Massachusetts General Hospital & Luziibangi International Health School

WELCOME TO THE GBV WEBINAR SERIES

Promoting Dialogue on Gender-Based Violence Between Survivors and Heath Care Providers: Analyzing Interventions and Ethics of Care

Presenters:

Dr. Nalwadda Gorrette, PhD – Nurse Midwife

Dr. Ellen Robinson, PhD, RN – Nurse Ethicist

Moderator

Dr. Jesca Nsungwa, PhD

Massachusetts General Hospital
Founding Member, Mass General Brigham

Session Overview

- A practical, skills-building session focused on clinical recognition and immediate response to GBV
- This moves from understanding (Topics 1-2) to doing, that is, equipping healthcare providers with concrete tools to identify survivors and provide trauma-informed first response in SRH settings
- Apply a ‘principle-based’ ethical lens to enhance understanding in assessment and intervention in gender-based violence

Session objective

- Identify physical and emotional indicators of gender-based violence in clinical settings
- Apply the '*WHO LIVES*' framework to GBV screening and response
- Demonstrate trauma-informed approaches to clinical assessment and documentation
- Navigate Uganda's referral pathways and clinical guidelines for GBV survivors
- Apply ethical frameworks to guide survivor-centered decision-making

Gender-Based Violence: A Healthcare

- GBV is a violation of human rights and a critical public health issue
- 1 in 3 women worldwide experience physical or sexual violence
- Healthcare settings are often the first point of contact for survivors
- Healthcare providers play a crucial role in:
  - Identification and early intervention
  - Providing compassionate, trauma-informed care
  - Connecting survivors to resources and support

Violence in the family

Intimate partner violence (Physical, Sexual, Psychological and emotional, Economic)

Non-partner violence (Physical, Sexual, Psychological and emotional, Economic)

Violence against the girl child (violence related to exploitation; non-spouse violence)

Harmful practices

- Early/Child marriage
- Forced marriage
- Pre-natal sex selection
- Female infanticide
- Female genital mutilation
- Dowry-related violence
- So called 'honour crimes'
- Violence against widows
- Acid violence
- Inheritance related violence
- Witchcraft and sorcery related violence

Violence against domestic workers

Violence in the community

Sexual violence by non-partners (rape/sexual assault)

Femicide

Sexual harassment and violence in public spaces/institutions

- Violence in schools
- Violence in the workplace
- Violence in public spaces
- Technology-facilitated violence

Trafficking in women and girls

Violence against women and girls related to climate change

Violence perpetrated /condoned by duty bearers or at societal level

Custodial violence

Conflict-related sexual violence

Sexual and gender-based violence in crisis settings (during and in the immediate aftermath of conflict, or following natural disasters, etc.)

Sexual and gender-based violence in refugee/internally displaced persons (IDPs) camps

Sexual Exploitation and Abuse

Violence against women in public life, including during political activities, elections, or in exercising public functions

Violations of women's sexual and reproductive health and rights

WHO LIVES Framework for GBV Response

- L - Listen actively and empathetically without judgment
- I - Inquire about needs and concerns, assess safety
- V - Validate survivor's experiences and feelings
- E - Enhance safety through safety planning
- S - Support by connecting to services and resources

Recognizing Physical Indicators

- Injuries inconsistent with explanation provided
- Pattern- Injuries in various stages of healing
- Injuries to head, neck, face, chest, abdomen, or genitals
- Pregnancy-related trauma (abdominal injuries in pregnant women)
- Frequent visits with vague or chronic complaints
- Delayed seeking of medical care for injuries
- Evidence of sexual assault or unwanted pregnancies

Behavioral & Emotional Indicators

- Anxiety, depression, or fearfulness
- Avoidance of eye contact or defensive body language
- Partner who insists on being present or answers for the patient
- Excessive apologizing or minimizing injuries
- Suicidal ideation or self-harm
- Social isolation or restricted communication

SRH-Specific Presentations

- Repeat STIs despite reported monogamy
- Late initiation of antenatal care
- Contraceptive sabotage (requests for covert methods)
- Unwanted/unintended pregnancy
- Requesting termination with partner resistance
- Chronic pelvic pain
- Sexual dysfunction

Digital Violence Indicators

- Anxiety when phone rings/messages arrive
- Partner monitors phone/social media
- Recent social isolation online
- Mentions of online harassment/threats

Recognizing the Red Flags: A Case Vignettes Discussion

Identifying Red Flags in Clinical Practice

Case Study 1: The Frequent Visitor

Amina, 28, presents to the antenatal clinic for her 5th visit this trimester with vague complaints of headaches and abdominal pain. Clinical findings are normal. She appears anxious, avoids eye contact, and asks detailed questions about clinic operating hours. When asked if everything is okay at home, she quickly changes the subject. Her husband is waiting outside. What red flags do you notice? What would be your next steps?

Key Red Flags & Discussion Points:

- Frequent visits with non-specific complaints (possible help-seeking behavior)
- Anxiety and avoidance of eye contact (psychological distress)
- Deflection when asked about home situation
- Partner waiting outside (potential control/monitoring)
- Questions about clinic hours (safety planning/seeking safe time to disclose)

Case 1: Recommended Approach

- Create a private, safe space away from the partner
- Use gentle, open-ended questions: 'How are things at home?'
- Apply LIVES framework - Listen without judgment
- Validate her feelings: 'It's okay to feel anxious. You're safe here.'
- Provide information about support services discreetly
- Document observations objectively in medical records
- Respect her autonomy - she decides next steps and timing

Case Study 2: The Unexplained Injuries

Grace, 32, arrives with her 6-year-old daughter who has a fractured arm from 'falling from a tree.' Grace has bruises on her neck in various stages of healing and winces when sitting down. The daughter is quiet and clings to her mother. Grace declines social worker referral, saying 'We're fine, we just need the arm treated. 'What indicators of GBV are present? How do you balance treating the immediate injury with addressing potential violence?

Key Red Flags & Discussion Points:

- Inconsistent injury explanation (fracture from tree fall)
- Bruises in various stages of healing (repeated trauma)
- Grace's pain with sitting (possible sexual or physical assault)
- Child's behavior (possible witnessing of violence)
- Immediate decline of support services (fear, control, or lack of awareness)

Case 2: Recommended Approach

- Treat the child's immediate medical needs with compassion
- Speak with Grace separately about her injuries if possible
- Mandatory reporting considerations for child protection
- Use trauma-informed language: 'I'm concerned about your safety and well-being'
- Provide written information about support services (discreet card/pamphlet)
- Document all injuries objectively with body maps
- Follow-up appointments to maintain contact and build trust

Case Study 3: The Controlled Patient

Sarah, 24, comes for family planning services. Her partner insists on accompanying her into the consultation room and answers most questions directed at Sarah. When asked about contraceptive preferences, her partner interrupts: 'We've already discussed this—she wants the injection.' Sarah nods but appears uncomfortable. She's wearing long sleeves despite hot weather. What concerns does this scenario raise? How would you create space for a confidential conversation?

Key Red Flags & Discussion Points:

- Partner controlling the consultation (coercive control)
- Partner answering for the patient (reproductive coercion)
- Patient's discomfort and passive agreement
- Long sleeves in hot weather (possible concealment of injuries)
- Denial of patient's autonomy in reproductive decisions

Case 3: Recommended Approach

- Establish clinic policy: 'For privacy, we speak with patients alone'
- Create opportunity for confidential conversation
- Screen for reproductive coercion: 'Do you feel pressured about contraception?'
- Explore her preferences and concerns in private
- Assess for other forms of control or violence
- Provide information about her reproductive rights
- Offer multiple contraceptive options she can control discreetly

Immediate Clinical Response

Emergency Priorities (First 72 Hours)

1. Treat Injuries

- Assess and manage wounds
- Pain management
- Refer severe injuries appropriately

2. Pregnancy Prevention

- Emergency contraception (up to 120 hours, most effective within 72 hours)
- Options: Levonorgestrel, Ulipristal acetate, Copper IUD
- Pregnancy test if indicated

Immediate Clinical Response

3. STI/HIV Prevention

- HIV PEP (within 72 hours, ideally <24 hours)
- STI prophylaxis (gonorrhea, chlamydia, trichomonas)
- Baseline STI testing
- Hepatitis B vaccination

4. Mental Health Support

- Screen for acute distress, suicidality
- Provide crisis counseling
- Offer mental health referral

5. Pregnancy Management

- If pregnant: assess for ongoing risk
- Discuss pregnancy intentions
- Increased ANC frequency for monitoring

Clinical Documentation Best Practices

- Use objective, descriptive language (avoid judgmental terms)
- Document patient's own words in quotation marks
- Use body maps to record location, size, and type of injuries
- Note injuries in various stages of healing
- Record behavioral observations (affect, demeanor)
- Document all assessments, interventions, and referrals made
- Maintain strict confidentiality - secure storage
- Note if documentation is for potential legal use

Safety Assessment and Planning

Immediate Safety Questions

- Is it safe to go home today? Is your partner/perpetrator at home now? Do you have somewhere safe to go? Are children at risk? Has violence increased recently? Are there weapons in the home?

Danger Assessment

- Escalation of violence frequency/severity; Threats to kill, Access to weapons, Strangulation attempts (high lethality indicator); Forced sex; Substance abuse by perpetrator; Obsessive jealousy/stalking

Safety Assessment and Planning

Safety Planning Components

- Safe place: Identify where to go in emergency
- Safe person: Someone to call/stay with
- Emergency bag: Documents, money, clothes, medications (if possible to prepare secretly)
- Code word: Signal to friends/family for help
- Children's safety: Plan for children
- Exit strategy: How to leave safely
- Phone safety: Delete call/message history, use friend's phone
- Digital safety: Change passwords, check device for tracking apps

Safety Assessment and Planning

Context-Specific Considerations

- Rural vs. urban access to services
- Economic dependence realities
- Cultural/family pressure
- Legal system accessibility (remember: 2.9% conviction rate)

Referral Pathways and Multidisciplinary Response

1. Health Services

- Ongoing medical care
- Mental health/counseling
- Specialized trauma services

2. Legal Services

- Police (local stations)
- Legal aid organizations
- Protection orders
- Court accompaniment

3. Shelter/Safety

- Safe houses/shelters
- Temporary accommodation
- Relocation assistance

4. Social Support

- Counseling services
- Support groups
- Economic empowerment programs
- Child protection services

Includes: Health, Psychosocial, Security& Protection, Legal/Justice, Economic Reintegration support

Referral Pathways in Uganda

- Healthcare Facilities: Medical treatment, PEP, emergency contraception
- Police (Family Protection Units): Legal protection, investigation
- FIDA-Uganda: Free legal aid and representation
- SafiNet Uganda: Psychosocial support and counseling
- Probation and Social Welfare Officers: Social support
- Local Council Courts: Community-level conflict resolution
- Know your district-specific resources and contact information

Trauma-Informed Care Approach

- **Safety**: Create physically and emotionally safe environment
- **Trustworthiness:** Be transparent and consistent
- **Peer Support:** Connect to survivor support groups where available
- **Collaboration:** Work with survivor as partner in care
- **Empowerment**: Support survivor's choices and voice
- **Cultural Sensitivity:** Respect cultural context and beliefs

Overcoming Barriers in Uganda's Context

Stigma: Normalize screening, maintain non-judgmental stance

Limited Resources: Know available services, be creative with safety planning

Confidentiality Concerns: Ensure privacy, explain limits

Provider Training Gaps: Seek continuing education, peer support

Cultural Norms: Balance respect for culture with human rights

Time Constraints: Brief screening tools, prioritize safety

Provider Self-Care & Vicarious Trauma

Recognize signs of compassion fatigue and burnout

Establish boundaries between work and personal life

Seek supervision and peer support regularly

Practice stress-reduction techniques (mindfulness, exercise)

Access mental health support when needed

Remember: You cannot pour from an empty cup

Key Takeaways

The first response matters profoundly - how we respond determines if survivors seek further help or retreat into silence

Recognition requires awareness - physical injuries are only one indicator; behavioral and SRH patterns are equally important

LIVES provides a framework for survivor-centered response - but must be adapted to cultural context and individual circumstances

Immediate clinical care saves lives - EC, PEP, STI prophylaxis within 72-hour window

Safety first, always - clinical care without safety assessment puts survivors at risk

Documentation serves multiple purposes - medical care & legal evidence

No one can do it alone - effective response requires functional referral

Provider wellbeing matters - you cannot pour from an empty cup

Application of a ‘principle-based’ ethical lens to enhance understanding in assessment and intervention in gender-based violence

Goal: Apply a ‘principle-based’ ethical lens to enhance understanding in assessment and intervention in gender-based violence

DESCRIBE THE FOUNDATIONS AND ROLE OF ETHICAL PRINCIPLES

REVIEW DEFINITIONS OF EACH PRINCIPLE

IDENTIFY INSTANCES FROM ONE'S PRACTICE WHERE ETHICAL PRINCIPLES MIGHT BE HELPFUL IN PROVIDING CLARITY.

The Nature of Ethical Principles: What Are They?

Broad rules for determining human conduct towards others

Reflections of what is valued in a given society

Normative rules about conduct or action

e.g. If we believe autonomy is important then we should, all things being equal, promote autonomous action

The Work of Ethical Principles: How Do They Help in GBV?

- Identify salient issues
- Clarify important factors
- Reveal underlying assumptions
- Offer a language to explain emotions
- Affirm appropriate actions

How can principle-based ethics help with ethical problems that accompany GBV?

- Ethical principles that reflect our primary values can provide a mechanism to illuminate complicated ethical questions in GBV prevention and care.
- Beauchamp and Childress's book *Principles of Biomedical Ethics*, first published in 1979, became an important initial step to framing and guiding ethical decision making in health care, and has applications in GBV.

Principle	Value
Autonomy	self-determination
Beneficence	doing good
Nonmaleficence	anticipating and/or avoiding harm
Justice	fair treatment

Ethical Principles in Healthcare & Public Health Practice

Autonomy	• Veracity (truthfulness) • Confidentiality
Non-maleficence	
Beneficence	• Fidelity
Justice	

Autonomy

A complex principle - the right to determine one's own actions is based on:

Human ability to reason

Capacity for personal decision-making

Possession of personal goals

Self-knowledge

Civilized society's respect for individual human dignity and self-worth

Underlies informed consent, privacy and confidentiality

Is always a 'more or less' rather than an absolute condition

Application of Autonomy in Prevention & Care Management of GBV:

- Respect for girls and women:
  - Agents of their own self-determination and bodily autonomy
  - Ability to set goals and build a life around achieving their goals
  - Right to refuse infringement upon actual & threat of body/mind/space and be assured of community/legal processes that support their refusals
- Role of health/public health professionals:
  - Creating community spaces where voices of girls & women are cultivated, heard and respected
  - Create clinic/hospital environments where care is delivered that respects & restores autonomy (LIVES framework)

In addition to Autonomy….

Veracity

Truthfulness supports patient autonomy

Cultivates trusting relationships with health care/public health professionals

Facilitates respect for persons and their decision-making abilities

Confidentiality

The rule that respects the privacy of a patient's personal and medical information

In GBV, recognizes the stakes that a female is up against in pursuing justice for self in community and legally, and aims to facilitate such pathways with their utmost safety in mind

Overriding Autonomy in GBV Care

Examples to consider (STD & pregnancy testing; deter patient from returning to setting with pervasive GBV; consideration of woman's statement of preference & need to explore vs. accept at face value)

- Purpose of Overriding:
  - To exercise autonomy in the future
  - Regain clarity of thinking
  - Protect a vulnerable person from the consequences of ill-considered actions/Incapacity to exercise autonomy
- Considerations
  - Fear
  - Safety
  - Confidentiality

Non-Maleficence (Do no harm)

- Professional competence - knowledge and skills to:
  - Foresee consequences
  - Trauma Informed approaches to GBV patients is required ethical care and ‘harm reduction’ strategy. Patient enters the system ‘harmed’ and health professionals engage first steps to reduce, rather than intensify that harm
- Accountability
- Advocacy (prevent harm from others)
- Good result outweighs foreseeable harms

Beneficence (Promote a 'good' for persons)

- Goals of nursing, medicine & public health professionals are to 'do good'.
- Best Interests of patient *are primary*
- Can potentially conflict with autonomy in care of GBV scenarios
- Paternalism/Maternalism
- Professional knowledge & discernment are required

In addition to Beneficence…

- Fidelity
  - Remain faithful to professional commitments
  - Trustworthiness
  - Perseverance and follow through, i.e. LIVES ‘warm handoff’

Justice

(viewed as fairness – John Rawls 'Veil of Ignorance')

- Fair allocation of goods and services
- Respect and equality for all
- Inequity follows the disadvantaged
- Appearances of 'advantage' don't necessarily protect from GBV (*Casting couch in Hollywood; Epstein scandal). Continue awareness of 'injustices' related to gender roles across continents, cultures and socio-economic realms*)
- As health/public health professionals caring for GBV- prevent future undue burdens

Egalitarianism (Theory of Justice)

- Equal and fair start in the race of life
  - This is not actualized in the world for a number of reasons included but not limited to poverty, male dominated structures, education, cultural-ethnic influences, effects of war
  - A ‘good society’ will aim to equalize opportunity for life flourishing
  - Refugee settings, even with best of intentions preclude guaranteed respect, safety and bodily/psychosocial autonomy for girls and women, further disadvantaging them
  - Think of the myriad ways that flourishing (intellectual, psychosocial, spiritual) is impeded for girls and women affected by GBV

Ethical Considerations When caring for Patients with sexual violence histories

Confidentiality

- Protect the identity of survivors
- The sensitive and often dangerous nature of GBV cases.

Avoid Re-traumatization

- Do not further traumatize the survivor.
- Sharing personal details requires careful consideration of how they will be used and interpreted.

Ethical Considerations When caring for Patients with sexual violence histories

Systemic Issues

- Highlight systemic barriers to justice, such as when a police officer records a survivor's statement inaccurately because it was given in a native language and the officer is writing it in English

Power Dynamics

Don't not reinforce power imbalances or victim-blaming narratives.

- It is important to consider the power dynamics between the clinician and the participant and the potential for exploitation.

Intervention & support

- Advocate for effective interventions
- Provide training to community members on how to respond to and reduce GBV

Summary

- Ethical principles and concepts can illuminate and guide in ethically challenging GBV situations
- Developing knowledge and facility in utilizing these principles in team discussions can enhance shared understandings about infringed upon values and behaviors that result in GBV
- Articulation of a shared position using ethics terminology may facilitate action and policy in the fight against GBV

QUESTIONS & DISCUSSION

Thank you for your commitment to ending GBV

Connect With Us

Luziibangi International Health School

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In Partnership with:

Harvard Medical School - Division of Gynecological Oncology

Massachusetts General Hospital

Strength and Serenity Project to End GBV

Website: www.massgeneral.org

Massachusetts General Hospital
Founding Member, Mass General Brigham