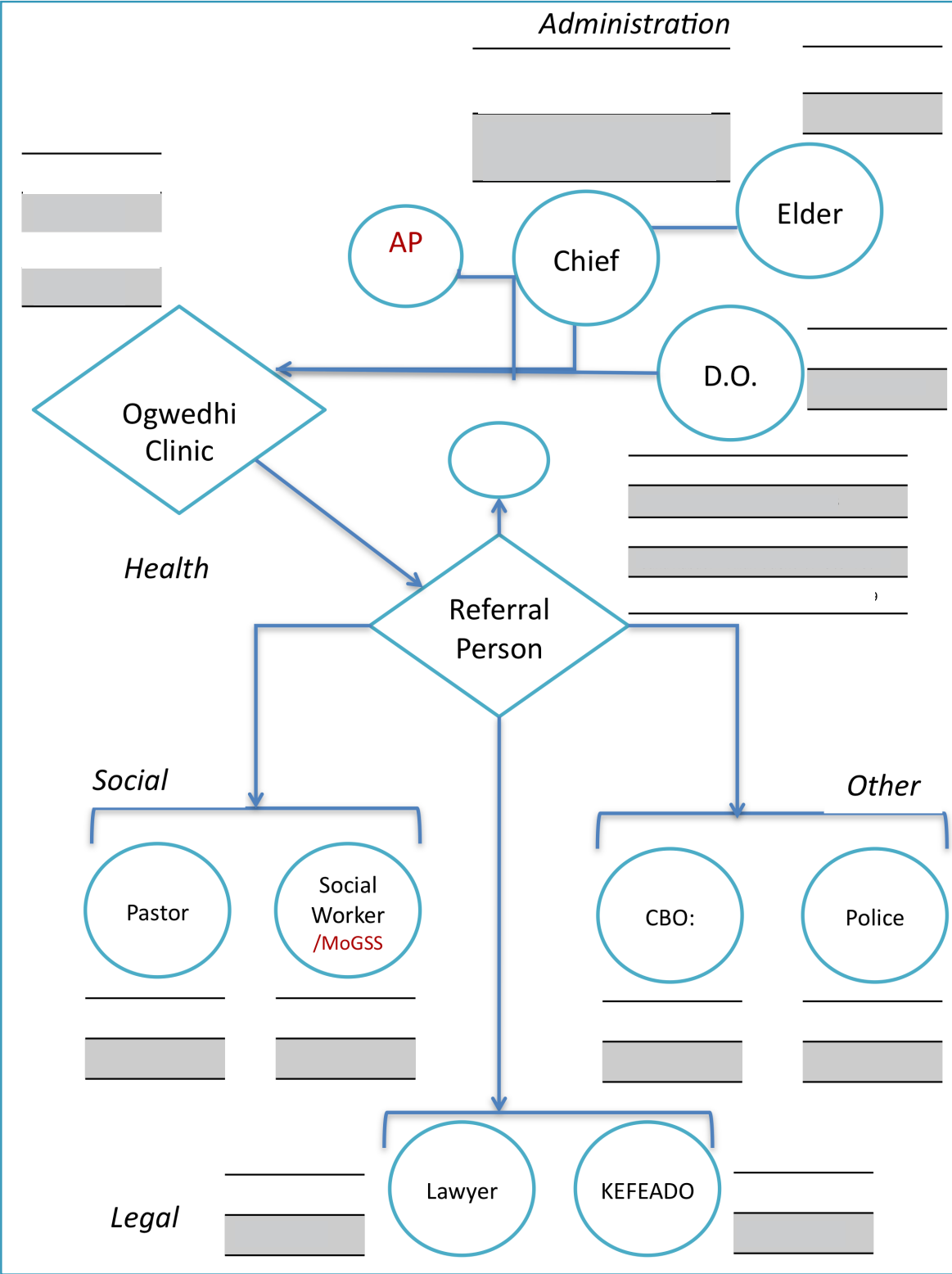


IMAGE 2. Community Referral Persons and local leaders receive certificates for attending the Local Partners Meeting.

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APPENDIX A. LOCAL REFERRAL TREE



APPENDIX B. GBV SCREENING GUIDE

Say: “I always ask the following questions because some people are in relationships where they don’t feel safe and this affects their health.”

QUESTIONS:	YES	NO
If you told your partner that you came here for health services today, would s/he react angrily or negatively?		
Has your partner (or another person close to you):		
<i>Pushed, grabbed, slapped, choked, hit, or kicked you?</i>		
<i>Threatened to hurt you, your children or someone close to you?</i>		
<i>Taken away money/resources that you/your children need to survive?</i>		
<i>Sent you back to your maternal home?</i>		
<i>Forced you to have sex when you did not want to?</i>		
Has your partner tried to get you pregnant when you didn’t want to be? (women only)		
If you wanted to use a condom or another family planning method, would you be afraid to ask your partner?		
Are you worried your partner (or another person close to you) will be angry and/or hurt you if s/he finds out you were tested for HIV?		
Do you feel <u>unsafe</u> returning to your home today?		

If the client answers YES to any of these questions, their health and safety may be in danger! Offer to phone the community GBV Referral Person (tel: 0xxx, xxx xxx), who can assist him/her with getting further social, economic, medical, legal, and counseling services.

Referral:	Yes	no
Did you provide counseling?		
Did you refer the client to the GBV-referral person?		
Did you refer the client to another person / place?		
If yes, to where/whom?		
Did you fill in a P3-form?		

Date:	Sex of Client:	Female	Male
HCW:	Age of client:		

TIPS:

- 1) Be supportive and listen attentively**
- 2) Remind patients that all questions are confidential, are offered to further support clients - not to get someone into trouble**
- 3) If you have time during the visit, provide counseling or emotional support**

Note: A negative response to screening does not mean that abuse is not present. It may indicate that the person is not comfortable disclosing abuse at this time.

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