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**INTEGRATING VIOLENCE
AGAINST CHILDREN PREVENTION
AND RESPONSE INTO HIV SERVICES**

FACILITATOR MANUAL

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ACRONYMS

CBT	Cognitive Behavior Therapy
CFS	Child Friendly Service
CPET	Child Protection Enquiry Tool
CRC	Convention on the Rights of the Child
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IEC	Information, Education and Communication
IPV	Intimate Partner Violence
LIVES	Listen Inquire about needs and concerns, Validate, Enhance Safety and Support
PTSD	Post Traumatic Stress Disorder
SOLER	Sitting position, Open posture, Lean forward, Eye contact, Relaxed
SOP	Standard Operating Procedure
SSA	Sub-Saharan Africa
STS	Secondary Traumatic Stress
SV	Sexual Violence
UNCRC	United Nation on the Rights of the Child
VAC	Violence Against Children
WHO	World Health Organization

KEY DEFINITIONS

Burnout: A prolonged response to chronic emotional and interpersonal stressors on the job which consists of three components: exhaustion, depersonalization (defined as: disengagement or detachment from the world around you) and diminished feelings of self-efficacy in the workplace. It reflects a form of “energy depletion”.

Child Protection Enquiry Tool (CPET): A tool that is designed to help the health care providers to look out for specific symptoms during a consultation where he/ she suspects that the child is at risk of or has experienced violence. It also provides a set of simple questions that the health care providers can ask the child and/ or caregivers to ascertain whether the child requires referral for more specific diagnostic test and services for violence.

Child: All human beings below the age of 18 years unless under the law applicable to the child, majority is attained earlier” (United Nations Convention on the Rights of the Child, 1989).

Disclosure: The discovery of child violence as narrated by the very survivor to either a healthcare provider or another individual.

First line support: The minimum level of primary psychological support and validation of the respondent’s experience that should be received by all who disclose violence to a health-care (or other) provider.

Informed assent: Used when a child is too young to give informed consent, but is old enough to understand and agree to participate in services. Assent in this case may be verbal. In such cases, the health worker should clearly record the verbal assent provided, stating how this was provided, in case notes and ensure that these are kept on file.

Informed consent: The voluntary agreement of an individual, adult or child, who has the capacity to give consent, and who exercises free and informed choice.

Perpetrator: Person who directly inflicts or supports violence or other abuse inflicted on another against his/her will. (IRC, 2012). This can include caregivers, peers, romantic partners or boyfriend or girlfriend, neighbors, strangers, authority figures such as teachers, police, employers, religious or community leaders, and health care workers. The violence can be perpetrated physically or online.

Risk of violence: Factors that make one more vulnerable to or increases likelihood of experiencing abuse and/or perpetration.

Secondary Trauma: The reactions to the emotional demands on health care providers from exposure to trauma survivors’ terrifying, horrifying, and shocking images; strong, chaotic affect; and intrusive traumatic memories.

Survivor: Any individual adult or child who has experienced violence. A child who has experienced violence is a child survivor (Day & Kim, 2013).

Violence against children: All forms of physical or mental violence, injury and abuse, neglect or children negligent treatment, maltreatment or exploitation, including sexual abuse. (UNCRC, 1989). Violence can be perpetrated directly or indirectly through digital media, such as through taking of or exposure to images that are sexually or otherwise violent or through sexual harassment or bullying online.

Violence: An intentional use of force or power, threatened or actual, against one self, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation (World Health Organization, 2002).



INTRODUCTION

INTRODUCTION TO FACILITATOR MANUAL

Children are exposed to violence in various settings and circumstances. An estimated one billion children globally are exposed to physical, sexual or emotional violence. There is a direct link between all forms of violence in childhood and increased risks of acquiring HIV in later life.

Policy makers and service providers who are working with children in health and community settings recognize the critical need to integrate violence prevention and response within all forms of child care, including the HIV continuum of care. However, health workers working within HIV settings report that they often find it challenging to respond to children who report experience of violence due to the following

- Few people in health and community settings with sufficient experience and tools in detecting and responding violence against children;
- Lack of sufficient skill, knowledge and confidence to treat child survivors of violence – VAC is often not a core part of health worker training;
- Limited opportunity to record VAC services in HIV clinic registers;
- Limited time that a health worker can spend with each individual patient.

VAC awareness and response has not been systematically integrated into health worker pre- and in-service training on HIV prevention and treatment, based on a review of global and national health worker training curricula.

This training seeks to equip health workers who have contact with children in HIV settings with the knowledge and skills to better integrate VAC services into their work. It seeks to transmit information and skills to make them: feel comfortable talking with, providing services and making appropriate referrals to children and their caregivers who are at risk of or experiencing violence. The expected result is that there will be successful integration of VAC services into HIV settings.



This facilitator manual is aimed at trainers of a three-day 'Integrating VAC prevention and response into HIV settings' course. It is for use by all facilitators who are delivering the training.

The overall package is a training for 25-30 health workers, primarily in HIV-affected contexts and resource-constrained settings. The training is aimed at different cadres of health workers, including: nurses and midwives; clinicians; HIV counsellors; medical social workers; pharmacists; community health workers, and others who are involved in children's health care in health settings.

The complete package for this includes:

- Facilitator manual: an overview of the workshop and detailed agenda and facilitation notes and training preparation tools;
- PowerPoint slides for use with the facilitator manual;
- Participant handbook: background information, tools and learning aids for participants;
- Training preparation tools to assist in preparation for the training, including facilitator preparation notes, pre- and post-test evaluation tools, checklist for the workshop.

A complementary training package has been adapted for use with non-health facility staff, such as social workers, auxiliary social workers and child protection workers, and others working primarily in the community with children affected by HIV and other vulnerable children.



This manual is a step-by-step guide for delivering the training. It includes:

1. Preparation and guidance notes, which should be reviewed carefully before agreeing on a detailed training plan;
2. A sample agenda, which can be adapted for local context;

3. Training notes for the facilitator. Each module includes an:

- an introduction to the session;
- learning objectives and desired outcomes;
- timing allocation overall and per activity;
- preparation and materials needed;
- Step-by-step activity guidance, including links to the power point slides, case studies and other teaching aids.

Although the manual explains how to conduct each session, the trainer has the flexibility to adapt it to suit the specific needs of the participants. The participant manual complements the facilitator manual. It also includes session overviews, but includes detailed information for background learning, job aids and other support resources. Links to the participant manual are included in the facilitator manual.



PREPARATION

PREPARATION AND GUIDANCE BEFORE THE TRAINING

Is this the right training for us?

This training course is a short introduction to VAC for non-VAC specialists working primarily in or with health facilities.

What the course does: It aims to deliver basic information on what violence against children is, how important it is to be aware of VAC in my daily health work, and provide some basic skills in identifying possible VAC, knowing when and how to refer concerns, and providing immediate support.

What the course does not do: This is not a detailed clinical training to provide detailed clinical care for children who are experiencing violence. It does not cover training issues on the non-clinical response to VAC that must be provided by the broader child protection team, including social workers and police.

A companion guide has been developed for use with primarily community-based actors, such as social workers and community child protection actors.

ADAPTING THE TRAINING TO LOCAL CONTEXT

Once you have decided to use this training, the first step is to review in detail and adapt for context. This includes:

- Reviewing the background information and training resources to reflect national laws and local guidance
- Contextualizing the training methods, by reviewing and modifying case studies and scenarios e.g. local names, local norms and traditions, local experiences for the context
- Reviewing the proposed timing and approach and adapting, where necessary, to local approaches.

IDENTIFYING THE FACILITATORS

It is recommended that the workshop is delivered by at least two experienced facilitators, and ideally three, with logistical support provided separately. This is in order to have at least one lead facilitator and one co-facilitator for each session whose role is to observe, provide back up and work in small group work.

The training covers a lot of complex issues in a short time and therefore it is essential that facilitators are:

- a) Familiar with both VAC and health care provision, so that they understand the context that is being taught;
- b) Confident and experienced participatory (adult) trainers.

IDENTIFYING PARTICIPANTS

The ideal number of participants is 25-30 people.

The training is designed to draw on participants' practical experiences. The following tips may help ensure a productive training:

- Having clear participation criteria: people who already have practical experience within health facilities or in community health services, some contact with children through their work;
- Having a cross-section of participation from different sites or cadres, to encourage exchange;
- Ability to attend the full three-day course – the training develops learning over the process so it is not possible to only attend parts of the training;

It may be useful to include some people with management experience to support any discussions about how the training is applied. It is ideal of have a mix of clinical and non-clinical participants.

DEALING WITH SENSITIVE ISSUES

Training on violence, especially violence against children, can raise strong emotions in all of us, including those of us involved in delivering the training. It is possible that some participants and sometimes members of the training team are survivors of trauma or know of people who are at risk of or surviving trauma.

Before delivering the training, make sure that everyone on the training team is familiar with the content and feels confident to deliver the material.

Prepare a small poster or handout that is available to all participants giving information about where they can access further support – this includes making sure that there is a trained counsellor available from your organization or a local support service and any other useful local information. These include:

- Violence support helplines
- GBV support organizations
- Access to a trained child protection worker who can take action should anyone disclose active concerns about a child at risk of violence or other protection concern. This can be the local government social worker or any local child protection organizations with trained child protection staff.

PARTICIPATORY FACILITATION STRATEGIES

To allow for smooth session facilitation, it is recommended that a lead facilitator and a co-facilitator are identified and assigned to sessions. Other facilitators (if available) will be on standby for technical backstopping, and support with session activities. This will ensure that the lead facilitator is not distracted with other activities, and pays full attention to participants.

The manual uses participatory, experiential learning approaches. The facilitators should encourage active participation from the participants by allowing them to share their experiences and ideas and ask questions where they need clarification, while at the same time being able to manage the group and steering meaningful and constructive discussions in line with the agenda.

The participatory approach encourages participants to reflect on everyday experiences and apply their own experience as they prepare to provide integrated VAC services.

At each stage, the facilitators should ask simple questions to determine if the issues have been understood. They should acknowledge and respond to all questions (no matter how trivial they may appear) and give appropriate feedback. Facilitators should always encourage other participants to discuss and respond to questions asked by participants before responding him or herself. There may be questions or issues that trainers are unable to respond to immediately, or that may be covered during a later session. These questions should be parking lot (a flip chart titled "Parking lot" should be pinned up on the wall) and the facilitators should make sure that they respond to these before the end of the training.

Facilitators should find ways of encouraging reserved participants and avoiding one person dominating. Group presentations should be rotated among group members. The workshop uses varied training methods in order to promote sharing, reflection, and application, and to maintain variety during the training. The following are the main approaches and techniques.

Facilitator presentation

The facilitator presents information by speaking to the whole group, sometimes using visuals such as PowerPoint presentations, pictures or a flipchart. Presentations work well for introducing new information, but they should be short and accompanied with visuals and discussion.

Large group or plenary discussion

These are used for brainstorming with a large group. Plenaries provide a quick way of getting ideas from all or many of the participants and are used to quickly check understanding or gather rapid feedback from the whole group.

Small group discussion

Small group discussion is a technique to ensure that all participants have a voice. Small groups of ideally 4 to 6 participants per group can be used to identify emerging issues. They usually work best if the facilitators have provided one or two questions and the group can identify many possible answers.

Brainstorming

Brainstorming is a method in which the facilitator asks a question or poses a problem and asks participants to give as many ideas as they can in response. This is a way of generating lots of new ideas quickly and, if well facilitated, ensures that everyone with an idea has a voice.

Role play

This involves acting out pre-assigned roles that illustrate the problem or issue at hand. These can be done in small groups or with some people showing the role play to participants in plenary. The role play is followed by a discussion about the issues illustrated in the role play.

Case Scenarios / Case Studies

Use of simulated real life scenarios to help participants demonstrate how they will approach each case in a systematic manner, including paying particular attention to guiding principles and ethical considerations.

Icebreakers

A short activity used at the beginning of a lesson to help participants relax and get to know each other.

Energizer

A short activity used in between sessions that usually involves physical movement, raising participants' energy when they're tired or need a break after a long session. This manual has not specified the use of icebreakers and energizers, but expects facilitators to introduce these where useful. Below are some suggestions:

- *Juggling ball game (suitable during introduction session)*
Everyone stands in a close circle. (If the group is very large, it may be necessary to split the group into two circles.) Start by saying your name and then throwing the ball to someone in the circle, saying their name as you throw it.

Ask the person who has caught the ball to say your name and then throw to someone new, saying their name as they throw the ball. Once the ball has been thrown several times, and a pattern is established, you can introduce one or two more balls.

- *Names and adjectives*

Ask participants to think of an adjective to describe how they are feeling or how they are. The adjective must start with the same letter as their name, for instance, “I’m Helen and I’m happy”. Or, “I’m Andrew and I’m amazing.” As they say this, they can also mime an action that describes the adjective.

- *Three truths and a lie*

Everyone writes their name, along with four pieces of information about themselves on a large sheet of paper. For example, ‘Mike likes singing, loves football, has five wives and loves football’. Participants then circulate with their sheets of paper. They meet in pairs, show their paper to each other, and try to guess which of the ‘facts’ is a lie.

- *Fruit salad*

The facilitator divides the participants into an equal number of three to four fruits, such as oranges and bananas. Participants then sit on chairs in a circle. One person must stand in the center of the circle of chairs. The facilitator shouts out the name of one of the fruits, such as ‘oranges’, and all of the oranges must change places with one another. The person who is standing in the middle tries to take one of their places as they move, leaving another person in the middle without a chair. The new person in the middle shouts another fruit and the game continues. A call of ‘fruit salad’ means that everyone has to change seats.

- *Tide’s in/tide’s out*

Draw a line representing the seashore and ask participants to stand behind the line. When the facilitator shouts “Tide’s out!” everyone jumps forwards over the line. When the leader shouts “Tide’s in!” everyone jumps backwards over the line. If the facilitator shouts “Tide’s out!” twice in a row, participants who move have to drop out of the game.



TRAINING

SUGGESTED WORKSHOP AGENDA

The agenda below provides suggested times for each session. Facilitators should review the agenda closely to make changes for local context and for participant profile.

SESSION	CONTENT	SUGGESTED TIME
Pre-session: Workshop introduction	Introduction to agenda, expectations, pre-test	1 hour
Module 1: Introduction to Violence Against Children	Overview of VAC definitions, scope and scale, consequences	2 hours
Module 2: Guiding principles for health workers working with children at risk of or having experienced violence	Overview of guiding principles for child rights and application to VAC	1 hour 30 minutes
Module 3: Violence against children and HIV	Interlinkages between VAC and HIV, and importance of integration of VAC and HIV	1 hour 30 minutes
Module 4: Communication skills	Practical review of communication skills for children who have experienced VAC	2 hours
Module 5: Identification of VAC in HIV clinical settings	Basic skills for identifying potential VAC risk and immediate referral actions	1 hour 45 minutes
Module 6: First-line support for VAC	Principles of immediate, first-line VAC support in health settings	1 hour 30 minutes
Module 7: Responding to children who are at risk or have experienced VAC	Importance of a comprehensive approach and how to ensure that a child's comprehensive VAC needs are identified	2 hours 30 minutes
Module 8: Referral, linkage and follow-up support	Identification of referral options and practical action to identify and address challenges and develop referral list	2 hours
Module 9: Documentation and reporting	Review of use of documentation and referral tools in health facilities and for referrals	1 hour
Module 10: Support for VAC service providers	Development of options for self-support for health workers engaged with VAC	1 hour
Workshop closing session	Post-test and evaluation	1 hour

For more information on adaptation and training needs assessment, see the Preparation and guidance notes



PRE-SESSION

PRE-SESSION WORKSHOP INTRODUCTION

This session is a preparatory session to introduce the workshop and ensure that logistics have been covered. Although you are encouraged to adapt this session to local need, ensure that there is space to discuss how people will deal with sensitive issues and establish ground rules relating to sensitive issues.

OBJECTIVES

At the end of this session:

- Participants will understand the training aim and objectives and receive their training materials;
- Participants will get to know each other, share their expectations and have concerns clarified;
- The group will have defined ground rules;
- The agenda and logistics will have been agreed.



METHOD

Method: Presentation; group discussion



TIME

Time: 1 hour (recommended)



MATERIALS

Materials: Laptop, projector, flip chart, marker pens, masking tape and sticky notes.



PREPARATIONS

Preparations before session:

- Invite any individuals who will be opening the workshop in advance.
- Ensure that you have a complete learning package for all facilitators and participants, including pre-test

questionnaire, participant manual and teaching resources per module (see the training resource checklist in the annex).

- Ensure that you have prepared a handout or have contact details for support sources for participants.

FACILITATION NOTES

Pre-activity: Registration

1. Check that the registration form is completed and returned. A sample form is available in the training preparation kit.



ACTIVITY 1

Opening session (20 minutes)

1. Provide a background and context that emphasizes the benefits of the course and the agenda. Invited guests, if any, should include project stakeholders and local health and other representatives.
2. Show the workshop objectives on a PowerPoint slide or provide handouts.



ACTIVITY 2

Introductions (10 minutes)

1. Welcome the participants into the training, introduce yourself and explain your role.
2. Introduce any housekeeping information e.g. accessibility issues, refreshments and lunch arrangements, what to do if there is an emergency, any other administration issues
3. Ask the participants to introduce themselves to the group. For example:
 - Ask participants to sit in a circle and everybody says their name, then the group is made to repeat the exercise, this time saying the name of the person on the right/left.
 - Alternatively, ask participants to sit in pairs, preferably with someone they had not met before the workshop and introduce each other using any of the following options or any other found suitable by trainer; i.e. name, country, one expectation for the workshop, one thing you like /do not like.
4. Review the workshop agenda with participants, especially start and end time times.
5. Give all participants their Participant Manual, briefly

explaining that it is organized by module and includes handouts and training exercises.



Expectations and ground rules (20 minutes)

1. Explain that you are going to review participants' expectations. This can be done in various ways. For example, ask participants to work in pairs or small groups to write their expectations and then share them, conduct a discussion in plenary, or ask each participant to write down their own expectations and then share these together.

2. Note key expectations on a flip chart for reference at the end of the session. Clarify if there are any expectations that cannot be met and indicate how the training will be met.
3. Show a PowerPoint slide [not prepared in this pack, facilitator can show locally adapted version], or direct participants to the workshop objectives that are in their handbook.
4. Ask participants how they can help make the learning more effective during the training – “ground rules”.
5. Record answers on flip chart and give additional suggestions if needed. The norms may include the following but are not limited to:

DO'S & DON'TS

- Listen
- Ask questions
- Share personal examples
- Ask for help/clarity
- Participate in discussion-everyone should have a chance to speak
- Voice opinions
- Respect everyone's opinions and culture

- Be late
- Try to memorize everything
- Sleep during the training
- Talk while someone else is talking
- Receive calls on cell phones(or silence or vibration mode)

6. Remind participants that the training will be covering very sensitive issues and talking about VAC may arouse strong emotions and feelings. Advise participants that they can take 'time out' and ensure they know who they can talk with, should they wish to do so during or after the training.



FACILITATOR TIPS:

How to manage sensitive issues

- Establish ground rules so that productive discussions do not turn into heated arguments.
- At the beginning of the training (i.e. before any difficult/ sensitive or heated conversations take place) clarify that there will be a space for contentious conversations to be “parked” for later discussion. Sensitive issues or heated conversations can become easier to discuss rationally once emotions have settled.
- Remind the group that discussions related to VAC can bring feelings of anger, hostility and embarrassment for some people. Be sure to alert participants that some of the topics covered can make them sad or angry and that if they would like to talk to somebody, a range of professionals will be available for them. Be aware that some of the trainers and participants may have survived childhood trauma.
- Decide how the group can support each other: allow them to share feelings, suggest taking a break, and/or talking to or someone else privately.

The facilitator may want to ensure the following principles as his or her own ‘ground rules’.

- Confidentiality: keep all discussions held during the training sessions private.
- Not passing judgement: avoid letting our own values get in the way of delivering the training. When a participant has a different opinion this should be addressed with respect. Emphasize that individual values differ and there are no right or wrong answers. Allow the participants to express and explain their values, whilst ensuring that information is based on evidence and children’s best interests.



ACTIVITY 4

Pre-test (10 minutes)

1. Explain the importance of assessing the successes and challenges of the course, and to do this we are asking participants to complete a short test at the start of the course and will complete a post-test at the end of the course. The tests will be used to measure changes in participants’ new information and skills during the course.
2. Emphasize that the answers are not an individual test at this stage and will not be shared with others. The course organizers will use them to measure the course impact.
3. Hand out the pre-test and give participants time to complete.

A pre-test is provided below; this can be adapted to local context.

PRE-SESSION HANDOUT 1 PRE-TEST

1. Mark the following statements TRUE or FALSE

- a) VAC is often hidden, unseen and under reported
- b) Majority of children survivors of violence do not access health services
- c) Emotional or psychological, Intimate partner violence, Bullying and child maltreatment are types of violence against children
- d) Obesity, pregnancy complication and low antiretroviral adherence are some of the consequences of violence against children.
- e) The UN convention on rights of the child (UNCRC) defines a child as person below the age of 18 years

2. The following are guiding principles for addressing Violence Against Children (VAC). Match the statements below with the choices provided:

- a) Principle of best interest of the child
 - b) Principle of evolving capacities of a child
 - c) Principle of non-discrimination
 - d) Principle of participation
- Children have a right to participate in decisions that have implications for their lives, in accordance with their evolving capacities
 - Health care providers should ensure fairness in all interactions with the child at all times and in all service provision. All children are equal and shall have equal access to services
 - Health care providers should provide information that is appropriate to age, seek informed consent as appropriate and respect the autonomy and wishes of children
 - Health care providers should protect and promote safety, provide sensitive, caring and non-judgmental services

3. The following are ways through which VAC may increase risk of HIV. Select the correct answer from the choices below.

- a) Direct transmission
- b) Female genital mutilation
- c) High risks behaviour
- d) All the above

4. The following are ways through which HIV may lead to VAC. Select the correct answer from the choices below.

- a) Occurrence of domestic violence which children witness
- b) HIV related stigma and social isolation
- c) Child experience emotional abuse and maltreatment including lack of family support
- d) All the above

5. The following is true about effective communication, which one is not?

- a) Effective communication and listening happens through a combination of verbal and non-verbal skills
- b) Effective communication is when the guardian is allowed to talk on behalf of the child
- c) Effective communication makes the speaker “feel heard”
- d) Active and supportive listening allows survivors to be heard which is an important step towards healing

6. Name 3 common reasons why children may / may not disclose violence to health care providers?

- a) _____
- _____
- b) _____
- _____
- c) _____
- _____

7. The following are key steps in providing first line support for children who have undergone or experienced violence, which one is not.

- a) Listen to the child closely with empathy and without judging
- b) Support and connect the health care provider to information, social support and VAC services
- c) Show the child that you understand and believe her/him
- d) Discuss a plan to protect the child from further harm

8. Name 3 internal referral services for child survivor of violence

- a) _____

- b) _____

- c) _____

9. The following should be considered when setting up a good referral system. Circle which is not.

- a) Create a directory list, including contact details of focal person in each referring and receiving service.
- b) Identify a focal person such as a social worker or a psychologist who is or will be trained as an advocate and champion for children
- c) Establish referral pathways that respond to children's multiple needs e.g. child protection or rescue centers, legal and psychosocial services.
- d) Development of tools for monitoring referrals and coordination are not necessary

10. The following are control measures in addressing secondary trauma in service providers when managing children who are at risk of violence or experienced violence. Which statement is TRUE and which one is FALSE.

- a) Be aware of their own emotional reactions and distress when confronting others' traumatic experiences, and know what traumatic material may trigger them.
- b) Disconnect with others by talking about their reactions with trusted colleagues or others who will listen.
- c) Maintain a balance between their professional and personal lives, with a focus on self-care (e.g., relaxation, exercise, stress management, etc.) to prevent, and lessen the effects of, workplace stress.
- d) Function of debriefing is to identify aspects of team performance that went well, and those that did not. The discussion then focuses on determining opportunities for improvement at the individual, team, and system level.
- e) Ongoing professional supervision is not crucial to developing health care providers' case management schools, nor to reducing the risk of traumatization.



**MODULE 1:
INTRODUCTION
TO VIOLENCE
AGAINST
CHILDREN**

INTRODUCTION

This module introduces the definition, types, causes, magnitude, and consequences of violence against children (VAC). It outlines the existing international legal frameworks and guidelines that regulate a VAC response.

OBJECTIVES

At the end of this module, the participant should understand the following:

- The definition of violence against children;
- The different types of violence against children;
- The main causes of violence against children;
- The magnitude of violence against children;
- The main consequences of violence against children;
- The minimum package of a multisectoral response to children and adolescents at risk of or who have experienced violence
- International legal frameworks and guidelines that regulate the violence against children response.



Methods: Interactive powerpoint lecture; brainstorming.



Time: 2 hours



Materials: Laptop, projector, flip chart, marker pens, masking tape and sticky notes.



Preparations before session:

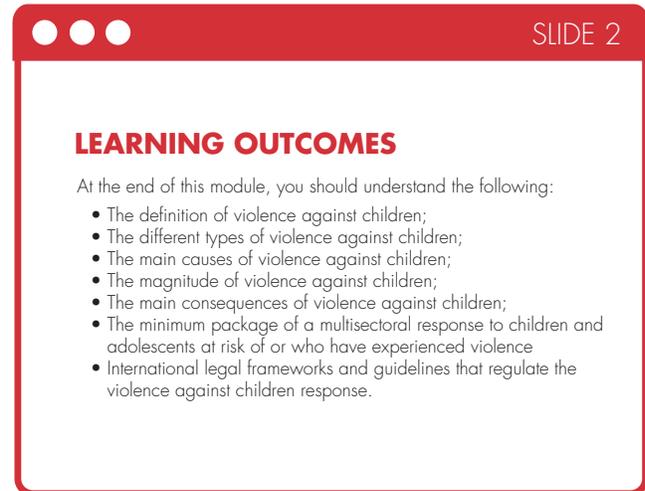
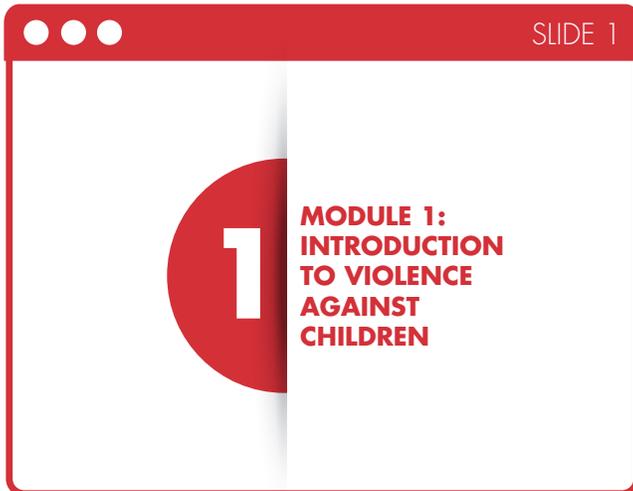
Activity 1: Write the six different types of violence as titles on six sheets of flip chart paper and place on the wall (Child maltreatment, Bullying, Youth violence, Intimate partner violence (IPV), Sexual violence, Emotional or psychological violence). Ensure that you have added national / local data and national laws and guidelines on VAC in the powerpoint presentation.

FACILITATION NOTES



Powerpoint presentation and group brainstorming (2 hours)

1. Introduce the module and the objective (slides 1 and 2)



2. Show slide 3, with the word 'Violence'. Ask for a volunteer to briefly explain what this means.



3. Then show the definition (the slide includes animation and will show title and text in two clicks). Either read the definition or ask a participant to read the definition. Allow time for any clarifications that are needed.

4. Move onto slide 4, with the word 'child'. Repeat this process until all the definitions have been completed (slide 8).

SLIDE 4

CHILD

"All human beings **below the age of 18 years** unless under the law applicable to the child, majority is attained earlier"

United Nations Convention on the Rights of the Child, 1989).

SLIDE 5

VIOLENCE AGAINST CHILDREN

All forms of physical or mental violence, injury and abuse, neglect or children negligent treatment, maltreatment or exploitation, including sexual abuse.

United Nations Convention on the Rights of the Child, 1989

SLIDE 6

PERPETRATOR

A person who directly inflicts or supports violence or other abuse inflicted on another against his/her will.

International Rescue Committee, 2012

SLIDE 7

RISK OF VIOLENCE

Factors that make one more vulnerable to or increases likelihood of experiencing abuse and/or perpetration.

SLIDE 8

SURVIVOR

Any adult or child who has experienced violence.

5. Next, divide the participants into groups of three to five participants. Ask the small groups to think of: (slide 9).

- the common types of violence against children that happen in their community
- the causes of violence

They should write all their answers on the sticky notes provided. They should spend around 10 minutes.

SLIDE 9



GROUP DISCUSSION (15 MINUTES)

- What are the common types of VAC in your community?
- Who are the common perpetrator(s) of these types of VAC?

6. Call the participants back to plenary and ask a representative from each group to summarize their responses in 10 minutes.

7. The facilitator should use slide 10 to give a summary of the types of violence that are set out as per WHO guidelines.

SLIDE 10

TYPES OF VIOLENCE AGAINST CHILDREN

BULLYING 	CHILD MALTREATMENT 	YOUTH VIOLENCE 
INTIMATE PARTNER VIOLENCE 	EMOTIONAL OR PSYCHOLOGICAL VIOLENCE 	SEXUAL VIOLENCE 

REFER TO   **PARTICIPANT HANDBOOK:**
MODULE 1: HANDOUT 1:
CONCEPTS OF VIOLENCE
AGAINST CHILDREN



NOTE:

Participants may have listed other types of violence that are common within their communities but not mentioned above. The facilitator should affirm these types of violence, and see whether / how they fit within one of the categories listed on the slide and in Participant Handout Module 1: Handout 1, which shows the table of types of violence.

8. Then show slide 11 to discuss the magnitude of VAC globally and in Sub-Saharan Africa. [In preparation before the session, the facilitators can include national and/or local data).

● ● ●SLIDE 11

MAGNITUDE OF VIOLENCE AGAINST CHILDREN

- Close to 1.6 billion children globally experience any type of VAC annually
- The WHO has estimated that 150 million girls and 73 million boys under the age of 18 have experienced sexual violence involving physical contact (WHO, 2006).
- According to the VACS, only 10% of children who had experienced violence received services (UNICEF, 2014).
- **ADD ANY NATIONAL OR LOCAL DATA AVAILABLE ON VAC**



NOTE:

Emphasize the following points:

- VAC is often hidden, unseen and under-reported
- The majority of child survivors of violence do not access health services
- Only 10% of survivors receive health services

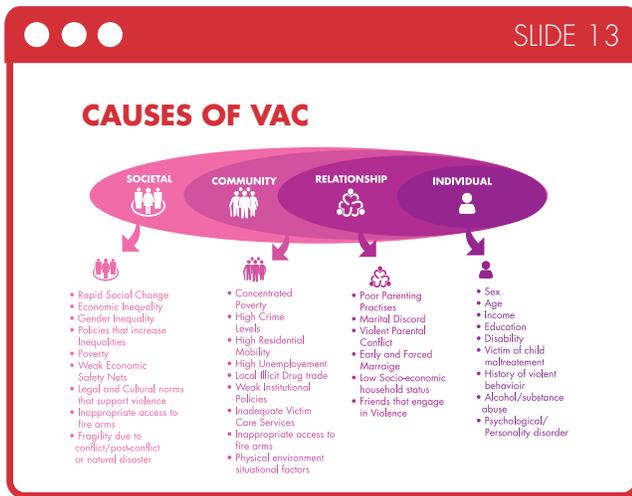
9. Show slide 12 and ask participants to suggest: What are the main causes of VAC?

● ● ●SLIDE 12



WHAT DO YOU THINK ARE THE MAIN CAUSES OF VIOLENCE AGAINST CHILDREN?

10. After you have received a few suggestions, show slide 13 to summarize the causes of violence using the Social Ecological model in 10 minutes. (The slide is animated, with the first image showing the 'individual' level. Ask for a volunteer to list factors that cause violence against children at that level. Then click the slide forward and list the some factors.



NOTE:

Remember that there are no 'right' or 'wrong' answers and the participants may have suggested additional important factors.

11. Complete the remaining elements of the diagram that illustrate the socio-economic levels, each time asking for examples. Allow time for any clarifications that are needed.



NOTE:

The socio-ecological approach aims to ensure that program interventions consider and address the factors across different levels (e.g. individual, family, community and society), which affect children who are at risk of or experiencing violence. Interventions should identify and reinforce protective factors that will decrease the likelihood of children experiencing violence, at each level within the ecological model. Protective factors include, for example, keeping children in school or challenging negative gender norms in communities.

Programs should be mindful of the different levels in the ecological model to achieve results, since each level is interconnected. However, it is not necessary to operate at all the levels, but to choose interventions at one or more levels that will influence the risk and protective factors within other levels. For example, implementation of laws and policies at the societal level, for example, through institutionalization of protocols and training, can improve police responses to child survivors at the community level and discourage violence within homes and the community at large.

12. Ask participants “What do you think are the consequences of violence against children?” Allow 5 minutes for discussion in plenary. (slide 14)

● ● ●
SLIDE 14



**WHAT DO YOU THINK ARE THE
 MAIN CONSEQUENCES OF VIOLENCE
 AGAINST CHILDREN?**

13. Once participants have offered their suggestions, show slide 15 and summarize the key points, adding any that have been suggested by participants. Allow 10 minutes to allow for clarifications or questions.

● ● ●
SLIDE 15

CONSEQUENCES OF VAC

Mental health problems	Risk behaviours	Communicable and non communicable diseases
<ul style="list-style-type: none"> Depression Anxiety Suicide Post traumatic stress disorder Conduct disorder / Delinquency Eating disorder Self harming behaviour 	<ul style="list-style-type: none"> Smoking Alcohol and drugs Unsafe sexual practises Multiple partners Low ARV adherence 	<ul style="list-style-type: none"> Stroke Obesity Sexually transmitted diseases Chronic ling disease Heart disease Cancer Diabetes

14. Show slide 16 showing the international and national laws and guidelines that address violence against children. Allow time for any clarifications that are needed.

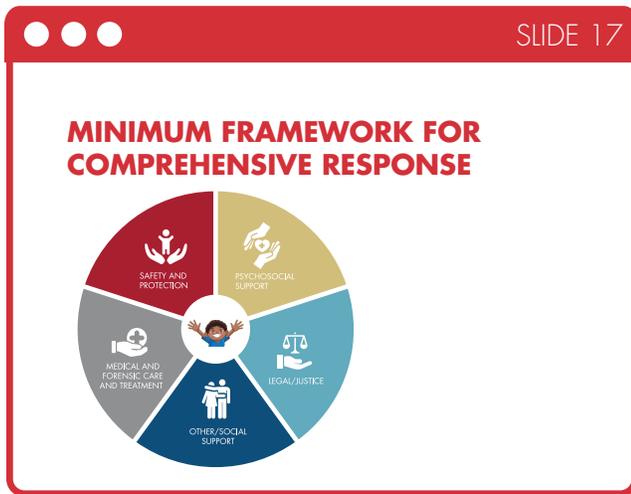
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SLIDE 16

HUMAN RIGHTS INSTRUMENTS FOR CHILDREN

The main human rights instrument is the Convention on the Rights of the Child (CRC). Human rights instruments focus on:

Protection from violence and abuse	Privacy
Participation	Health including access to care

15. Show slide 17 to introduce the Minimum package for a multisectoral response to children and adolescents who have experienced violence. Confirm that participants have understood.



16. Ask: “Who do you think are the key actors who provide these comprehensive VAC prevention and response services?” Allow five minutes for discussion.



17. Before finishing, provide an opportunity for question and answers from the participants and give any clarifications needed.



Wrap up and Take Away Message

- The rate of violence against children is extremely high
- VAC in all its forms is caused by a range of factors from individual up to society factors
- All forms of VAC have adverse consequences on children and their lifetime development
- There are international legal frameworks, and national specific laws that confer protection and safeguarding of children



**GUIDING
PRINCIPLES FOR
RESPONDING
TO VIOLENCE
AGAINST
CHILDREN**

INTRODUCTION

This module discusses the guiding principles that must be observed by health workers when providing care to children and adolescents who are at risk of or have, or may have experienced VAC. The principles are derived from the United Nations Convention on the Rights of Children (CRC) and other important human rights standards.

OBJECTIVES

At the end of this module, the participant should be able to:

- Apply guiding principles for promoting children’s rights when providing care to children who are at risk of or have experienced violence.



Methods: Interactive lecture, case studies.



Time: 1hours 30 minutes



Materials: Laptop, projector, case study handouts, flip chart, marker pens, masking tape.



Preparations before session:

- **Activity 1:** Think of a practical example, suitable for your context that illustrates each of the best interest principles in the PowerPoint presentation.
- **Activity 2:** Print two pieces of A3 paper with the case studies (or write them out) and stick them on two opposite walls (stations). Place flip charts placed next to the case studies.

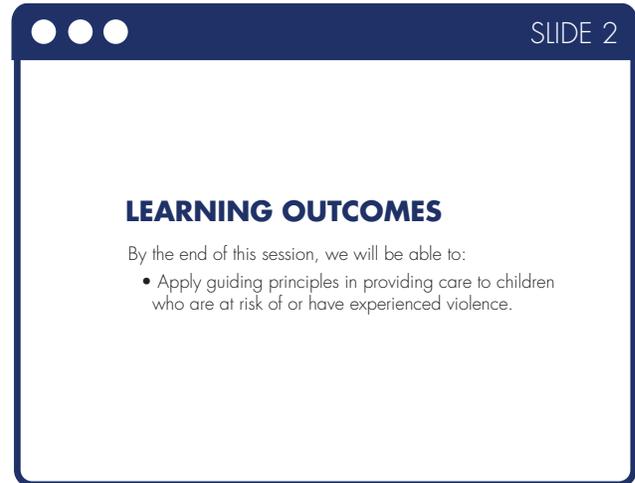
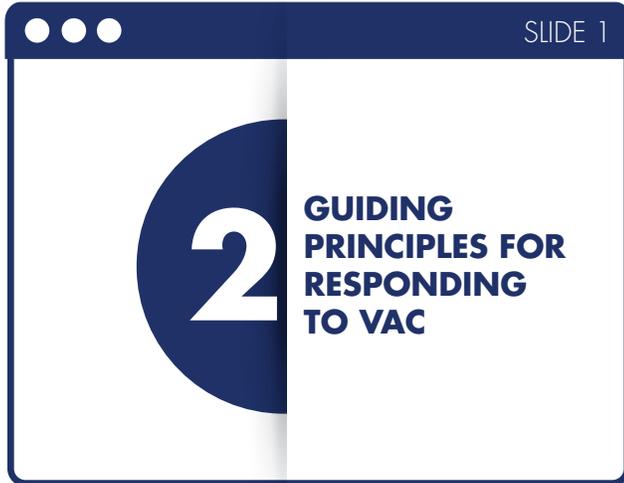
FACILITATION NOTES



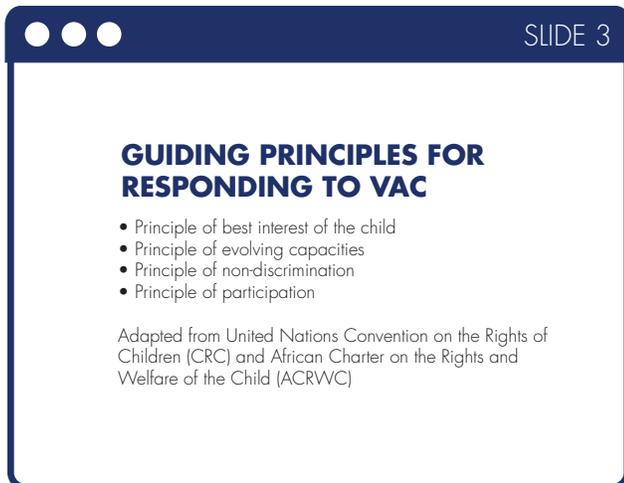
ACTIVITY 1

PowerPoint presentation (40 minutes)

1. Introduce the module and the objective (slides 1 and 2)



2. Show slide 3 and briefly explain the four guiding principles according to the United Nations Convention on the Rights of the Child (CRC).



3. Explain that the group are going to see in practice how we apply these four principles in practice, starting with *Best Interests*. Show slide 4 and explain that this is the first principle of the best interest of a child – protect and promote safety. Either read the list or ask a participant to do this.

SLIDE 4

PRINCIPLE 1: BEST INTERESTS

Health workers should:

- Protect and promote safety
- Provide sensitive, caring and non-judgmental services
- Protect and promote privacy and confidentiality

4. Once the points have been made, give a practical example using slide 5 of how to promote and protect the physical and emotional safety of the child at their workplace.

SLIDE 5

**PRINCIPLE 1: BEST INTERESTS -
PROTECT AND PROMOTE SAFETY**

Example: If a child told you that he or she is scared that a person who is harming the child could come to the health facility to further harm him or her, the child's best interest principle necessitates that you assist the child to move to a safe, private place within the facility and seek immediate support.

 **Do you have other examples to share?**



NOTE:

This practical example can be used; preferably think of a local suitable example:
“If you were talking to a child and he/she informed you that there is a risk that the perpetrators could come to the health facility to further harm him/her, then the principle of best interest of the child necessitates that you assist the child to move to a safe place to continue the consultation.”

5. Ask for one or at most two examples from participants of how they might apply this principle.
6. Continue through slides 6 to 8, to discuss the principle of best interest of a child. For each principle, offer a practical example (on the following slide) to help participants understand the principle and allow them to share their own experiences.

SLIDE 6

PRINCIPLE 4: PARTICIPATION

Example: Before giving a caregiver a child's treatment plan for HIV, talk with the child about what might help him take his drugs regularly and if he has other concerns about his HIV status. Provide regular opportunities for him to ask questions about his illness and treatment.

Help him to draw up his own treatment plan using a simple calendar that he has illustrated himself.



Do you have other examples to share?

SLIDE 7

PRINCIPLE 1: BEST INTERESTS - PROTECT AND PROMOTE PRIVACY AND CONFIDENTIALITY

Example: Most people think that children don't need to be interviewed on their own. But sometimes you need to find a space where children are happy to talk to you without someone else is there.

You may sometimes need to tell someone else. In this case, you should make it clear to the child that you may need to tell someone else



Do you have other examples to share?



NOTE:

The examples on the slides can be used; preferably think of a local suitable example:

7. After discussing confidentiality, show slide 8 and summarize the limits to confidentiality. Allow time for people to briefly react.

SLIDE 8

LIMITS TO CONFIDENTIALITY

- (Where mandatory reporting is in the law) Ensure that the child or caregiver understands what may need to be reported before they disclose
- Always ensure the child's safety first – if he or she is afraid of consequences to reporting, address the fear first
- Where it is in the best interests of the child that a case of violence is reported, explain simply and clearly to the child what must be done
- Best interests and limits of confidentiality: When keeping silent would have a negative impact on the child, cause the child greater harm or have an impact on the future prospects of the child



NOTE:

The facilitator must be familiar with national and local policies and guidance on confidentiality for health staff and for other social service providers.



PARTICIPANT HANDBOOK:
MODULE 2: HANDOUT 1:
GUIDING PRINCIPLES FOR RESPONDING
TO VIOLENCE AGAINST CHILDREN

8. Show slide 9 and explain that applying these principles will differ according to the age of the child. List the principle of evolving capacities of a child. Give a practical example to help participants understand the principle.

SLIDE 9

PRINCIPLE 2: EVOLVING CAPACITIES OF A CHILD

Applying these principles will differ according to the age of the child
Health workers should:

- Provide age-appropriate information according to the child's age and developmental stage.
- NB: Module 4: Communication will practice working with children of different ages.
- Seek informed consent / assent as appropriate to the child's age and the legal age of consent for obtaining clinical care for all decisions. (See Job aid on informed consent and assent)

9. Then show slide 10 which explains 'consent' and 'assent'.

SLIDE 10

CONSENT

Informed consent
Voluntary agreement of an adult or child who has the capacity to give consent, and who exercises free and informed choice.

Informed assent
Used when a child is too young to give informed consent, but is old enough to understand and agree to participate in services.
Assent may be verbal. In such cases, the health worker should clearly record that verbal assent has been given.

10. Encourage participants to share their examples of how they have applied principles differently according to the age of the child. Tell participants that *Module 4: Communication skills* will practice working with children of different ages.

11. Show slide 11 and ask participants to give other examples on how they would apply this principle while providing services to children.

SLIDE 11

PRINCIPLE 2: EVOLVING CAPACITIES

Example: Health workers should ask the child what they think about the options of services that are available to support them and their opinions should be respected and taken into account when decisions are being made in relation to clinical care being offered to them. else.



Do you have other examples to share?

12. Repeat this process for the remaining two principles – non-discrimination and participation – shown on slides 12 to 15. After reading the text, give a practical example to help participants understand the principle and allow them to share their own experiences. Then move to the next slide and ask participants to give other examples on how they would apply this principle while providing services to children.

- Discrimination occurs when people are treated unfairly or unequally e.g. to adopt unfair presuppositions based on personal tendencies and beliefs.
- Discrimination can be a result of multiple causes e.g. their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status
- Discrimination can take multiple forms e.g. it can be physical or material, through actions, reactions, or emotions.

SLIDE 12

PRINCIPLE 3: NON-DISCRIMINATION

Health workers should:

- Ensure fairness in all interactions with the child
- Recognize and take into account gender, disability and other social inequalities that can increase vulnerabilities to violence and pose barriers in access to services.
- Pay special attention to the specific needs of vulnerable groups e.g. adolescent girls from poor communities

SLIDE 13

PRINCIPLE 3: NON-DISCRIMINATION

Example: A child has not been receiving treatment at the health facility because she is often seen in the bars at night with older men and is known to sell sex occasionally. The nurse has often told her that she is a disgrace to her family and should go back to church.



Do you have other examples to share?

PRINCIPLE 4: PARTICIPATION

Children have a right to participate in decisions that have implications for their lives, in accordance with their evolving capacities.

- At the end of the slide, give a practical example to help participants understand the principle and allow them to share their own experiences.
- When communicating with children, involve them in their own care, let them know where they are ailing, and support them to make decisions as required.
- Always speak with the child, and not to the child; this way the child feels involved in his or her care."

PRINCIPLE 4: PARTICIPATION

Example: Before giving a caregiver a child's treatment plan for HIV, talk with the child about what might help him take his drugs regularly and if he has other concerns about his HIV status. Provide regular opportunities for him to ask questions about his illness and treatment.

Help him to draw up his own treatment plan using a simple calendar that he has illustrated himself.



Do you have other examples to share?

**Case studies (40 minutes)**

1. Inform the participants that they will now have an activity to help them apply the four guiding principles in practice. Explain that in this session, everyone will have a chance to discuss two case studies that address the four guiding principles.
2. Refer participants to the case studies in their Handbook. Divide the participants into two groups and ask one group to go to Station 1 (Case Study 1) and the second group to move to Station 2 (Case Study 2).

**NOTE:**

Groups should be no more than 7 people maximum. If you have a large group, allocate the same case study to more than one group. You will have to have more than one copy of each case study.

3. Ask each group to choose at least one facilitator to guide the discussions and a note-taker to document the group's discussion on the flip chart. Ask them to discuss a case study for 30 minutes and then switch to the next case study station.
4. At the end of the discussion, summarize the group discussion and affirm the content learned previously.



APPLICATION OF PRINCIPLE OF BEST INTEREST OF THE CHILD AND EVOLVING CAPACITIES

Elena, a 14-year-old student was raped by John, her 17 year old boyfriend on their way back from school. Upon visiting the health facility, she tried to narrate what happened, however the health worker was too busy to listen to her ordeal and directed her to an adjacent room to await further assessment. When it was her turn to be called, the health worker shouted “where is the girl who has been raped?” Elena, who by this time looked embarrassed and ashamed, reluctantly followed the health worker to a room where post violence services were offered. The health worker then gave Elena a prescription form to take a HIV test, but she said that she was not ready to take the test. The provider advises her that she must take it as it mandatory to test all survivors of violence as per the national guidelines and it will do her good.

DISCUSS:

1. What concerns do you have with Elena’s management at the health facility?
2. Do you think the principle of best interest of a child was observed?
3. Do you think the principle of evolving capacities was observed?
4. What could have been done differently to improve the quality of services that were offered to Elena?

If you have time, can you think of similar experiences from your area of work where these two principles have been bypassed and how you might react differently moving forward.



APPLICATION OF PRINCIPLE OF BEST INTEREST OF THE CHILD AND EVOLVING CAPACITIES

Peter, a 10-year-old street boy living with HIV reports to the health facility unaccompanied, badly beaten and bruised on the face and left arm. When Peter arrives at the health facility, the health worker takes one look at his unkempt appearance and straight away starts to dress the wound. The health worker has not asked Peter what has happened to him or explained the treatment. The health worker then sends Peter away with anti-bullying handouts but without a referral card or follow up appointment.

Discuss:

1. Discuss some of the good practices you notice from Peter’s consultation visit
2. Do you think the principle of participation was observed?
3. Do you think the principle of non-discrimination was observed?
4. What could have been done differently to improve the quality of services that were offered to Peter?

If you have time, can you think of similar experiences from your area of work where these two principles have been bypassed and how you might react differently moving forward.



ACTIVITY 3

Activity 3: Q & A Session: (10 minutes)

1. Call back the groups to plenary and provide an opportunity for question and answers from the participants give any clarifications needed.



Wrap up and Take Away Message

There are four core child rights principles:

- Best interests – safety, services, confidentiality
- Evolving capacities – age-appropriate, consent, child’s wishes
- Non-discrimination – fairness, equality, inclusion
- Participation - children have a right to participate in decisions that have implications for their lives.

It is a fundamental obligation of all health workers to apply these principles when working with all children. Children at risk of or experiencing VAC will have particular need of these principles.



**VIOLENCE
AGAINST
CHILDREN
AND HIV**

INTRODUCTION

Violence against children plays an important and devastating role in the HIV epidemic. It is both a cause and a consequence of HIV infection and is a driving force behind the epidemic.

This module examines the relationship between VAC and HIV and highlights the importance of integrating VAC into HIV clinical settings.

OBJECTIVES

At the end of this module the participants should understand the following:

- Interlinkages between VAC and HIV
- The importance of integrating VAC into HIV services.



Methods: Group discussion, interactive lecture by PowerPoint.



Time: 1 hour 30 minutes



Materials: Module 2 Teaching Aid 1, laptop, projector, flip chart, marker pens, masking tape.



Preparations before session:

Activity 1: Set up stations with blank flip charts for group discussion.

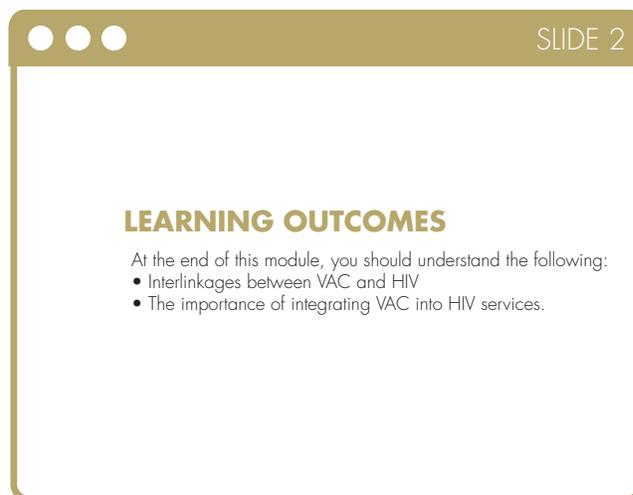
Activity 2: Review the 'vote with your feet' questions and statements and adapt to local context if appropriate.

FACILITATION NOTES



Group discussion on relationship between VAC and HIV (25 minutes)

1. Explain that we will be looking at how VAC and HIV are connected and therefore why it is very important that HIV services are sensitive to VAC issues and vice versa. Show the module objectives on slide 2.



2. Then divide participants into three groups, with no more than five people per group, and give them flip paper and assorted marker pens.



NOTE:

Note: If you have more participants, organize six groups and allocate the same question to two groups.

3. Ask the groups to discuss the following questions for 15 minutes – the questions are on slide 3.

- How might HIV lead to VAC?
- How might VAC lead to HIV?

SLIDE 3



GROUP DISCUSSION (15 MINUTES)

1. How might HIV lead to VAC?
2. How might VAC lead to HIV?

4. After 15 minutes, call participants back to plenary and ask a representative from each group to summarize their discussions for no more than 4 minutes per group.



ACTIVITY 2

VAC and HIV linkages: Vote with your feet (40 minutes)

1. Everyone move to a space in the room where everyone can move around. Make sure that there is an 'Agree', a "Neutral" and a 'Disagree' sign (or a simple tick or cross) on the wall or on the floor.



NOTE:

If the group is too big, split into 2-3 groups and conduct the exercise in 2-3 different spaces (e.g. breakaway room or pick different ends of the room).

2. Ask all the participants to stand in the middle of the room (where the "Neutral" sign is placed) and show them the 'Agree' and 'Disagree' signs. Say that you will read out a number of statements. After each statement, everyone should decide if they agree or disagree with the statement and then move to the relevant sign.
3. Read the first statement. Once people have moved, facilitate a discussion about why people chose the response they did. Allow some time for debate between people of differing viewpoints by asking each side to explain their view to the other side.



NOTE:

This exercise can stimulate strong feelings. Although the statements are intentionally 'neutral' and do not focus on highly personal perspectives, the exercise may stimulate discussion about values related to children's exposure to violence. This may be uncomfortable for some participants and can result in some participants feeling isolated if their values don't align with other group members or create feelings of negativity towards their peers.

It may also highlight concerns about roles and responsibilities and financial, human or time resource constraints.

Allow each person to express his or her thoughts without making a judgment about who is right or wrong. Note any significant concerns and ensure that, as facilitators, you are able to return to the concerns expressed in later sessions. If necessary, 'park' any significant issues.

6. After the exercise is complete, facilitate a group discussion using the following questions as a starting point.

- How did it feel to confront values that you do not share?
- What did you learn from this experience?
- Did you change your opinion about any of the issues?

7. Conclude the session by noting that the statements were designed to stimulate reflection on the necessity to 'think VAC' and be willing to address the issue in the HIV setting. You may want to note the following issues.

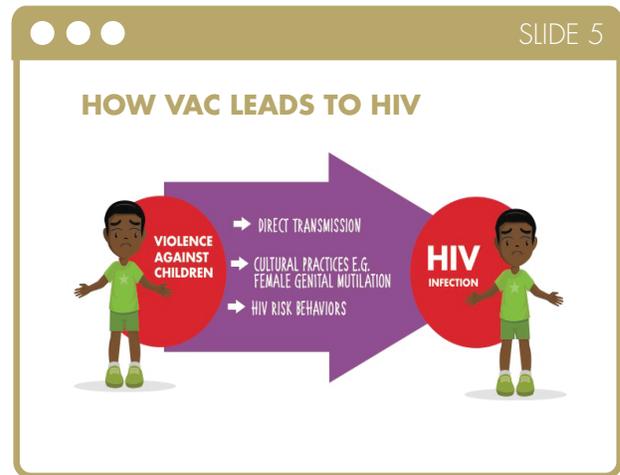
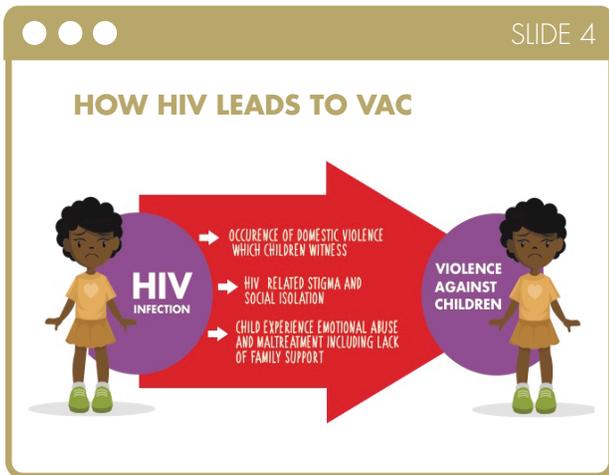
- It is important to consider our own values and beliefs and reflect if they can harm others or affect how they treat survivors. Changing mind sets takes time. But it is possible to change our beliefs and it is healthy to examine our attitudes and adjust them if necessary.
- If appropriate, based on the group discussion, remind people that child survivors are often acutely aware of their surroundings and can sense when someone has a negative opinion about them because of their beliefs. It is therefore important to be conscious of these beliefs as the main purpose is to minimize trauma and establish trust with the survivor and express the fact that you trust their choices and decisions.



ACTIVITY 3

PowerPoint presentation (20 minutes)

1. Show slides 4 to 7, which address the key messages on the relationship between VAC and HIV and the rationale for integrating VAC into HIV care. Briefly provide the key messages and encourage participants to comment or question based on their experiences.



SLIDE 6

RATIONALE FOR INTEGRATION OF VAC AND HIV

1. Global HIV policies and standards recognize that VAC is linked to HIV and the need to integrate VAC prevention and response into HIV services
2. Children who are at risk of or have experienced violence rarely disclose VAC, so it is important that health workers have the confidence to suspect and identify these children.
3. Healthcare providers regularly encounter child survivors of violence, in their routine practice but do not have the knowledge and skill on how to appropriately respond.
4. Available evidence shows that integrating VAC prevention and response into HIV services can improve HIV and other health related outcomes, health seeking behavior and partner communication (for adolescents).

SLIDE 7

"Inequality, a lack of empowerment and violence against women are human rights violations and are continuing to fuel new HIV infections. We must not let up in our efforts to address and root out harassment, abuse and violence, whether at home, in the community or in the workplace."

Michel Sidibé, UNAIDS Director, July 2018

2. Note any key concerns or issues that will have to be addressed during the rest of the workshop, relating to concerns that participants have about integrating the area of VAC into their work.



Wrap up and Take Away Message

- VAC is a known risk factor for HIV infection or worsened HIV outcomes.
- Similarly, HIV is a known risk factor for increased risk of violence amongst children.
- Integrating VAC prevention and response into HIV services can improve HIV and other health related outcomes, health seeking behavior and partner communication (for adolescents).



VAC and HIV linkages 'Vote with your feet' statements

Read the statements below. The suggested key talking points are highlighted below.

Statements:

1. HIV service providers have a responsibility to provide VAC services.

Talking points: Yes, HIV service providers do have a responsibility to provide VAC services. Programs within HIV settings have shown that HIV service providers regularly encounter child survivors of violence in their routine practice. Recognizing and being able to respond to VAC by offering, at a minimum, the basic VAC services and referral to more specialized support, can improve HIV and other health-related outcomes, health-seeking behavior and psychosocial outcomes.

2. Once a child survivor of violence discloses their experience he/ she must receive a comprehensive service from the health worker that they disclose to.

Talking points: No. A health care provider to whom a child has disclosed experience or imminent risk of violence is obliged to take action to ensure the safety of the child, in line with the four guiding principles when handling children. The health worker must offer the child first line support by listening to the child and offering them necessary support. The health worker's responsibility is then to ensure that the child receives a comprehensive service from qualified service providers, which will usually be provided by referral for other VAC response services.

3. Violence is a direct barrier to offering HIV services to children.

Talking points: Yes. Violence is a direct barrier to offering HIV services to children. Children and adolescents who are at risk or have experienced violence are likely to have difficulty accessing health services, including HIV services. They may be prevented from accessing services, are likely to be afraid to disclose and may be afraid of seeking care. Children and adolescents living with HIV who are enrolled into HIV treatment services and are experiencing violence may have lower ARV adherence and face other health issues because of the violence.

4. VAC prevention and response services can only be offered within health facilities.

Talking points: No. VAC prevention and response services involve multiple sectors, including those within health services, and the community players/stakeholders. Normally, most medical prevention and response strategies are offered within health facilities. Community also has a role in the prevention and response to VAC. Community-based services and other actors provide an essential role, including prevention and post-violence support through counselling, legal services, and interventions to address stigma and discrimination and support long-term recovery.

5. The best place to identify VAC is to focus on adolescent girl HIV services.

Talking points: No. Boys are vulnerable to, at risk of or have experienced all forms of violence, including sexual violence. VAC prevention and response services should target girls and boys, of all ages. In encouraging disclosure of violence amongst both girls and boys, more attention needs to be placed on boys, and boys and girls of younger ages because of they may struggle more to disclose HIV.

6. Key population HIV programs must always work with GBV and VAC services.

Talking points: Yes. Key population HIV programs must always work with GBV services. Key populations are at continuous risk of violence of any form, and as they access any HIV services, offering opportunistic GBV services would help address GBV. Literature shows there is interlinkage between GBV and HIV thus both services need to be offered concurrently.

7. Social workers and child protection teams should have ongoing linkages with HIV services.

Talking points: Yes. Social workers and child protection teams should have ongoing linkage with HIV services. Programs have shown the interlinkage between HIV and VAC, and these linkages would help identify children who are at risk or and have experienced violence, who would be accessing HIV services. By VAC identification at sites offering HIV services, social workers and child protection teams, either based within the site or working nearby, are able to offer support to children identified through health services and refer to other forms of VAC services. In most places, government social workers or managers are likely to be the main case manager of support for children experiencing violence.



4 **COMMUNICATION
SKILLS**

INTRODUCTION

Our communication style and attitude can influence the decisions of a child or caregiver to seek support and to remain in care. It is important that we, as providers, are able to build trust with the child, actively listen to the child and involve them in decisions made about their care.

OBJECTIVES

At the end of this module, the participant should:

- Be familiar with the different aspects of good listening to make the survivor feel more comfortable and believed;
- Understand the key approaches for appropriate communication with children who are at risk or have experienced violence;
- Practice techniques for communicating with children of different ages about sensitive issues.



Methods: Listening exercise, PowerPoint presentation and role plays.



Time: 2 hours



Materials: Laptop, projector, sticky notes, flip chart, marker pens



Preparations before session:

Activity 1: pin up two flip charts on the wall. One titled 'Negative listening skills (-)' and another titled 'Positive listening skills (+)'.

Activity 2: ensure that the two participants who are to play the demonstration are briefed.

Activity 2: print out the participant's role play scripts and facilitator's role play scripts.

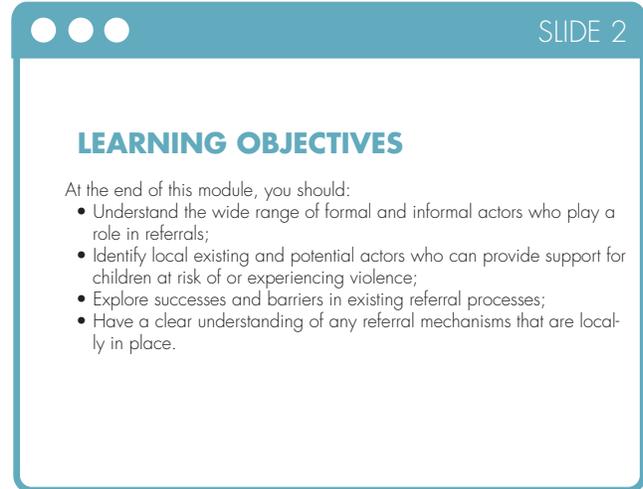
FACILITATION NOTES



Listening exercise (5 minutes)

1. Ask everyone to close their eyes give them the following instructions:

“Think back to a conversation you’ve had one to one. A conversation where something important was being discussed. It maybe any conversation with your boss, your significant other, a family member, a friend, a teacher one – the conversation doesn’t have to be about with an experience of violence. Think about one thing you recall that the other person did or said (verbal or non-verbal) that made you feel listened to or heard or at ease to express yourself.”



2. Allow around 1 minute for people to reflect. Then say:

“Now think of something you felt had the opposite effect – something a person did or said that closed you off, even if only momentarily. It was not conducive to an open conversation.”

3. Again, allow around 1 minute for people to reflect. Then say:

“OK, now open your eyes. On the top of one sticky, write a plus sign and write what the person did or said to make you feel listened to. Use a second sticky note, write a minus sign and write down what the person did or said that made you feel not listened to or closed off.

While I’m collecting them, keep thinking about the elements of good listening skills.”

4. Allow around 1 minute for people to complete the task, then collect the sticky notes.

5. Ask if anyone is comfortable to share what he or she wrote about a negative communication experience? (listen to up to three volunteers)

6. Ask if anyone is comfortable to share what you wrote about something that was positive in communication? (listen to up to three volunteers)



Communication skills demonstration (30 minutes)

1. Set up two chairs at the front of the room, set out in a way that promotes active supportive listening (i.e. using SOLER principles).

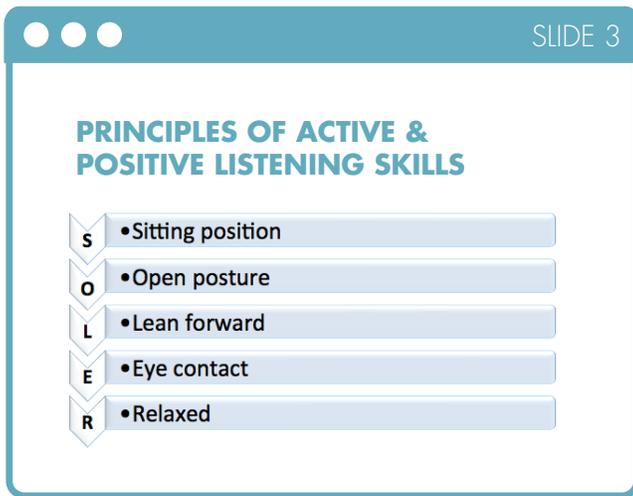
2. Two facilitators, or one facilitator and one participant who has been briefed prior to the session, simulate the scenario in Teaching Aid 2 below, to demonstrate how to apply SOLER principles of active listening. (5min)

3. After the demonstration, ask the participants to note any good communication practices they observed from the demonstration. Then ask them for areas that could be improved. (5 min)

4. Ask for two volunteers to replay the scenario in plenary, using similar principles. (5 min)

5. Once they have completed, thank them and ask for feedback from the other participants about good communication practices that were applied and any areas that could be improved. (5 min)

6. Show slide 3 and summarize the principles of active and positive listening skills



7. Explain that we will now all practice a short role play to practice SOLER.



Role play: Communication skills (35 minutes)

1. Give participants a copy of Teaching Aid 2, role plays.
2. Divide the participants into groups of three and ask each group to choose one person who will play the 'child' and one person will play the 'health worker'. The third person will act as the observer and will provide feedback to his or her team at the end of the session. Ask them to practice this. Allow no more than 15 minutes, including feedback from the observer.
3. Call participants back to plenary and ask the questions below (15 minutes):
"To the people who were 'Maria': How did you feel about your conversation with the health worker?"
4. Once several people have answered, ask further:
"Did you disclose abuse? If so, why? If not, why not? If you disclosed, how did this feel?"
5. Then ask: "To the people who were health workers, did you suspect violence? What made you suspicious about the possibility of violence? Did you find it difficult to ask about violence – if so why?"
6. Finally ask the observers what they noticed. Ask them to report on whether there was supportive verbal and non-verbal communication. Ask:
"How did health workers communicate or not communicate support?
What did you notice about the child's willingness to disclose her experience of violence – did she hesitate, or not?
What could the health worker have done better in the situation?"



ACTIVITY 4

Plenary Discussion: Alternative approaches for communicating with children (40 minutes)

1. Introduce the session by informing the participants that this activity will help them learn how to use alternative communication approaches when providing services to children who are unable to communicate verbally either due to age or disability.
2. Use the following case scenarios to generate discussions around the different approaches that can be used to communicate with children, using slides 4 and 5:
 - a. Lucy is a 10-year-old deaf girl who has been brought to your clinic with bruising all over her arms and legs. She is brought in by her school teacher who is concerned about the child's welfare but has no further clinical history. Discuss other approaches that you can use to communicate with Lucy
 - b. Mike is a three-year-old boy who has been brought into your clinic by his mother. As you examine him you notice unusual bruises on his belly and thighs. His mother says these were injuries after a fall. Discuss methods that you can use to take communicate with Mike to get further information.

SLIDE 5



ACTIVITY 4: CASE SCENARIOS

Mike is a three-year-old boy who has been brought into your clinic by his mother. As you examine him you notice unusual bruises on his belly and thighs. His mother says these were injuries after a fall.

What methods can you use to communicate with Mike to get further information?

3. Show slide 6 to recap tools for communicating with children at risk or are undergoing violence.

SLIDE 6

TOOLS FOR COMMUNICATING WITH CHILDREN

<p>FEELING CARDS OR PICTURES</p> 	<p>DRAWING</p> 
<p>STORYTELLING</p> 	<p>ROLE-PLAY AND DRAMA</p> 



Activity 5: Q&A Session (10 minutes)

Provide an opportunity for question and answers from the participants give any clarifications needed.



Wrap up and Take Away Message

- Effective communication and listening happens through a combination of verbal and non-verbal skills.
- Effective communication makes the speaker feel heard.
- Survivors of violence are often silenced by abusers, family members and others in the community – and even health care providers.
- By contrast, active and supportive listening allows survivors to be heard – an important step towards healing.
- Children who are too young to express themselves clearly verbally should be communicated to using alternative approaches that may include: feeling cards and pictures; role plays and drama; drawing and storytelling.



Communication demonstration and teaching point

Two facilitators act out the following roles for no more than 5 minutes, ideally around 3 minutes.



CHILD:

You are a 9-year-old girl called Maria and live with your father and step mother and 3 younger step children. Your step mother gives you a lot of housework, does not give you enough food and beats you when you fail to work in the house. Your other step siblings go to school, but you do not. Sometimes you sleep outside in the cold. Today you have been taken to the hospital by your step mother as you have been complaining of frequent headaches. This is your 3rd visit to the facility in the last 2 months.



HEALTH WORKER:

Maria is a 9-year-old girl who has come to the facility with complaints of recurring headaches. You have previously run tests with no evidence of disease that would cause the persistent headache. You notice that she is withdrawn and seems scared when you take her history.

Take the following communication tips into consideration while acting out the role play:

Effective communication tips

- SOLER – SOLER, Sitting position, Open posture, Lean forward, Eye contact, Relaxed
- Ask open-ended questions such as
 - o “Tell me about...”
 - o “What is it like when...” that start discussions,
- Avoid judging words like ‘right,’ ‘wrong,’ ‘bad,’ ‘good,’ and ‘enough.
- Show the child you are listening by saying things like “ok” or “mmm hmmm.”
- Allow the child to express their emotions — for example if they are crying, allow them time to cry.
- Don’t do other tasks while listening e.g. do not look at your phone or computer
- Don’t interrupt.
- Ask questions or gently probe if you would like more information.

Reassure the child using the following tips:

- “I believe you.” Builds trust
- “I am glad that you told me.” Builds a relationship with the child
- “I am sorry this happened to you.” Expresses empathy
- “This is not your fault.” Non-blaming
- “You are very brave to talk with me and we will try to help you.” Reassuring and empowering



**IDENTIFICATION
OF VAC IN HIV
CLINICAL
SETTINGS**

INTRODUCTION

Children who are at risk of or have experienced violence rarely directly seek help for the violence. Sometimes a child is taken to a health facility with a result of the violence. More commonly, the child will attend for another, unrelated health issue or will present with a violence-related issue such as headache or stomach pain, without saying that this is caused by violence.

Children may be afraid what could happen if they disclose abuse, especially if the abuser is a parent, caregiver, or other family member. Most children will feel embarrassed or ashamed to talk to anyone about it or may not be aware of the availability and importance of health services for violence. It is therefore important that health workers who routinely offer clinical care to children have the appropriate skills to observe and knowledge to ask the appropriate questions where they suspect possibility of child violence.

OBJECTIVES

At the end of this module, the participant should:

- Attain or increase skills to enable him or her to identify children who are at risk or are experiencing any form of violence.



Methods: Group discussion, PowerPoint presentation and role play.



Time: 1 hour 45 minutes



Materials: Flip chart, marker pens, masking tape, laptop, projector, copies of the CPET, role play scripts.



Preparations before session:

Activity 1: Set up stations with blank flip charts for documenting during the group discussion.

Activity 2: Ensure you have enough copies of the CPET tool for people to look at them; alternatively refer to the tool in the participant manual

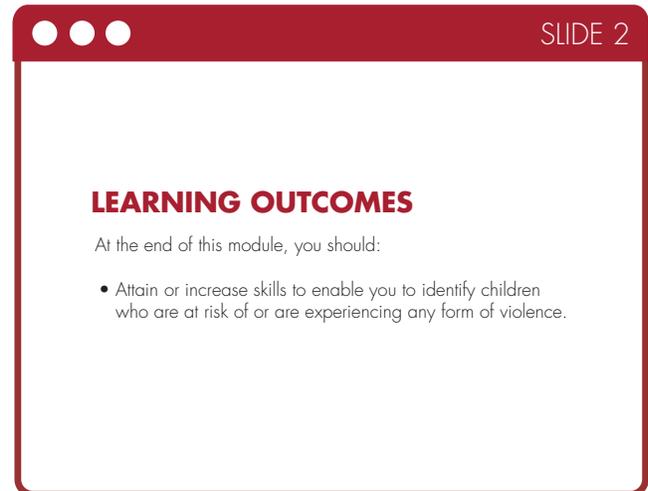
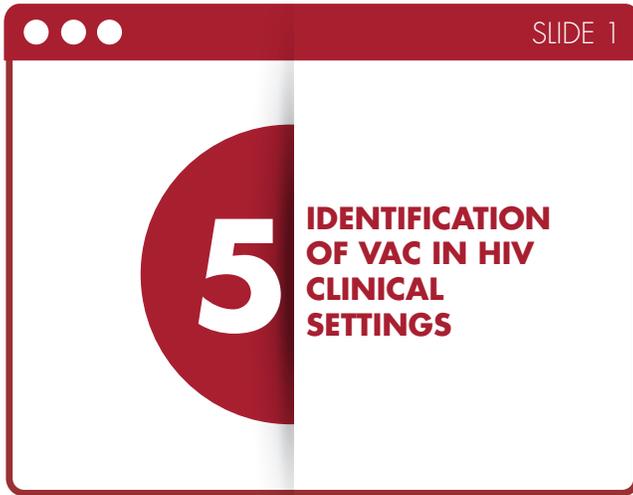
Activity 3: Print out the participant's role play scripts and facilitator's role play scripts (Teaching aid 3).

FACILITATION NOTES



Group discussion on disclosure of violence by children (10 minutes)

1. Introduce the module by showing slide 2, learning objectives. Then ask if anyone can explain what 'disclosure' is.



2. Show slide 3, which gives the definition of disclosure. Emphasize that children usually find it difficult to disclose their experiences of violence whether at school, home, playground etc.). Explain we will be looking at common reasons for non-disclosure by children who have experienced violence.



3. Divide the participants into groups of five to seven people. Provide each group with flip charts and assorted marker pens. Ask each group to discuss the questions below in 10 minutes (shown on slide 4)

SLIDE 4



DISCUSS (10 MINUTES)

What are the common reasons for children to disclose violence to health workers?

What are the common reasons for children to not disclose violence to health workers?

What are the common reasons for children to disclose violence to health workers?
What are the common reasons for children not to disclose violence to health workers?

4. After 10 minutes, call the groups back to plenary and ask two groups to briefly present their discussions. (10 minutes)



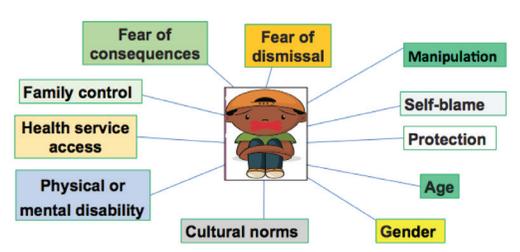
ACTIVITY 2

PowerPoint presentation (40 minutes)

1. Show slide 5, which illustrates some of the common reasons why children may not, or may, disclose VAC. (5 minutes) Be sure to add any reasons suggested by the group that are not on the slide. Make sure to emphasize the following facilitator notes below:

SLIDE 5

REASONS FOR NON-DISCLOSURE OF VIOLENCE BY CHILDREN



The diagram features a central cartoon child with a speech bubble. Ten boxes are connected to the child by lines, representing reasons for non-disclosure:

- Fear of consequences
- Fear of dismissal
- Manipulation
- Family control
- Self-blame
- Health service access
- Protection
- Physical or mental disability
- Age
- Cultural norms
- Gender



NOTE:

Facilitator notes:

It can be harder for boys to disclose sexual violence than girls.

It is often hard for girls to accept that coercion from a boyfriend is not 'normal' but is violence.

It may be hard for children to disclose possible violence in the presence of their parent or caregiver. They may be afraid. In some cases, the parent or caregiver may be the perpetrator or may feel unable to challenge the perpetrator.

You might think that you are helping the child feel more comfortable by having a supportive parent present, but more often the child will not tell us as much information about what happened. Children even as young as five years know that talking about abuse makes their mum sad or mad, so children often minimize what happened. They may say "he only touched me" and they don't tell the full story that they were also raped. Sometimes they may be too scared or ashamed to disclose the abuse at all. Thus the child won't receive the medical care, psychosocial support and protection that they need.

2. Show slide 6 and ask participants in plenary to briefly state what they can do to support children to disclose safely. (5 minutes)

SLIDE 6



What can you do in your workplace to support children to safely disclose violence?

3. Then show slides 7 and 8 to introduce the CPET tool (5 minutes)

SLIDE 7

INTRODUCTION TO THE CHILD PROTECTION ENQUIRY TOOL (CPET)

The CPET IS a tool that:

- is designed to help the health worker look out for and recognize signs that the child may be at risk of or has experienced violence, during a standard consultation;
- provides a set of simple questions that the healthcare providers can ask the child and/ or caregivers to ascertain whether the child requires referral for further violence support and services.

The tool was developed in response to request for tools to help explore potential violence. It is based on global child violence research tools. It has not been validated yet.

SLIDE 8

INTRODUCTION TO THE CHILD PROTECTION ENQUIRY TOOL (CPET)

- There are two tools: 0-5 years and 6-18 years.
- The 0-5 age group tool is delivered to caregivers.
- The 6-18 age group tool may be delivered to caregivers but ideally to the child, especially for adolescents.
- The 6-18 age group tool will be used differently for different ages:
 - The way the questions are asked will be different for different ages.
 - The answers will be provided differently for different ages.
 - The basic information that you want to find out will be the same, regardless of age.

4. Distribute copies of the CPET to the participants and use slide 9 to take the participant through each component of CPET. (10 minutes)

SLIDE 9



NOTE:

Emphasize that the questions are designed to be non-invasive and do not directly ask about type of violence. They are not for the health care provider to make definitive diagnosis on the type of violence but to indicate their suspicion of possible violence occurrence.

Any child who gives a positive response to any of the questions or observations should be offered appropriate referral for more specific diagnostic and test services by a trained health care provider.

REFER TO



PARTICIPANT HANDBOOK:
CPET

5. Explain the steps for administering the CPET using slides 10 and 11 and referring to the Participant’s Manual.

SLIDE 10

STEPS FOR ADMINISTERING THE CPET

1. Ideally, interview the child alone (if they are old enough)
2. Use all the techniques from Module 5 on SOLER, Sitting position, Open posture, Lean forward, Eye contact, Relaxed
3. Introduce yourself
4. Build rapport by talking to a child for a few minutes about school or who they live with, to make the child feel more comfortable with you
5. Explain the rules of the interview

SLIDE 11

STEPS FOR ADMINISTERING THE CPET

6. Transition to the open-ended questions about abuse
7. Stay silent if they don’t answer immediately
8. Only ask enough questions to know what medical treatment they need and whether they are safe to return home today
9. What to say when a child become quiet and they look afraid:
 - Acknowledge their fear
 - Explore their fear (sensitively)
 - Educate

6. Use slide 12 to discuss the key considerations for the introduction of CPET at the health facilities. (10 minutes)

● ● ●SLIDE 12

KEY CONSIDERATIONS FOR INTRODUCTION OF CPET AT HEALTH FACILITIES

Health facilities should introduce the use of the CPET ONLY after ensuring that health care providers:

- can provide child survivors safety, privacy and confidentiality
- have the appropriate attitudes and skills
- are able to offer immediate violence response services and appropriate referrals.

7. Use facilitator notes to summarize the session. (5 minutes)

**NOTE:**

Consultation rooms where child survivor’s history is taken should not be overheard by others. There should be policies in place at the health facility about who can access the survivor’s clinic records and when providers are allowed to disclose survivor information. Also there should be well trained staff who understand how to provide good reception, clinical assessment, immediate response and appropriate referrals to the survivor and be able to alert the receiving point, so as to prevent further abuse. A sensitive and supportive reaction by health care provider can help initiate the process of getting the child survivor out of the violent situation and begin the recovery process.

Also ensure that the child survivor is safe and any emergency condition is treated and structures of referral systems including referral directories and link the child to the nearest and affordable services where possible.



ACTIVITY 3

Role play (45 minutes)

1. Divide participants into groups of four people. Each group will be asked to use copies of CPET previously issued. Hand out the two role play scripts (Teaching Aid 3). One script is for younger children and one script is for older children. Divide the two scripts between the groups.
2. Ask the groups to identify three participants who will act as a “child”, “guardian/caregiver”, “health worker”, and each of them should use the script below to play their role.
3. Give 5 minutes to allow each participant to have a chance to practice as a health worker (30 minutes)
4. The fourth participant in the group will act as an observer and check whether the health worker is able to use the CPET appropriately

5. Convene the participants back to plenary and ask them to share the lessons learned from the role play exercise. (15 minutes) Ask the participants the following questions (slide 13):

- a. Was the CPET tool easy or difficult to apply?
- b. What challenges did you encounter while utilizing the tool?
- c. How would you overcome some of the challenges?
- d. What resources would you require in order to use the CPET effectively?

● ● ●SLIDE 13

ACTIVITY 3 FEEDBACK

- Was the CPET tool easy or difficult to apply?
- What challenges did you encounter while utilizing the tool?
- How would you overcome some of the challenges?
- What resources would you require in order to use the CPET effectively?



ACTIVITY 4

Q & A Session (10 minutes)

1. Provide an opportunity for question and answers from the participants give any clarifications needed
2. Use slide 15 to summarize the session on the CPET.

● ● ●SLIDE 15

SUMMARY OF THE CPET

- It can be used at any point of contact with child
- It can be used by different cadres of health care providers, as well as non-clinical service providers
- The questions in the CPET are deliberately designed to be general and non-invasive
- They are formulated to aid the healthcare providers get more details in cases where they suspect risk of or have experienced violence.
- Any child who gives a positive response to any questions in the tool should be appropriately referred for more specific diagnostic tests and services.



Wrap up and Take Away Message

- CPET can be used at any point of contact with a child and can be used by different cadres of health care providers, as well as non-clinical service providers
- The questions in the CPET are deliberately designed to be general and non-invasive; they are formulated to aid healthcare providers get more details in cases where they suspect risk or experience of violence
- Any child who gives a positive response to any questions in the tool should be appropriately referred for more specific diagnostic tests and services.



Role play script (0-5 years)



CHILD SCRIPT:

You are a 5 year old girl called Maria and live with your father and step mother and three older step children. Your step mother gives you a lot of housework, does not give you enough food and beats you when you fail to work in the house. Your other step siblings go to school but you do not. Sometimes you sleep outside in the cold. Today you have been taken to the hospital by your step mother for medical review.

- Act withdrawn, picking fingernails, fidgety
- Altered gait / difficulty in walking
- Bruise on the forehead, holding your arm



CLINICIAN'S SCRIPT:

You are attending to Maria in the consultation room. She has come for a medical review with her guardian. Engage with Maria and the guardian. Gather history and presenting issues then manage appropriately.



GUARDIAN'S SCRIPT (OFFENDING GUARDIAN) :

You are Maria's step mother accompanying her for medical review.

Act as follows while in the consultation room:

- Appear more concerned with what the clinician is doing with Maria
- Interject before Maria answers the clinician
- Appear intimidating – tone of voice
- Unsettled / nervous

Act like you are providing satisfactory responses for all questions asked by the clinician about Maria's health status

Role play script (6-18 years)



CHILD SCRIPT:

You are a 14 year old boy called Adam in an abusive family where both parents are in constant fights. Your classmates in boarding school have isolated you for being a bully and abusing drugs, a habit which was not there before. Lately, you were noted to be missing classes and the school matron observed bruises on your swollen face. You visit the clinic today for your HIV treatment refill.

Act as follows:

- You are adherent to treatment
- Revengeful, angry, irrational and irritable, unkempt
- Hesitate to share family indifferences
- Report being beaten



HEALTH WORKER'S SCRIPT:

You are attending to Adam in the consultation room. He has come for a medical review. Engage with Adam and gather history and presenting issues then manage appropriately.



**FIRST-LINE
SUPPORT
FOR VAC**

INTRODUCTION

First-line support provides practical care and responds to the child’s emotional, physical, safety and support needs, without re-traumatizing them or intruding on their privacy. Often, first-line support is the most important care that health workers can provide. Even if this is all the health worker can do, it will have greatly helped the client. First-line support has helped people who have been through various upsetting or stressful events, including children subjected to violence.

OBJECTIVES

At the end of this module, the participant should gain or improve:

- Knowledge and skills to be able to provide immediate, first-line support to children who are at risk of or have undergone violence.



Methods: Interactive lecture by PowerPoint presentation, role play.



Time: 1 hour 30 minutes



Materials: Laptop, projector, participant’s role play scripts, facilitator’s role play scripts.



Preparations before session:

Note: For this session, it is important for the facilitators to be familiar with existing safety protocols in government health facilities, for example in relation to gender-based violence, with national child protection laws and policies, and with any institutional safeguarding norms (see Child Protection and Safeguarding definitions below). It may be useful to bring in a social worker or child protection representative from the health facility or from social welfare sector to support the preparation and presentation of this and the following session, if such skills and knowledge are not already available in the facilitation team.

If there is already a referral flowchart for GBV that applies to children, or an existing child protection referral flow chart that is being used by participants or in your country or project, use the existing tool to substitute the sample flowchart used in this training; slide 5 will have to be adapted and a copy of the local referral guidance should be shared.



NOTE:

Definitions of child protection and safeguarding

Child protection is the act of preventing or responding to specific concerns about individual children or groups of children who are at risk of harm. It is the interventions taken to protect that child. A child protection system is the full set of components needed at national or program level to address the risks that all children face from abuse, violence, exploitation and neglect. Child protection is increasingly an explicit part of a government's laws and policies that set out the roles and responsibilities of all adults to ensure that children are free from harm.

Child safeguarding "is the responsibility that organisations have to make sure their staff, operations, and programmes do no harm to children, that is that they do not expose children to the risk of harm and abuse, and that any concerns the organization has about children's safety within the communities in which they work, are reported to the appropriate authorities." Keeping Children Safe definition. Keeping Children Safe has set the international norms and standards for ensuring that children are protected in all aspects of work. <https://www.keepingchildrensafe.org.uk/>

FACILITATOR'S INSTRUCTIONS:



ACTIVITY 1

Group discussion (30 minutes)

Set up stations in the room with blank flip charts and marker pens for documenting the group discussion.

1. Introduce the session, explaining the objectives of the session (slide 2).

SLIDE 2

LEARNING OUTCOMES

At the end of this module, you should gain or improve:

- Knowledge and skills to provide immediate, first-line support to children who are at risk of or have undergone violence.

2. Show slide 3 to introduce the key components of first line support (LIVES). Emphasize the following points:

- Listening is the most important part of good communication, and the basis of first-line support. It involves more than just hearing the child's words. It means:
 - Being aware of the feelings behind the child's words;
 - Hearing both what the child says and what s/he does not say;
 - Paying attention to body language – both the child's and yours – including facial expressions, eye contact, gestures;
 - Sitting or standing at the same level and close enough to the child to show concern and attention, but not so close as to intrude;
 - Showing understanding of how the child feels (empathy).

SLIDE 3

LIVES

- Listen** - Listen to the child closely, with empathy and without Judging
- Inquire** - Assess and respond to the child's needs and concerns
- Validate** - Show the child that you understand & believe them – don't blame them
- Enhance Safety** - Discuss a plan to protect the child from further harm
- Support** - helping connect the child & the caregiver to information, services & social support

REFER TO



PARTICIPANT HANDBOOK:
MODULE 5: HANDOUT 1:
THE FIVE KEY STEPS IN FIRST-LINE
SUPPORT

3. Remind people that the first three components: L, I, and V have been practiced in the previous module (Module 4: Communication skills). Ask for a volunteer to briefly summarize what L, I and V mean.
4. Show slide 4 and explain that this is possibly the most important role that any health worker can do if they feel that a child may be at risk of or experiencing VAC is to enhance the safety of that child.

● ● ●
SLIDE 4

E = ENHANCE SAFETY

- The most important thing is to make sure that the child is not placed in further danger immediately.
- The health worker should know when to provide immediate safety support and ensure safety

NOTE:

It is important in this session to emphasize that ‘identification’ is not confirmation of VAC. It is having a suspicion that something is ‘not quite right’ and acting on that.

All suspicion must be followed up by a more detailed consultation with someone who is experienced at discussing VAC. This may be a trained health worker or it could be a qualified social worker.

First-line response is not screening, nor responding to full disclosure.

‘Identification’ is making sure that a child who may be at risk is safe until a more detailed response is possible.

5. Before moving to the next slide, ask participants if they have been in such a situation, and ask what they did to ensure the safety of the child in that situation.

NOTE:

If there are a number of examples, encourage brief sharing but focus on the action that people took. The value of this contribution is to identify whether people are already making safety plans, so that the next slide can build on participants’ experience.

Make a mental note of any experiences that can illustrate the ‘E’ and ‘S’ aspects of LIVES, as illustrated in the following two slides.

6. Introduce the flowchart – this is shown on slide 5 and participants have a copy in their Participant’s Manual.

● ● ●
SLIDE 5

FLOWCHART TO ENHANCE SAFETY OF A CHILD AT RISK OF VAC

- When there is any doubt or suspicion, refer!
- Always have a referral focal point who can be contacted, with a support plan.
- Prioritize the child’s safety.
- The flowchart helps to be clear what should be done in all cases and what must be done when a person suspects that a child is at risk of severe harm or death.
- Must be locally adapted.



PARTICIPANT HANDBOOK:
MODULE 5: HANDOUT 2:
FLOWCHART FOR ACTION WHEN
VAC IS SUSPECTED]



NOTE:

If there is already a referral flowchart for GBV that applies to children, or an existing child protection referral flow chart that is being used by participants or in your country or project, use this tool, instead of the sample flowchart used here..

7. Ask participants to briefly review the flowchart with the person sitting next to them. Once they have had 2 minutes, ask if someone can explain how they think it can work. Refer participants to Module 6: Handout 2: Process chart for ensuring a child's safety.

8. Once one volunteer has explained their understanding, ask for any further explanations. After any discussion on the process, provide your own explanation and show slide 6 to summarize the key points.

SLIDE 6

ENHANCE SAFETY - SUMMARY

- The flowchart:
 - is not a screening tool
 - assists health worker to decide when to make an immediate referral to a VAC focal point or, if that focal point is not available, to a social worker.
- Whenever there is suspicion, report to the child protection focal point.
- Make sure that there are no negative consequences for child or family. Confidentiality is essential.
- The most important thing to help a child to be safe is to listen to the child, validate the child's experiences and ensure that the child has had the chance to say what she or he is comfortable saying. It is not necessary to encourage a child to disclose.
- Always have easy-to-access information for sharing with children, e.g. Child Helpline (116) if available and other sources of local support.



NOTE:

Note: The key points to highlight in the flow chart are:

- The flowchart helps to be clear what should be done in all cases and what must be done when a person suspects that a child is at risk of severe harm.
- The chart is not a screening tool. It encourages people to decide when to make an immediate referral to a VAC focal point or, if that focal point is not available, to a social worker.
- Whenever a person has a suspicion, they should make a report to the focal point for child protection. Often once a concern has been raised, further investigation shows that there is not a direct child protection concern. The person doing the investigation should make sure that there are no negative consequences for child or family. Confidentiality is essential.
- The most important thing to remember about helping a child to be safe is to listen to the child, validate the child's experiences and ensure that the child has had the chance to say what she or he is comfortable saying. It is not necessary to encourage a child to disclose.
- Always have easy-to-access information for sharing with children, including child helpline numbers if available and other sources of local support.

9. Show slide 7, explaining that this is the S in LIVES. Introduce the type of support that a child who is at risk or is experiencing violence may require and let the participants know that the next module will look into the importance of making effective referrals to the appropriate VAC services.

SLIDE 7

ENHANCE SAFETY - SUMMARY

- It is critical to connect a child who is at risk or is experiencing violence with other resources for her/his health, safety, and social support.
- Violence prevention and response requires a multidisciplinary response.
- These multidisciplinary services may be within the health facility and will always include some referrals to external service providers.
- Health care providers can help by discussing the child's needs with them and or their non-offending care giver telling them about other sources of help, and assisting them to get help if the child wants it.



ACTIVITY 2

Case study on LIVES (50 minutes)

1. Explain that the group will now practice 'LIVES', and especially the Enhancing safety and Support components. Remind the participants that the LIV component was comprehensively covered in Module 4: Communication skills but that they should still apply the LIV principles as they discuss the case.
2. Ask participants to look at the case study in the Participant Manual: Module 6, Case study 1.
3. Divide the participants into two groups and ask one group to go to Station 1 and the second group to move to Station 2. The questions are on slide 8.



NOTE:

Groups should be no more than 7 people maximum. If you have a large group, allow for more stations (this is also dependent on availability of a facilitator to lead the discussions).



Application of LIVES

Fatima is an 11-year-old orphan living with her guardians (Uncle and Aunt) with their 3 younger children. Her aunt gives her a lot of housework, does not give her enough food and beats Fatima when she fails to work in the house. Unlike her cousins, Fatima does not go to school. There are many instances where Fatima sleeps outside in the cold without food. Fatima's uncle has previously been abusing her sexually. She reported these acts to her Aunt who beat her, saying that she is lying and that her uncle cannot act in such a way. Fatima runs away from her guardian's home to the neighbor who offers to take her to the hospital because she is experiencing lower abdominal pains, pain while urinating, and headaches.

The health care provider listens to Fatima, and disregards her story saying that she is disrespectful to her guardians. Fatima is provided painkillers for the abdominal pains and the neighbor is advised to make sure Fatima gets back home.

Discuss:

- What concerns do you have with how Fatima was attended to at the health facility?
- What steps could be taken to ensure Fatima's safety?
- What steps could be taken to provide the appropriate social support to Fatima?
- Have you ever experienced a situation where a child's safety and support were not fully addressed? How could this situation be improved if it happened again?

4. Once the group has discussed for 20-30 minutes, ask for feedback in plenary.

5. At the end of the discussion, summarize the group discussion and affirm the content learned previously.



ACTIVITY 3

Q & A Session: (10 minutes)

1. Allow time for any question and answers from the participants give any clarifications needed.



Wrap up and Take Away Message

- Whenever you have a concern about a child's safety, remember LIVES.
- Have a focal person for contacting in case of any concern.
- If you have a concern that a child is facing risk to life or serious harm, keep the child safe and bring in support immediately.
- If in doubt, assume that a child is at serious risk and contact the focal point.
- Have a set of simple 'keeping safe' instructions for a child who may be at risk but does not appear to be in immediate harm.
- Ongoing referrals and support are essential. These will be looked at in the next session.



**RESPONDING
TO CHILDREN
WHO ARE AT
RISK OR HAVE
EXPERIENCED
VIOLENCE**

INTRODUCTION

This module provides information on the key responses needed to support children and seeks to help identify local sources of support. It does not give detail on intensive support to child survivors of violence, because this course is a simple introduction.

OBJECTIVES

At the end of this module, the participants should have explored:

- The role of different actors in provision of VAC services;
- The minimum requirement that any health facility must have in place to provide VAC prevention and response with;
- The commodity and supplies required by health facilities to provide VAC prevention and response services.



Methods: PowerPoint presentation and group discussion.



Time: 2 hours 30 minutes



Materials: Flip chart, marker pens, masking tape, laptop, projector, Module 7 Teaching Aid 4.



Preparations before session:

Activity 1: Set up stations with blank flip charts for documenting during the group discussion.

FACILITATION NOTES



Group discussion - Role of different actors in provision of VAC services (60 minutes)

1. Introduce the activity by informing the participants that it is aimed at helping them to understand the multisectoral nature of VAC services and the roles that the different actors play to ensure that children who are at risk or have experience VAC receive comprehensive services. Learning objectives are on slide 2.

SLIDE 2

LEARNING OUTCOMES

At the end of this module, you should have explored

- The role of different actors in provision of VAC services;
- The minimum requirement that any health facility must have in place to provide VAC prevention and response services;
- The commodity and supplies required by health facilities to provide VAC prevention and response services.

2. Divide the participants into groups of four to six participants. Provide each group with flip charts and assorted marker pens.

3. Distribute Teaching Aid 4: Minimum package of a multisectoral response to children who have experienced violence (on slide 3).

SLIDE 3

MINIMUM PACKAGE OF A MULTISECTORAL RESPONSE TO CHILDREN WHO ARE AT RISK OR HAVE EXPERIENCED VIOLENCE

Activity 1: Group discussion
In group of 4-6 using teaching AID 4; discuss the following questions

You will be asked to feed the discussion back to the whole group

4. Ask each group to discuss the questions below (on slide 4).

- Write down all the actors involved in the delivery of comprehensive VAC services, across the five components.
- If you can, divide these into preventive, immediate response and long-term across the five components.
- List the key services offered by each of these actors.

SLIDE 4

GROUP DISCUSSION 1

1. Write down all the actors involved in the delivery of comprehensive VAC services, across the five components.
If you can, divide these into preventive, immediate response and long-term across the five components.
2. List the key services offered by each of these actors.



Activity 2: Group discussion: Role of health workers in provision of VAC services (20 minutes)

1. On new flipchart ask the health workers to now think of their specific roles with their workstation and answer the following questions (10 minutes) (slide 5)

SLIDE 5

GROUP DISCUSSION 2

1. Who should be involved in provision of services in the health facility?
2. What are their roles and responsibilities?

2. Call the participants back to plenary and ask a representative from each group to summarize their discussions for 10 minutes.



Activity 3: Group discussion (60 minutes)

1. Introduce the activity by explaining that we will be looking at health facility requirements for VAC prevention and response services.



NOTE:

If the group is too big, split into 2-3 groups and conduct the exercise in 2-3 different spaces (e.g. breakaway room or pick different ends of the room).

2. Divide the participants into groups of individuals who are working in the same facilities, if possible.
3. Give each group Job aid 1 and 2 and ask them to review both and complete the checklists (35 minutes). (slide 6)

● ● ●
SLIDE 6

GROUP DISCUSSION 3

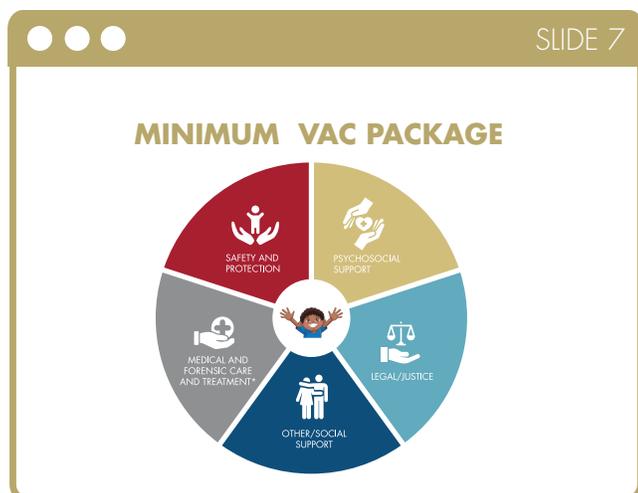
In your groups from same facilities, review EITHER

- Job Aid 1: Assessing VAC services readiness
- OR
- Job Aid 2: Checklist of equipment, medicines and other supplies for examination and care of children subjected to violence.

Feedback:

- How well is your facility prepared?
- What can you do to improve preparation?

4. In plenary, ask a representative from one group to summarize their discussions for Job Aid 1, noting:
 - How well is their facility/ies prepared?
 - What can they do to improve preparation?
5. After they have presented ask for others to comment. Then ask representative a different group to summarize their discussion for Job Aid 2 (Checklist of equipment, medicines and other supplies for examination and care of children subjected to violence). (Total 15 minutes)
6. Summarize the discussions by showing the key considerations for health facilities for integrating VAC prevention and response interventions into the HIV clinical settings.
7. Refer people to the minimum package (slide 7), as currently developed through global guidance. (10 minutes)





PARTICIPANT HANDBOOK:
HANDOUT 3 MODULE 7



Q & A (10 minutes)

1. Provide an opportunity for question and answers from the participants give any clarifications needed.



Wrap up and Take Away Message

- Health care service providers should have the ability and commitment to put child friendly values and beliefs into practice and to respond compassionately and comprehensively to children.
- The providers should consider multisectoral nature of VAC services and the roles that the different actors play, to ensure that children who are at risk or have experience VAC receive comprehensive services.

List the actors who have a role in the comprehensive response





MINIMUM PACKAGE OF SERVICES FOR VAC: SERVICES

For the actors that you have listed in the circle, note down the key services that they provide.

Well-being component	Preventive actions	Immediate response	Long-term response
Clinical & Forensic			
Safety & Protection			
Legal/Justice			
Psychosocial			
Other support			



**REFERRAL,
LINKAGE AND
FOLLOW-UP FOR
VAC SERVICES**

INTRODUCTION

This module provides an overview of all the different actors that play a role in supporting a child who is at risk of or experiencing violence. An effective referral system requires that each actor knows their roles and responsibilities and communicates clearly with other people in the referral system. A strong referral system requires that every health worker knows what support is available at different service delivery points within the health sector, and what support is available outside the health center. A strong referral system requires clear lines of reporting and documentation, to ensure that the child receives the necessary care.

OBJECTIVES

At the end of this module, the participant should:

- Understand the wide range of formal and informal actors who play a role in referrals;
- Explore what is already working well and areas for improvement in coordination of existing referral processes;
- Be familiar with any already existing referral mechanisms locally;
- Create a referral directory for supporting children at risk of or experiencing violence in his or her own workplace.



Methods: Role play, PowerPoint presentation and discussion, group work, group discussion,



Time: 2 hours



Materials:

Activity 1: Ball of string or wool, 10 character cards on paper (Teaching Aid 5).

Activity 2: Copies of the blank referral pathway worksheet (Teaching Aid 6), PowerPoint presentation.



Preparations before session:

Activity 1: Prepare character cards for the 10 different roles, with instructions written on front and back.

FACILITATION NOTES



Role play (45 minutes)

1. Introduce the module by explaining that this focuses on the next important aspect of responding to VAC – referring and following up so that a child receives the comprehensive services. The learning objectives are shown on slide 2.

SLIDE 2

LEARNING OBJECTIVES

At the end of this module, you should:

- Understand the wide range of formal and informal actors who play a role in referrals;
- Identify local existing and potential actors who can provide support for children at risk of or experiencing violence;
- Explore successes and barriers in existing referral processes;
- Have a clear understanding of any referral mechanisms that are locally in place.

2. Ask for ten volunteers to come to the front and form a circle. Ask one of them to volunteer to be in the center to play the role of a violence survivor. Ask the other group members to observe the role play from outside the circle.



NOTE:

Note to facilitator: If the group is larger than 20 people, you can divide the group into two smaller groups who both carry out the activity separately.

3. Give each volunteer in the circle a character card with instructions at the bottom as to what they are supposed to do – see Teaching Aid 5. Explain that the basic instructions are included but each person must play ‘in role’ and decide how they are going to respond, as realistically as they can.
4. Explain to the group that we are going to role play a situation where a child survivor is seeking support. Read out Rose’s story to the group.
5. Ask ‘Rose’ to stand in the centre of the room and the other nine characters form a wide circle around ‘Rose’. Make sure that the circle is large enough that everyone including observers can see and hear what is happening.
6. Give ‘Rose’ a ball of string or wool.
7. Ask ‘Rose’ to walk over to her ‘sister’ and explain to her sister what is happening to her. The volunteer playing Rose must think how ‘Rose’ might do this and play the role in character. When ‘Rose’ talks to her ‘sister’, she hands her sister the end of the ball of string or wool and wraps it around her finger. She must hold this until the end of the role play.
8. Ask the sister to respond to Rose, following the instructions on her character card.
9. When the ‘sister’ advises ‘Rose’ to talk to the community/religious leader, Rose takes the ball of wool or string (with the sister

still holding the end) and walks over to the community/religious leader. The ball of wool is handed to this person who, in turn, holds onto the thread, with Rose still holding the ball. Rose again explains her situation to the community / religious leader, who responds in character as instructed on the card.

10. The role play continues, with each character in turn holding the thread. Rose should keep the ball of red thread with her, but each time she goes to a new character, that person takes the end of the thread that is, by now, stretched from the sister to the religious leader, and so on.

11. By the end of the story, Rose has re-told her story to multiple people and should be standing in the middle of a tangled web of red thread.

This exercise should take about **30 minutes**

12. Reconvene in plenary and ask the group: **(15 minutes)**

- To Rose: How did you feel repeating your story multiple times?
- To other characters (select several in turn): How did it feel when Rose told you her story? Why did you decide to refer her to someone else?
- To the observers: How many times did Rose have to repeat her story?
- To everyone: The thread shows Rose's journey. What do you think about this?

13. Then ask the whole group:

- Is this situation realistic?
- What could be done to avoid the tangled web?
- What could be done so that Rose doesn't have to tell her story so many times?
- Do you have any other observations?



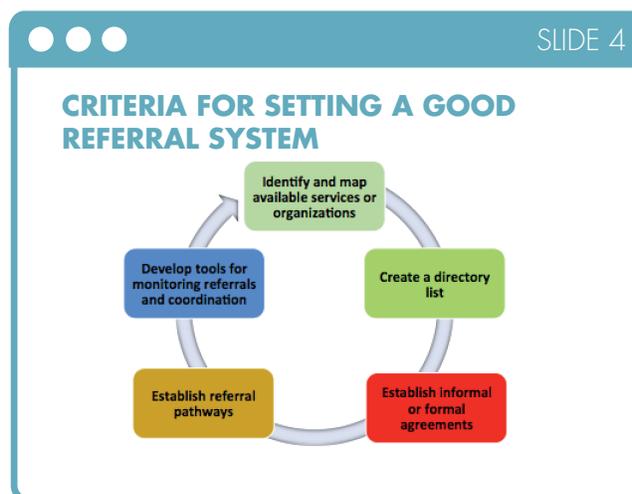
Activity 2: Developing a referral pathway (60 minutes)

1. Show slides 3 and 4 briefly and explain that we will now develop our own referral pathways.

SLIDE 3

WHY IS IT IMPORTANT TO HAVE AN EFFECTIVE REFERRAL PROCESS?

- A violence response requires interventions from multiple actors
- A referral process can enhance rapid access to multiple services
- The child is less likely to 'fall through the cracks' and get lost to the system
- A referral process enables a child to receive comprehensive services from different people who have different skills
- Can reduce stress and workload for individual service providers, if a referral process is well coordinated



2. Organize the participants into smaller groups with people who have come from the same health facility sitting together.



NOTE:

Note: If participants do not come from the same facility, or are not based within facilities, the facilitator can decide how to best organize the groups, or simply ask people to get into group of two or three people.

3. Hand out Teaching Aid 6: Referral pathway worksheet, one to each participant. Explain that they have some time to complete this sheet for themselves. They will take this sheet back with them to their work stations.
4. Before they start discussing in groups, check that they understand the task:
 - Step 1: Remind them of the 'LIVES' discussion – this person is the person that they must always report to in case of a safeguarding concern.
 - Steps 2 and 3: They should think of all current and possible sources of support across all different sectors.
 - Step 4: Identify the documentation that needs to be completed for different types of referrals.



NOTE:

Note: The facilitator should be familiar with existing referral procedures (including available referral forms). If there are no known local referral procedures, the facilitator can use Teaching aid 10 (Module 9): Sample referral and counter referral form.

5. Allow up to 60 minutes for them to complete their forms. Circulate around the groups – if people are struggling to complete the forms, ensure that they understand. If some people have no referral options, make a mental note and address this challenge in Activity 3.



ACTIVITY 3

Guided discussion (15 minutes)

1. Ask participants to come back to the plenary.
2. Lead a guided discussion, asking questions to elicit the following:
 - Get a snapshot of the wide range of referrals that people know of. If all participants are from the same area, you could ask for volunteers to briefly feedback the referral sources that they have identified;
 - Ensure that they have a named person for emergency child protection concerns – if not, discuss what actions need to be taken to raise these issues with their managers;
 - Discuss any challenges that they face in making referrals – for example, ask people to list the referrals that work for them and check if everyone is able to make similar referrals; if not, encourage the group to identify solutions.

3. If wished, complete the session by showing slides 5 to 7 that summarize the key elements of an effective referral. (This is not necessary if the group have already identified this together.)

SLIDE 5

PRINCIPLES FOR AN EFFECTIVE REFERRAL PROCESS

- Have one lead 'case manager' responsible for following the referral through
- Be clear why you are making the referral, and to whom, and for what
- Be sure that the required support can be provided at the referral point
- Ensure that the child or caregiver knows why and agrees to the referral being made
- Only refer to places that the client can get to
- Always get consent from the client before making the referral
- Referral or case management information system, that can confirm the referral has been made and track onward and counter-referrals

SLIDE 6

MAKING THE REFERRAL CHILD-CENTERED

- Always explain what you would like to do and why – a brochure is not enough
- Think of the child's best interests – respect a child's right to not seek the referral service; if there is a risk of harm to the child, explain why you are making a report
- Actively help the child access the referral
- Offer to make a call or contact the referral point on the child's/guardian's behalf
- Invite the referral person to the health center and introduce, if appropriate or escort the child if appropriate

SLIDE 7

MAKING A REFERRAL PATHWAY WORK FOR YOU

- Be clear who the lead case manager is (for you and for your institution)
- Get to know at least one individual at that service personally
- Be able to refer them by name in discussion with child/guardian
- Understand what is provided so you can tell child/guardian
- Maintain relationships through:
 - Regular meetings (e.g. child protection coordination forums)
 - Information-sharing and visits to each other's facilities
 - Hosting co-training



Wrap up and Take Away Message

- Violence requires interventions from multiple actors
- Be child-centered – ask, explain, support
- Always keep the child's best interests first – think safeguarding
- Support can come from multiple sources – both formal and community / informal

REFERRAL ROLE PLAY CHARACTER CARDS

The following cards should be copied out with the name on the front, clearly visible, and the description on the back, where only the individual playing that character can read it. One of each card should be given to the ten volunteers in Activity 1. Explain that the basic instructions are included but each person must play 'in role' and decide how they are going to respond, as realistically as they can. Other participants should observe the role play.



NOTE:

Note to facilitators: You can change any of the referral cards to reflect the local context.

<p style="text-align: center;">ROSE</p> 	<p>You are a 17-year-old girl who has been experiencing physical and sexual abuse from her boyfriend for the last 6 months. You don't know what to do</p>
<p style="text-align: center;">POLICE #1</p> 	<p>Rose comes to talk to you. Listen to her, talk to her and send her back to doctor/clinic #2. Doctor #1 is not available, so you must explain to her that no charges can be filed without medical proof.</p>
<p style="text-align: center;">SISTER</p> 	<p>Your sister Rose comes to talk to you. Listen to her, talk to her and then send her to the community/religious leader</p>
<p style="text-align: center;">DOCTOR/CLINIC #2</p> 	<p>When Rose comes to talk to you, listen to her, talk to her, take her history, perform a medical examination and send her back to police #2 with medical details</p>
<p style="text-align: center;">COMMUNITY/RELIGIOUS LEADER</p> 	<p>When Rose comes to talk to you, listen to her, talk to her and send her to the youth group for support.</p>

POLICE #2



When Rose comes to see you, listen to her, talk to her and send her to legal aid services

YOUTH GROUP LEADER



When Rose comes to see you, listen to her, talk to her and send her to the doctor/clinic for health care

LEGAL AID LAWYER



Ask Rose to tell her story, request all the documents for the case, prepare her case and make her practice telling her story in court again

DOCTOR/CLINIC #1



When Rose comes to see you, listen to her, talk to her and send her to Police #1 for the official medical reporting form

COURT



Welcome Rose and instruct her to re-tell her story at court

Steps for developing your referral pathways for care of children at risk of or experiencing violence

STEP 1

Identify focal point person for reporting all cases of VAC at your health facility.
(List name)

STEP 2

List the key entry points within your health facility where VAC cases are served.

STEP 3

List key players within other sectors that you will work with to ensure that child survivors of violence receives a comprehensive service.

Social Services

Community

Civil Society

STEP 4



COORDINATOR

Write down name and contact of the person in your health facility that will coordinate the VAC referrals and linkages

**STEP
4**

Step 4: List the roles and responsibilities for all the linkages that you can make directly between yourself and others.
Note all the forms that you may need to use

Name & function

Contact details

Form used for referral

Once completed and validated with colleagues, this can be your personal referral directory.
Keep a copy near your work station for ease of reference.



**DOCUMENTATION
AND REPORTING
OF VAC SERVICES**

INTRODUCTION

Health workers have an obligation to accurately record the details of VAC services and interventions offered to children survivors who present at health facilities.

OBJECTIVES

At the end of this module, the participants should be familiar with:

- The importance of documentation of VAC services;
- The tools used at health facilities to collect data from children who are at risk of or have experienced violence;
- Data quality assurance methods.



Methods: PowerPoint presentation, demonstration exercise.



Time: 1 hour



Materials:

Laptop, projector, Teaching Aid 7: Data collection tools (Client Information Form, VAC Register and VAC reporting Summary Form)



Preparations before session:

Activity 2: Set up stations with blank flip charts for documenting during the group discussion. Ensure there are enough blank copies of data collection tools.

FACILITATION NOTES



Activity 1: PowerPoint presentation (30 minutes)

1. Explain that this session focuses on ensuring consistent data collection, reporting and data quality assurance for VAC services. Learning objectives are on slide 2

SLIDE 2

LEARNING OUTCOMES

At the end of this module, you should understand the following:

- The importance of documenting VAC services that have been provided;
- Types of tools used at health facilities to collect data from children who are at risk of or have experienced violence;
- Data quality assurance methods

2. Show slide 3 to summarize the importance of documentation for VAC services.

SLIDE 3

DOCUMENTATION FOR VAC SERVICES

Provides estimate trends of the incidence and prevalence of VAC	Guides provision of appropriate follow-up care.
Aids the court in decision making.	NB: Information collected from the child at every service delivery point must be treated with utmost confidentiality and privacy.

Importance of Documentation

3. Show slide 4 to discuss the data collection tools for VAC services.

SLIDE 4

DATA COLLECTION TOOLS FOR VAC SERVICES

- Referral documents, e.g. client-held records, can be given to an older child or a trusted caregiver.
- Referral documents provide information to the service providers, e.g. social workers, regarding survivor follow-up and care.
- Any referral made should be followed up and referrals coordinated with other service providers to ensure that the child receives essential services beyond the health facility.

Emphasize the following points:

Referral documents, for example client-held records, can be given to an older child or a trusted caregiver. The referral documents provide information to the service providers, e.g. social workers, regarding survivor follow-up and care.

It is essential for any referral to follow up and coordinate with other service providers to ensure that the child receives essential services beyond the health facility.



Activity 2: Documentation demonstration (30 minutes)

1. Distribute samples of Teaching Aid 7: Client Information Form, VAC Register, VAC reporting Summary Form and Referral form.



NOTE:

Note that local tools should be used; the samples below in Teaching Aid 7, 8, 9 & 10 are samples only.

2. Ask a volunteer to first explain how to fill the client information form. Once explained in plenary, check that this is correct. Then ask for another volunteer to explain how to transfer the information into the VAC register and the VAC reporting tool. Ask another volunteer to explain how to fill the client referral form. Clarify any understanding.
3. Ask the participants form to groups of three to five participants and practice as below for 20 minutes.
 - a) Fill the client information form from Module 9, Activity 2 (Case study)
 - b) Fill the VAC register with data from the client information form; and
 - c) Summarize data from the VAC register.
 - d) Client referral form
4. Convene the participants in plenary ask them to share their experiences including the challenges faced while filling the VAC data tools. (20 minutes)

5. Show slides 5 and 6 to discuss the data quality assurance.

SLIDE 5

DATA QUALITY ASSURANCE – DQA (1)

- Information collected from the child during the consultation process should be accurate and complete in order for it to be useful for decision making.
- The processes is undertaken routinely by assigned personnel to ensure that the data is regularly audited and cleaned.

SLIDE 6

DATA QUALITY ASSURANCE – DQA (2)

1. Monthly data reviews of client documentation forms and the VAC register to ensure completeness and accuracy.
2. The corrective measures include data verification from source documents and data reconstruction where possible.
3. Continuous training of health care providers on importance of collecting quality data, maintaining confidentiality of data and protecting private and personal information.
4. Quality considerations in data management include completeness, correctness, timeliness, security and typing error.

6. Show slide 7 to discuss the storage of data.

SLIDE 7

STORAGE OF DATA

- Treat information collected with utmost confidentiality and privacy.
- Reassure the child and/or caregiver that the information will be kept safely
- Ensure the child's confidential and legal information is securely stored.
- Store files in a dry and safe place under lock and key.



Activity 3: Q & A Session (5 minutes)

1. Provide an opportunity for question and answers from the participants give any clarifications needed.



Wrap up and Take Away Message

- Proper documentation is important for decision making.
- Treat all VAC documents with utmost privacy and confidentiality



DATE:

CLIENT INFORMATION FORM

NAME:

AGE:

SEX:

LOCATION:

NATIONALITY

PARENT/GUARDIAN:

INSTRUCTIONS:

1. This form should be filled by a health care provider for all child survivors identified positive for violence upon use of CPET.
2. Information written on this form should not be diagnostic
Presenting complaint (This information should be as stated by the client/guardian)

DATE OF INCIDENCE (DD/MM/YY):

Observation (This information should be informed by questions in the CPET):

REFERRAL

YES

NO

DETAILS OF SERVICE PROVIDER:

NAME:

CADRE:

DATE:

DATE: _____

SAMPLE REFERRAL AND COUNTER REFERRAL FORM

Contact Person (If Known) And Name Of Organisation Referred To

Dear Colleague,

The client listed below has been a client of this Ministry/ organisation, and needs additional services. I am referring him / her to your organisation for the necessary support based on the background information provided below.

Please complete the attached feedback page and return it to me. Please contact me if required.

Client's surname:

First name:

Date of birth:

Sex:

Tel/Cell:

Contact of Client's Details (Physical Address):

Best way to reach client / family:

Contact Details Of Child's Parent / Guardian / Caregiver If A Minor

Name:

Tel/cell:

Address:

Details of the additional clients (adult / children concerned):

Surname:

First name

Date of birth

Summary of problems / issues:

Reasons for referral / recommendations or expected results:

These have been identified and discussed with client: Yes No

Other information that may be helpful to this referral:

Contact Details of Person Referring:

Name:

Contact details:

Signature:

Official date stamp

Referring organisation's details:

DATE:

I _____ (service provider receiving referral) _____, hereby acknowledge
the receipt of the referral for _____ (client's name) _____,
case number: _____ (if known) _____

for follow up services. We thank you for bringing this client to our attention.

Case is receiving attention and further investigations are being made:

We are able to, or have provided requested services:

Did not provide requested services because (explain in brief):

We value your interest in this client and sincerely appreciate your contribution to improving the lives of others.

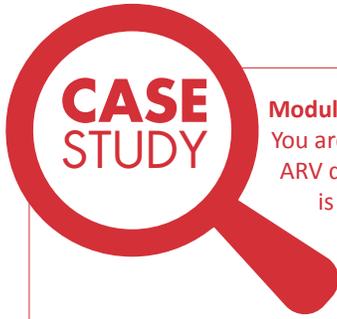
Yours sincerely,

Name of Staff / agency :

Signature:

Telephone number:

Official date stamp



Module 9, Activity 2

You are in the care clinic providing HIV services when Elena, a 14-year-old girl from Kawa location who picks her ARV drugs at your HIV clinic, entered the clinical room accompanied by her grandmother. You notice that she is sad, nervous and limping. After exploring further, Elena says that on 14th September at around 4.30pm on her way home from school she was attacked and sexually abused by her school mate John. You provide a first line support and refer her to the doctor for further medical management.



**SUPPORT FOR
VAC SERVICE
PROVIDERS**

INTRODUCTION

Health workers are often engaged in helping children who have experienced violence. Counselors do this on a day to day basis. Child survivors of violence share stories involving trauma or human suffering; stories that sometimes are difficult to forget about and can lead to burnout and in some cases secondary trauma.

OBJECTIVES

At the end of this module, the participant should learn about:

- Issues that service providers go through while providing VAC services;
- Mitigating secondary trauma, burn out and stress using debriefing sessions and other strategies.



Methods: Simulation, plenary discussion



Time: 1 hour



Materials: Facilitator simulation guide.



Preparations before session:

Activity 1: Ensure that the facilitators are briefed for the simulation.

Set up two stations with at least 8 chairs each arranged in a circle (if class has more than 20 participants, you can have additional groups).

FACILITATION NOTES



Activity 1: Simulation of a debriefing session to support workers

1. Introduce the activity by informing the participants that this session is aimed at learning how to conduct a debriefing session at your work place. (Using slide 1)

SLIDE 2

LEARNING OUTCOMES

At the end of this module, you should learn about:

- Issues that service providers go through while providing VAC services;
- Mitigating secondary trauma, burn out and stress using debriefing sessions and other strategies.

2. Using slide 3, introduce the concepts of secondary trauma.

SLIDE 3

SECONDARY TRAUMA

- Burnout ("All I do is work, I don't have a life.") – is a prolonged response to chronic emotional and interpersonal stressors on the job which consists of three components:
- Exhaustion
- Depersonalization (defined as: disengagement or detachment from the world around you) and Diminished feelings of self-efficacy in the work-place. It reflects a form of "energy depletion".

3. Divide the participants in groups of six to eight people. Ask them to move to into their groups and sit in a circle (no tables). Each group should include a facilitator or someone additional who has been prepared beforehand.
4. In each group, a facilitator welcomes the participants and asks them to put themselves into the shoes of a health worker at a heath facility who is attending a debriefing session. Many may have already done this!
5. Ask for a volunteer to share a difficult or stressful experience at work. (Remind the team of the confidentiality ground rule, but also reassure people that they do not have to share any experiences that they are uncomfortable to discuss. If they like, they can make up a situation.)

6. Ask the other participants to listen keenly and respond to the volunteer with reassuring messages.
7. If time allows you can take a second volunteer and repeat the process.
8. After 40 minutes, ask all the participants who shared their experiences how they feel right now. Then ask the other members to provide feedback. The facilitator then provides an opportunity to the participants to list the potential sources of support.
9. Refer people to Participant Manual Session 10 which provides more information about debriefing.
10. Thank everyone for actively participating and remind them to maintain confidentiality, then assure them of continuous support where one would want one-on one counselling.



Wrap up and Take Away Message

- It is common for service providers who provide VAC services, to experience secondary trauma.
- Debriefing and support supervision facilitates the following
 - Personal and professional development of the health care provider and helps relieve burnout.
 - The educative function supports the development of health care provider competencies.
 - Promotes provision of quality services



**WORKSHOP
CLOSING
SESSION**

INTRODUCTION

This session has been left open for facilitators to identify. The key activities to be included are listed below but should be delivered in locally appropriate ways.



Time: 1 hour



Materials: Post-test evaluation, evaluation sheets, certificates (optional).



Preparations before session:

Review the pre-test and ensure that there are enough blank copies of the same questionnaire for post-test.

Develop local evaluation resources for the workshop, according to your own requirements

Key activities to undertake

Post-test

The same tool should be used as for the pre-test in pre-session. Each person should have the same time. Ideally people will be fed back their results. The findings are used to address challenges.

Evaluation

This is an organization-specific evaluation of the overall workshop. A sample evaluation form is included in the annex: Workshop preparation tools

Next steps or action points (optional)

You may wish to include a short session on next steps if participants are representing organizations that need to further develop a referral or reporting mechanism, for example. This is an important time to revisit the parking lot.

Formal closure (e.g. certificates if wishes)

As decided by the facilitators and workshop organizers.



ANNEX: WORKSHOP PREPARATION TOOLS

WORKSHOP PREPARATION TOOLS

The following are suggested resources for workshop preparation.

Annex 1: Training resource checklist

ITEM	
Facilitator's manual	
Participant's manual	
Audio visual equipment – LCD projector, Lap top	
Participants registration form	
Name tags	
Training evaluation for both participants and facilitators	
Training checklist	
Pre and post-test questionnaire	
Flip charts	
Marker pens	
Sticky notes	
Maskig tape	
Cards	
A4 notebooks	
Flip chart stands	
Red string/wool	
Printing paper	
Flash disk for materials	

Coordinating Comprehensive Care for Children (4Children) is a five-year 2014-2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International and Westat.

